No. 17-1994

IN THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims
No. 16–649C
Before the Honorable Thomas C. Wheeler

BRIEF FOR APPELLEE

August 21, 2017

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CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, Counsel for Appellee certifies the following:

1. Full name of Party represented by me	**2. Name of Real Party in interest (Please only include any real party in interest NOT identified in Question 3) represented by me is:**	**3. Parent corporations and publicly held companies that own 10% or more of the stock in the party**
Moda Health Plan, Inc.	None	Moda, Inc.

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (and who have not or will not enter an appearance in this case) are:

Covington & Burling LLP.

Dated: August 21, 2017

/s/ Steven J. Rosenbaum
Steven J. Rosenbaum

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STATEMENT OF RELATED CASES

1. No other appeal in or from the same civil action or proceeding in the lower court was previously before this or any other appellate court.

2. Cases pending in this Court or any other court that will directly affect, or be directly affected by, this Court's decision in the pending appeal include the following:

This Court designated the pending appeal in *Land of Lincoln Mutual Health Insurance Co. v. United States*, No. 16-1224, as a companion to this appeal and ordered that the two appeals be assigned to the same merits panel. An appeal in a third risk-corridors case, *Blue Cross and Blue Shield of North Carolina v. United States*, No. 17-2154, was docketed on June 14, 2017, and an appeal in a fourth risk-corridors case, *Maine Cmty. Health Options v. United States*, No. 17-2395, was docketed on August 7, 2017.

The following cases pending before the Court of Federal Claims are related cases within the meaning of Federal Circuit Rule 47.5(b):

- *Alliant Health Plans, Inc. v. United States*, No. 16-1491C (Braden, J.);
- *BCBSM, Inc. v. United States*, No. 16-1253C (Coster Williams, J.);
- *Blue Cross and Blue Shield of Alabama v. United States*, No. 17-347C (Campbell-Smith, J.);
- *Blue Cross and Blue Shield of Kanas City v. United States*, No. 17-95C (Braden, J.);
- *BlueCross BlueShield of Tennessee v. United State*s, No. 17-348C (Horn, J.);

- *Blue Cross of Idaho Health Service, Inc. v. United States*, No. 16-1384C (Lettow, J.);
- *Common Ground Healthcare Cooperative v. United States*, No. 17-877C (Sweeney, J.);
- *EmblemHealth, Inc. v. United States*, No. 17-703C (Wheeler, J.);
- *Farmer v. United States*, No. 17-363C (Campbell-Smith, J.);
- *First Priority Life Ins. Co. v. United State*s, No. 16-587C (Wolski, J.);
- *Health Alliance Medical Plans, Inc. v. United States*, No. 17-653C (Campbell-Smith, J.);
- *Health Net, Inc. v. United States*, No. 16-1722C (Wolski, J.);
- *Health Republic Ins. Co. v. United States*, No. 16-259C (Sweeney, J.);
- *HPHC Ins. Co., Inc. v. United States*, No. 17-87C (Griggsby, J.);
- *Medica Health Plans v. United States*, No. 17-94C (Horn, J.);
- *Minuteman Health Inc. v. United States*, No. 16-1418C (Griggsby, J.);
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- *Neighborhood Health Plan, Inc. v. United States*, No. 16-1659C (Smith, J.);
- *New Mexico Health Connections v. United State*s, No. 16-1199C (Bruggink, J.);
- *Ommen v. United States*, No. 17-712C (Lettow, J.);
- *Sanford Health Plan v. United States*, No. 17-357C (Bruggink, J.).

STATEMENT OF THE ISSUES

1. Whether the Court of Federal Claims correctly held the Government liable for violating its money-mandating obligation, under the Affordable Care Act (ACA) Risk Corridors Program, to pay Moda a specified portion of the losses the Company suffered in 2014 and 2015.

2. Whether the Court of Federal Claims correctly held the Government liable for violating its contractual obligation to make Risk Corridors Program payments to Moda.

STATEMENT OF THE CASE

A. Summary of the Dispute

The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 ("ACA") extended health insurance to millions of uninsured and underinsured Americans. The ACA presented a straightforward offer: if an insurer would agree to provide "Qualified Health Plans" ("QHPs") through the ACA "Health Benefit Exchanges," the Government would under Section 1342 make "Risk Corridors" ("RC") payments covering a specified portion of any insurer losses during each of the first three years of operation (calendar years 2014-16).

Plaintiff Moda Health Plan, Inc. ("Moda") chose to participate and incurred losses, but the Government paid Moda only 16 percent of the money owed for 2014, and nothing for 2015. Moda seeks the shortfall, asserting Government breach of statutory and regulatory obligations (Count I) and implied in fact contractual commitments (Count II).

The Government raises five defenses: the ACA was by design "budget neutral," limiting the amount of RC payments to insurers suffering losses to the amount collected by the Government from profitable insurers; no payment is due because there purportedly is no applicable appropriation; appropriations riders adopted by Congress for FY 2015 and 2016 vitiated the Government's obligations; Moda and the Government did not enter into a contractual relationship; and any

RC payments owed were not due annually (although even under the Government's theory, they are due by the end of 2017).

Judge Wheeler rejected each, holding:

- "Section 1342 is not budget neutral on its face," and HHS regulations indicate that "HHS itself does not believe the [RC] program to be budget neutral." Appx23-26.

- Section 1342 is "clearly money-mandating" and "there is an appropriation" to meet the Government's obligations: "[t]he Judgment Fund pays plaintiffs who prevail against the Government" in Tucker Act claims, and "constitutes a separate Congressional appropriation" available to meet payment obligations under Section 1342. Appx17, 33. Moreover, Congress appropriated $3.6 billion to CMS Program Management for FY 2014, and an additional $750 million for the first two-and-a-half months of FY 2015, which were available to make RC payments and are "more than enough to cover HHS's 2014 [and 2015] [RC] obligations to Moda." Appx25, 27 n.13.

- Although the appropriations riders restricted HHS from using certain subsequent FY 2015 and 2016 "funds appropriated to…the 'Centers for Medicare and Medicaid Services-Program Management' account," they "d[id] not expand the limitation to other sources of funds," and "did not reduce the obligation of the Government" to make RC payments. Appx31, 33.

- "[T]he ACA created an implied-in-fact contract with insurers like Moda under which the Government owed Moda RC payments if (1) Moda sold QHPs on the Exchanges and (2) those QHPs were lossmaking." Because "Moda sold QHPs and suffered losses," the Government "breached the contract by failing to make full [RC] payments as promised." Appx39.

- "[T]he text of Section 1342, its reference to the Medicare Part D program, and the Section's function together mean that Congress required HHS to make annual [RC] payments." Appx20.

B. Counterstatement of the Facts

1. The ACA and the RC Program

The ACA created in each state Health Benefit Exchanges[1] through which qualified individuals can purchase QHPs from insurers (also known as "issuers"),[2] and provided Government subsidies to assist low-income individuals purchase such coverage, via premium tax credits and cost-sharing subsidies.[3]

An insurer considering ACA participation lacked reliable information regarding the likely future health expenses of the as yet unknown population of enrollees. Moreover, the ACA prohibited insurers from addressing that uncertainty

[1] ACA §§ 1311, 1321, 42 U.S.C. §§ 18031, 18041.

[2] A QHP is insurance that provides "essential health benefits" as defined in the ACA; complies with provider network adequacy standards; follows cost-sharing limits; and has been certified by an Exchange. ACA § 1301, 42 U.S.C. § 18021.

[3] ACA §§1401, 1402; 45 C.F.R. §155.305(f), (g).

by excluding or requiring higher premiums from individuals based on health status or medical history.[4]

To induce insurer participation despite this considerable uncertainty, ACA Section 1342 established a RC Program, to be in effect each of the first three years of ACA operations. The RC Program encouraged insurer participation in the Exchanges and "permit[ted] issuers to lower [premiums] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013).

Such a risk premium would have dramatically increased Government outlays for premium subsidies and tax credits. A dollar reduction in premiums can save the Government more than a dollar in tax credits.[5]

Under the RC Program, if an insurer's annual "allowable costs" — *i.e.*, its actual costs of providing enrollee benefits — are between 103 and 108 percent of the "target amount" — *i.e.*, the plan's premium revenue minus administrative costs

[4] ACA § 1201(2)(A); 42 U.S.C. §§ 300gg-1 - 300gg-5.

[5] *E.g.*, CMS, Alaska: State Innovation Waiver under Section 1332 of the PPACA (July 11, 2017) (HHS's waiver approval based on proposition that a 20% reduction in premiums will result in a 22% reduction in federal tax credit expenditures), *available at*: https://www.cms.gov/CCIIO/Programs-and-Initiatives/State-Innovation-Waivers/Downloads/Fact-Sheet.pdf; State of Alaska Waiver Application, at 63 (Dec. 30, 2016), *available at*: https://www.commerce.alaska.gov/web/Portals/11/Pub/Headlines/Alaska%201332%20State%20Innovation%20Waiver%20June%2015%202017.pdf?ver=2017-06-26-091456-033.

— the Government must pay the insurer 50 percent of the amount by which allowable costs exceeded 103 percent of the target amount. § 1342(b)(1)(A), (c)(1). If an insurer's annual allowable costs are more than 108 percent of the target amount, the Government must pay the insurer 2.5 percent of the target amount, plus 80 percent of the amount by which allowable costs exceeded 108 percent of the target amount. *Id*. §1342(b)(1)(B). In short, if an insurer is unprofitable, the Government must make RC payments reducing (but not eliminating) the insurer's losses.

Conversely, a sufficiently profitable insurer must make payments to the Government, *see* ACA §1342(b)(2).

2. HHS Regulations Assure Full RC Payments

In March 2012, HHS promulgated final RC Program regulations. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,251-52 (Mar. 23, 2012) (codified at 45 C.F.R. Pt. 153, Subpart F). The regulations confirm that unprofitable insurers "***will receive payment*** from HHS in the [prescribed RC formula] amounts," which "HHS ***will pay*** [to the] issuer," 45 C.F.R. § 153.510(b) (emphasis added).

HHS subsequently published in March 2013 its final rule setting forth benefit and payment parameters for 2014, the first operational year of the Exchanges. In the preamble, HHS confirmed: "The [RC] program is not statutorily

required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. This was the only pertinent HHS statement, other than the regulations themselves, prior to the QHPs going into effect January 1, 2014.

3. HHS Action Placing Additional Reliance upon the RC Program

The ACA mandated that all insurance plans in the United States meet new scope of benefits and other requirements effective January 1, 2014, unless "grandfathered" by being in effect in 2010 when the ACA was enacted and not subsequently changed materially. ACA § 1251, 42 U.S.C. § 18011; ACA § 1255; *see also* 45 C.F.R. § 147.140. ACA enrollees would thus include both the previously uninsured and those previously enrolled in non-ACA compliant plans.

However, reacting to public outcry when non-ACA compliant plans began to terminate, the Government in November 2013 — a date long after QHP premiums had been set and policies sold for 2014 (*see* n.6 *infra*) — announced a federal "transitional policy" under which non-grandfathered plans "will not be considered to be out of compliance with the [ACA's] market reforms," and encouraged state agencies to adopt the same policy, which most states did. Appx428-441. Thus, many individuals who had previously passed medical underwriting, and were

considerably healthier than the uninsured population, maintained their existing insurance and did not enroll in QHPs.

This transitional policy reduced ACA enrollment and skewed the QHP pool toward sicker individuals. For example, over thirty percent of Oregon small group plan enrollees in 2014 were covered by non-ACA compliant plans allowed to exist due to the transitional policy. Appx447.

HHS recognized that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014." Appx428-441. But HHS expressed confidence that "the [RC] program should help ameliorate unanticipated changes in premium revenue," *id*., and changed the RC formulas to provide increased payments to insurers facing losses. Appx445-447. Although initially promised to last only a year, Appx429, HHS later extended the transitional policy for the entire three-year RC Program, Appx448-462.

4. The Appropriations Riders, and HHS's Limited Payments

After Moda's 2014 QHPs had been in operation for nearly the entire calendar year,[6] and the Company had obtained approval for and sold its 2015 QHPs,[7] Congress in December 2014 inserted into the HHS FY 2015 appropriations

[6] Moda in July 2013 obtained Alaska and Oregon approvals for its 2014 QHPs and premiums, Appx7, and began selling Plans on October 1, 2013, with coverage effective January 1, 2014, *see* 45 C.F.R. §155.410(b), (c).

[7] Moda in August and September 2014 obtained Alaska, Oregon and Washington approvals for its 2015 QHPs and premiums, Appx463-502, and began selling Plans (continued…)

bill a rider providing: "None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used" for RC payments. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2491 (2014). The same rider was included in the FY 2016 HHS appropriations bill. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2624 (2015). Congress did not then, or ever, amend or repeal Section 1342.

On October 1, 2015, HHS announced it would only pay unprofitable insurers out of what it collected from profitable insurers, resulting in a prorated rate of 12.6 percent for 2014. Appx244. HHS acknowledged "that the Affordable Care Act requires the Secretary to make full payments to issuers," and that it was "recording those amounts that remain unpaid [as an] obligation of the United States Government for which full payment is required." Appx245.

Amounts collected in 2015 were applied to outstanding obligations for 2014, resulting in another 3.4% payment of the 2014 amount, and nothing for 2015. Appx545-547. Overall, HHS owed $8.69 billion in RC payments to

on November 15, 2014, with coverage effective January 1, 2015, *see* 45 C.F.R. § 155.410(e).

unprofitable insurers for 2014 and 2015 combined ($2.87 billion for 2014 and $5.82 billion for 2015). Appx504, 508-539, 675 n.6. Profitable insurers owed $456 million in RC collections ($362 million for 2014 and $94 million for 2015). Appx503-507, 675 n.6. The Government owed Moda $89,426,430 for 2014 and $133,951,163 for 2015, but only paid $14,254,303 for 2014 and nothing for 2015, leaving a $209,123,290 shortfall. Appx508-539.

SUMMARY OF ARGUMENT

The Government violated clear-cut statutory and regulatory duties, and breached contractual obligations, entitling Moda to an award of the RC shortfall. The Government's efforts to avoid its obligations are without merit.

1. The RC Program is not "budget neutral." The ACA unambiguously dictates that the Secretary "***shall pay***" RC payments to unprofitable insurers pursuant to statutory formula, with no hint that such payments are limited to receipts from profitable insurers. The statute is unambiguous and the inquiry should end there.

HHS's implementing regulations are entitled to *Chevron* deference if the ACA is deemed ambiguous. They unambiguously provide that unprofitable insurers "***will receive payment*** from HHS in the [prescribed] amounts," which "HHS ***will pay*** [to the] issuer," without reference to amounts received from profitable insurers. HHS provided additional unambiguous assurances in its

subsequent preamble to additional ACA regulations: "The [RC] program is not statutorily required to be budget neutral." Full RC payments will be made "[r]egardless of the balance of payments [to unprofitable insurers] and receipts [from profitable insurers]."

In sharp contrast, HHS made explicit that the two other ACA "market stabilization" programs, Reinsurance and Risk Adjustment, ***are*** budget neutral, and adopted regulations and formulas that so provide.

The Congressional Budget Office (CBO), Government Accountability Office (GAO), and HHS itself have each rejected the Government's litigation-driven "budget neutral" interpretation.

2. The Tucker Act provides a complete remedy where the Government has made an unfettered promise of payment under a money-mandating statute or regulation. The only necessary appropriation is the permanent, indefinite Judgment Fund. In any event, additional programmatic appropriations were available to make RC payments.

3. Congress's subsequent enactment of HHS appropriations riders did not vitiate Moda's statutory rights or affect the CFC's authority to award the RC payments to which Moda is statutorily entitled. Appropriations riders are presumed ***not*** to impact pre-existing substantive law; an intent to do so must be "clearly manifest" from the rider itself. The riders only blocked the use of

specified HHS annual appropriations to make RC payments. Substantively indistinguishable appropriations riders have consistently been held insufficient to meet the "clearly manifest" standard.

4. Moda's contract claim arises out of the Government's quid pro quo promises of RC payments in return for Moda's myriad commitments to provide ACA insurance coverage. These dealings created a binding contractual commitment, which the Government then breached.

5. RC payments for 2014 and 2015 are past due. The Government contention that payment is only due later in 2017 is wrong, but that disagreement will soon be mooted.

ARGUMENT

I. THE RC PROGRAM IS NOT BUDGET NEUTRAL.

A. Section 1342 Did Not Create a Budget Neutral RC Program.

Section 1342 is unambiguous: "the Secretary ***shall pay***" RC payments to unprofitable insurers, pursuant to fixed statutory formula. ACA § 1342(b)(1) (emphasis added). That obligation is unrelated to the extent to which the Government receives RC payments from profitable insurers whose plans met the criteria of Section 1342(b)(2). The statute's language is clear, and that is where the statutory interpretation "begins [and] ends." *Puerto Rico v. Franklin Cal. Tax-Free Tr.*, 136 S. Ct. 1938, 1946 (2016). Section 1342's placement in a subsection

entitled "payment methodology" (Brief for Appellant ("Gov.Br.") at 18) is unremarkable and has no bearing on its plain meaning.

B. The Government's Interpretation Is Inconsistent with the Purpose of the RC Program.

Courts "cannot interpret federal statutes to negate their own stated purposes." *New York State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973); *see also Holloway v. United States*, 526 U.S. 1, 9 (1999) (rejecting interpretation that would "exclude from the coverage of the statute most of the conduct that Congress obviously intended to prohibit"). These principles led the Supreme Court to reject an ACA statutory interpretation that, although "natural," would eliminate tax credits for insurance purchased on federally-established Exchanges, creating "the very 'death spirals' that Congress designed the Act to avoid." *King v. Burwell*, 135 S.Ct. 2480, 2493 (2015).

The RC Program existed to encourage insurers both to participate and "not [to] add[] a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." 78 Fed. Reg. at 15,413. But no protection from market uncertainties would be provided were RC payments contingent on the complete uncertainty whether other ACA insurers would be sufficiently profitable to cover the amounts owed to unprofitable insurers. Such an interpretation is at war with RCs' very purpose. *Cf. Thompson v. Cherokee Nation*, 334 F.3d 1075, 1088 (Fed. Cir. 2003) (rejecting HHS statutory interpretation providing discretion to limit

appropriations as "directly contrary to the purpose of…remedy[ing] the consistent failure of federal agencies to fully fund tribal indirect costs"); *American Paper Inst. v. American Elec. Power Serv. Corp.*, 461 U.S. 402, 421 (1983) (refusing to "imput[e] to Congress a purpose to paralyze with one hand what it sought to promote with the other").

C. HHS Regulations Confirm the Government's Payment Obligations.

Tasked by Section 1342(a) with "establish[ing]. . . a program of [RCs]," HHS adopted regulations providing forthrightly that unprofitable insurers "***will receive payment*** from HHS in the [prescribed RC formula] amounts," which "HHS ***will pay*** [to the] issuer. . . " 45 C.F.R. § 153.510(b) (emphasis added).

These unambiguous HHS regulations are the ***only*** HHS pronouncements entitled to *Chevron* deference (*i.e.*, deference to an agency's "reasonable" construction of a statute) should Section 1342 be found ambiguous. *See Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361, 1365 (Fed. Cir. 2005). The Government's disavowal of *Chevron* deference, although framed as a concession, represents a veiled effort to escape the regulations' legal effect. If the ACA is deemed ambiguous, *Chevron* deference ***would*** apply, to the pellucid HHS regulations.

HHS buttressed its regulations with March 2013 preamble language confirming that "[t]he risk corridors program is not statutorily required to be

budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. This preamble language constitutes the *only* additional pertinent HHS statement prior to the ACA's January 1, 2014 effective date, and thus relevant to real world decision-making. "While language in the preamble of a regulation is not controlling over the language of the regulation itself, we have often recognized that the preamble to a regulation is evidence of an agency's contemporaneous understanding of its proposed rules." *Wyo. Outdoor Council v. US Forest Servs.*, 165 F.3d 43, 53 (D.C. Cir. 1999) (citations omitted).

D. In Contrast, Reinsurance and Risk Adjustment Regulations *Are* Budget Neutral.

RCs, Reinsurance and Risk Adjustment comprise the "3Rs" market stabilization programs, and are set forth sequentially in the ACA (§§ 1341-43) and in the same Part of the ACA regulations (45 C.F.R. Part 153). Unlike the RC Program, Reinsurance and Risk Adjustment[8] ***are*** explicitly budget neutral, *see* 45 C.F.R. § 153.230(d) (if "reinsurance payments requested. . . will not be equal to the amount of all reinsurance contributions collected. . . , HHS will determine a uniform pro rata adjustment to be applied to all such requests"); HHS Notice of

[8] Reinsurance spreads the cost of very large insurance claims across all insurers. Risk Adjustment transfers funds from insurers with healthier enrollees to those with sicker enrollees. Appx396 n.20.

Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) ("[r]isk adjustment payments [to plans with sicker than average enrollees] would be fully funded by the charges that are collected from plans with lower risk enrollees (that is, transfers . . . would net to zero").

Indeed, HHS explained that "[t]he [RC] program is not statutorily required to be budget neutral" in the very same preamble explaining that the risk adjustment methodology provides a "budget neutral revenue redistribution among issuers," C*ompare* 78 Fed. Reg. at 15,473 *with id*. at 15,441.

E. Other HHS Pronouncements Neither Receive Deference Nor Support the Government.

RC regulations can only be altered through subsequent notice and comment rulemaking, which HHS has never done. *See Perez v. Mortg. Bankers Ass'n*, 135 S. Ct. 1199, 1206 (2015) ("agencies [must] use the same procedures when they amend or repeal a rule as they used to issue the rule in the first instance."). The various HHS statements the Government cites cannot overcome the non-budget neutral RC regulations.

Furthermore, these HHS statements only addressed ***when*** insurers are to receive full RC payments, assuring unprofitable insurers that they are entitled to receive full RC payments. *E.g.*, Appx505-507 ("HHS recognizes that the [ACA] requires the Secretary to make full payments to issuers, and [therefore] HHS is recording those amounts that remain unpaid following our 12.6% [pro rata]

payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required."); *see also* p. 11 *supra*. The *Land of Lincoln* court clearly erred in suggesting that HHS concluded the opposite, *see Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 107-08 (2016), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016).

F. The CBO Supports Moda.

Reliance on the CBO to discern Congressional intent (Gov.Br.20-21) is misplaced: "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent." *Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009). ***In any event,*** CBO explicitly endorsed the position advanced by Moda here:

> By law, risk adjustment payments and reinsurance payments will be offset by collections from health insurance plans of equal magnitudes; those collections will be recorded as revenues. As a result, those payments and collections can have no net effect on the budget deficit. ***In contrast, risk corridor collections (which will be recorded as revenues) will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit***.

CBO, *The Budget and Economic Outlook 2014 to 2024* ('CBO Outlook"), at 59 (emphasis added), *available at* https://www.cbo.gov/publication/45010.

This is the *only* statement CBO ever made regarding whether the ACA RC program was intended to be budget neutral.

Studiously ignoring what CBO ***actually said*** on budget neutrality, the Government claims that the CBO "omitt[ed] the risk-corridors program from the budgetary scoring" (Gov.Br.20; *see also Lincoln*, 129 Fed. Cl. at 92, 104-05), from which one purportedly should infer that RCs were budget neutral. But CBO indisputably scored "[R]einsurance and [R]isk [A]djustment [Payments]," *id*. at 104-05, and the Government is thus asserting that the RC program should be deemed budget neutral based on its ***absence*** from the CBO scoring of programs that ***are*** budget neutral.

Any CBO treatment of the RC program as budget neutral merely constituted a *prediction* that the operational results of the ACA RC Program would be approximately budget neutral. HHS contemporaneously recognized as much, *see* 76 Fed. Reg. 41,930, 41,948 (HHS explanation that CBO "*estimates*" and "*assumed* [RC] collections would equal payments to plans in the aggregate") (emphasis added)). The terms "estimates" and "assumed" are consistent with CBO's treatment being reflective of a prediction, not a legal requirement,[9] and with HHS's own later statement that RC is not budget neutral, *see* pp. 16-17 *supra*. Indeed, in describing a subsequent baseline projection, CBO explicitly stated that it

[9] *Maine Community Health Options v. United States*, No. 16-967C, 2017 WL 3225050 at * 4 (Fed. Cl. July 31, 2017), treated this HHS statement as "seemingly definitive," but in precisely the opposite way HHS intended, for the reasons just explained.

had "*estimated* that payments and collections for risk corridors would roughly offset one another." *CBO Outlook* at 114 (emphasis added).

CBO's prediction that RC results would be roughly budget neutral was perfectly logical, given that the Medicare RC program had operated in roughly a budget neutral manner, although not legally required to do so.[10] CBO later explicitly stated that it looked at Medicare RC experience in coming up with its ACA RC projection, because Medicare was "analogous to the ACA's insurance exchanges" and "included similar provisions for. . . risk corridors," while acknowledging that "there are many uncertainties about how the market for health insurance will function under the ACA and how various outcomes would affect the government's costs or savings for the risk corridor program." *CBO Outlook* at 115.

If not for the Government's post-enactment "transitional policy" that sharply skewed the ACA toward sicker individuals, CBO's prediction of rough budget neutrality might have been reasonably accurate. Despite federal urgings, some states did not adopt the transitional policy, and insurers there suffered relatively small ACA losses in 2014.[11]

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[10] The Medicare RC program vacillated between net revenue positive and negative between 2007 and 2010. *See* CBO, *The Budget and Economic Outlook 2014 to 2024*, Table 2-1.

[11] *See* Milliman, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 Individual Market, at p. 4 Figure 7 (July 2016), *available* (continued…)

But that is all ultimately beside the point, because whether the ACA RC Program was *accurately predicted* to have roughly offsetting outflows and inflows, and whether it was *legally required* to be budget neutral, are completely different questions. The latter is what matters, and CBO came down squarely on Moda's side: "***[R]isk corridor collections. . . will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit.***"

The Government suggests (Gov.Br.31) that the CBO score "is important not for its own sake but because Congress relied on it in enacting the ACA," citing ACA Section 1563(a). But Section 1563(a) refers only to the CBO prediction that the ***ACA as a whole*** would reduce the federal deficit: "Based on Congressional Budget Office (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019."

Given that CBO had predicted that the ACA would reduce the Federal deficit by ***$143 billion*** over that time frame,[12] Section 1563(a)'s prediction that the ACA would be budget-reducing would have remained the same regardless of the assumptions made regarding net RC outflows over the programs three-year lifespan. Nothing supports the Government averment that Congress in 2010

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at:
http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf.

[12]Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives, at p. 2 (Mar. 20, 2010), *available at* https://www.cbo.gov/sites/default/files/amendreconprop.pdf.

proceeded based upon its "understanding that ***risk-corridors payments*** would not increase the deficit." (Gov.Br.21).

G. The GAO Supports Moda.

Like CBO, GAO ***never*** interpreted Section 1342 to require that RC payments to unprofitable insurers be limited to payments received from profitable insurers. GAO instead concluded that RC payment obligations were also payable from general CMS appropriations, *see* Section II.F *infra*. "Although GAO decisions are not binding, [courts] 'give special weight to [its] opinions' due to its 'accumulated experience and expertise in the field of government appropriations.'" *Nevada v. Dep't of Energy*, 400 F.3d 9, 16 (D.C. Cir. 2005) (quotation omitted).

H. Later Actions by a Different Congress Do Not Inform Statutory Intent.

The notion (Gov.Br.2) that Congress's FY 2015 and 2016 enactment of appropriations riders "confirm[s]" that Congress in 2010 intended to make the RC Program budget neutral contravenes decades of judicial precedent. Post-enactment events are irrelevant to congressional intent, particularly those occurring years later. *United States v. United Mine Workers of Am.*, 330 U.S. 258, 281-82 (1947) ("We fail to see how the remarks of these Senators in 1943 can serve to change the legislative intent of Congress expressed in 1932."); *O'Gilvie v. United States*, 519 U.S. 79, 90 (1996) ("the view of a later Congress cannot control the interpretation

of an earlier enacted statute"); *Huffman v. Office of Pers. Mgmt.*, 263 F.3d 1341, 1354 (Fed. Cir. 2001) (same).

This is especially true given that the appropriations riders were enacted by a different Congress, controlled by the other political party. *Cf. N.L.R.B. v. Fruit & Vegetable Packers and Warehousemen*, 377 U.S. 58, 66 (1964) ("[W]e have often cautioned against the danger, when interpreting a statute, of reliance upon the views of its legislative opponents.")

I. A Comparison to Medicare Supports Moda's Claims.

Finally, the Government contrasts the Medicare Part D prescription drugs RC provision, which states that "'[t]his section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.'" 42 U.S.C. § 1395w-115(a)(1). But the commitment in ACA Section 1342 is stronger than the Medicare Part D statute, which provides only that the Secretary "shall establish a risk corridor," 42 U.S.C. §1395w-115(e)(3), not that it "shall pay" the RC payment in the amounts specified, *see* ACA §1342. "The stronger payment language in Section 1342 obligates the Secretary to make payments and removes his discretion, so a further payment directive to the Secretary is unnecessary." Appx24.

Moreover, as we now show, this Court and its predecessor have repeatedly held the Government liable for violating money-mandating statutes that, like Section 1342, do not contain or reference an appropriation.

II. MODA IS ENTITLED TO JUDGMENT ON ITS STATUTORY CLAIM.

A. Section 1342 Established an Unconstrained, Enforceable Entitlement to Payment.

The Tucker Act, 28 U.S.C. § 1491, entitles a plaintiff to a damages award when the Government fails to meet its obligations under a money-mandating statute or regulation. *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012). Statutes providing that the Government "shall" or must make a payment are money-mandating. *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007); *Fisher v. United States*, 402 F.3d 1167, 1174-75 (Fed. Cir. 2005). ACA Section 1342(b)(1) meets this standard (the Government "shall pay to the [insurance] plan an amount" set by specified formula), as does 45 C.F.R. § 153.510(b) (an unprofitable insurer "will receive payment from HHS in the [prescribed RC formula] amounts," which "HHS will pay").

This Court's recent decisions confirm that money-mandating obligations are enforceable in the CFC, ***unless*** Congress explicitly limited the obligation when creating it. *Greenlee* addressed a money mandating statute providing that "necessary amounts may be appropriated to the Secretary of the Interior to carry

out this chapter. *Amounts are available only as provided in appropriation laws.*" *Greenlee,* 487 F.3d at 878-79.

Because — and only because — this quoted language expressly limited the Government's obligation to the amounts provided in appropriations laws, the Government was statutorily required to make payments only to the extent of those amounts:

> It has long been established that ***the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute. . . .*** Rather than limiting the government's obligation, a failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but ***such rights remain enforceable in the Court of Claims***. . . .
>
> ***However, in some instances the statute creating the right to compensation (or authorizing the government to contract) may restrict the government's liability or limit its contractual authority to the amount appropriated by Congress***. . . .[W]e conclude that the language [at issue] limits the government's liability. . . to the amount appropriated by Congress.

Greenlee, 487 F.3d at 878-79 (citations and quotations omitted, emphasis added).

Thus, a statutory obligation to make payments is legally binding and "enforceable in the [CFC]," ***unless*** the statutory language expressly conditions that obligation. *Id*. *Prairie Cty. Mont. v. United States,* 782 F.3d 685, 690 (Fed. Cir.

2015), reaffirmed this rule following the intervening decision in *Salazar* v. *Ramah Navajo Chapter*, 567 U.S. 182 (2012).

The Government argues that *Prairie* stands for the proposition that a "freestanding directive to an agency to pay amounts calculated under a statutory formula would not — standing alone — create an obligation on the part of the government to make payments without regard[ing] to appropriations." (Gov.Br.28). To the contrary, the statutory "directive" in *Prairie*, like that in *Greenlee*, was ***not*** freestanding, but expressly conditioned on the availability of appropriations: "Amounts [for payments] are available ***only as provided in appropriations laws***." 782 F.3d at 686 (emphasis added).

Prairie simply reaffirmed *Greenlee's* holding that when the underlying statute expressly "'restrict[s] the government's liability to the amount appropriated by Congress,'" the Government's liability is so limited. 782 F.3d at 689 (quoting *Greenlee*, 487 F.3d at 878). *Greenlee* explicitly treated this as an exception — a "however" — to the general rule that "a failure of Congress to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights [remain] enforceable in the [CFC]." 487 F.3d at 878 (citations omitted).

Unlike the conditional statutory commitment in *Greenlee* and *Prairie*, Section 1342 lacks ***any*** language conditioning RC payments on the availability of

appropriations or otherwise limiting the Government's RC obligations. Thus, the general rule applies, not the exception, and Moda's "rights remain enforceable in the [CFC]."

B. No Appropriation Separate from the Judgment Fund Is Necessary.

1. The Validity of Moda's Statutory and Regulatory Claims Does Not Depend upon a Specific Appropriation.

ACA Section 1342 and its implementing regulations established an unfettered right to payment. Section 1342 need not contain, or refer to, an appropriation in order that its obligations be binding and enforceable in the CFC. Nor must Moda identify any related appropriation for its claim to proceed to judgment.

These principles have been stated repeatedly by the Supreme Court, this Court, and its predecessor, *e.g.*, *New York Airways v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) ("[t]he failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights [remain] enforceable in the Court of Claims"); *Greenlee*, 487 F.3d at 878-79 (same); *Geddes v. United States*, 38 Ct. Cl. 428, 444 (1903) (the sources and amounts of appropriations "are questions which are vital for the accounting officers, but [they] do not enter into the consideration of a case in the courts"); *Ramah*, 567 U.S. at 197 ("[a]n appropriation *per se*

merely imposes limitations upon the Government's own agents; . . . but its insufficiency does not. . . cancel its obligations.") (quotation omitted).[13]

Indeed, the Court of Claims seventy years ago cited ***22*** of its ***own*** precedents in observing: "In a long line of cases it has been held that lapse of appropriation, ***failure of appropriation***, exhaustion of appropriation, ***do not of themselves preclude recovery for compensation otherwise due***." *Lovett v. United States*, 104 Ct. Cl. 557, 582-83 (1945) (emphasis added). The U.S. House of Representatives' ("USHOR") contention that "[a]bsent an appropriation,. . . a statute should not be construed to create a judicially cognizable obligation to pay statutory benefits" (USHORBr.11),[14] a position also espoused by the Government (Br.37-39), is clearly wrong in light of the foregoing precedents.

The principle that a money mandating statute is enforceable regardless of whether it contains or makes reference to an appropriation, or the plaintiff can point to a related appropriation, has been applied repeatedly since the Court of Claims came into existence over 160 years ago, *e.g.*:

In *Graham v. United States*, 1 Ct. Cl. 380, 382 (1865), the statute provided that "[a]ll laborers in the employment of the government, in the executive

[13] These deep-rooted principles apply to both statutory and contract claims, *New York Airways*, 369 F.2d at 752.

[14] Because USHOR's amicus brief largely incorporates by reference its amicus brief in *Land of Lincoln*, No. 16-1224, references herein are to the latter brief.

departments and on the public grounds, in the city of Washington, shall receive an annual salary of six hundred dollars each, from and after the first day of July, eighteen hundred and fifty-six," and judgment was entered for the difference between the $600 so promised and the $480 appropriated by Congress.

In *Strong v. United States*, 60 Ct. Cl. 627, 629-30 (1925), the statute provided that "[e]ach of the professors of the Military Academy whose service at the academy exceeds 10 years shall have the pay and allowances of colonel, and all other professors shall have the pay and allowances of lieutenant-colonels," and the court awarded the plaintiff "[h]is pay and allowances [as] fixed by [that] law," even though "Congress made no appropriation . . . for the pay and allowances provided for one performing [his] duties. . . ," reasoning that "officers of the Treasury have no authority to pay the officer until an appropriation therefor has been made. But the liability of the United States to pay exists independently of the appropriation, and may be enforced by proceedings in this court."

Danforth v. United States, 62 Ct. Cl. 285, 287-88 (1926), applied a statute providing that "[t]he superintendent of the Military Academy shall have the pay of a colonel and the commandant of cadets shall have the pay of a lieutenant colonel," and entered judgment for such pay, holding that "[t]he fact that Congress made no appropriation for the two years for which he was not paid does not preclude the plaintiff from obtaining relief in this court."

In *Miller v. United States*, 86 Ct. Cl. 609, 610 (1938), the statute provided "[f]or salary of one disbursing clerk for the payment of pensions, to be selected and appointed by the Secretary of the Interior, at the rate of four thousand dollars per annum," and the court entered judgment for the $1,000 variance from the $3,000 Congress subsequently appropriated.

In *Gibney v. United States*, 114 Ct. Cl. 38, 41, 48 (1949), Immigration and Naturalization Service regulations provided that employees working in excess of eight hours a day were entitled to "one-half day's [extra] pay. . .," and also "entitled to two days' pay. . . for time on duty of eight hours or less on a Sunday or on a holiday," and the court entered judgment for these amounts, notwithstanding a subsequent appropriations bill providing that "none of the funds appropriated for the [INS] shall be used to pay compensation for overtime services. . ."

None of the substantive statutes in these cases contained or referenced appropriations. None of the plaintiffs pointed to any related appropriations. Yet judgments were uniformly entered in their favor.

2. The Judgment Fund Provides the Necessary Appropriation.

The Judgment Fund was created "to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims." *Slattery v. United States*, 635 F.3d 1298, 1317 (Fed. Cir. 2011) (en banc); *accord Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 430-31 (1990) ("Congress has, of course,

made a general appropriation of funds to pay judgments against the United States rendered under its various authorizations for suits against the Government, such as the Tucker Act…")

The contention of the Government (Br.37-39) and USHOR (Br.25) that there must have been a separate, specific RC appropriation is irreconcilable with the foregoing case law explaining the Judgment Fund's function. Moreover, in actual practice, damages are commonly awarded for which there has been no salient appropriation other than the Judgment Fund, including claims arising out of, *e.g.*, the Government's breach of contracts that do not themselves provide for payments to the private party,[15] and the Constitution.[16]

The Government relies heavily upon *Richmond*, citing it six times. Yet *Richmond* rejected a damages claim predicated upon promissory estoppel specifically because Congress has never appropriated funds to pay such a claim. 496 U.S. at 431. *Richmond* explicitly distinguished statutory and contract claims, noting both that "Congress has placed the individual adjudication of claims based on the Constitution, ***statutes, or contracts***, or on specific authorizations of suit against the Government, with the Judiciary [under] the Tucker Act, 28 U.S.C. §§

[15] *E.g.*, *Mobil Oil Exploration & Producing Se., Inc. v. United States*, 530 U.S. 604 (2000); *Amber Resources Co. v. United States*, 538 F.3d 1358 (Fed. Cir. 2008).

[16] *E.g.*, *United Nuclear Corp. v. United States*, 912 F.2d 1432, 1438 (Fed. Cir. 1990).

1346, 1491," and that "Congress has, of course, made a general appropriation of funds to pay judgments against the United States rendered under its various authorizations for suits against the Government, such as the Tucker Act. . . . See 31 U.S.C. § 1304." *Id*. at 430-31 (emphasis added).

The *Richmond* plaintiff lost for the specific reason that his "claim for relief does not arise under any of these provisions." *Id*. at 431. Moda's claims do.

The Government's talismanic treatment of *Richmond* is not new. Its Supreme Court brief in *Ramah* cited *Richmond* ten times.[17] But the Supreme Court was not spellbound, ruling against the Government and confining *Richmond* to a three-sentence footnote deeming the Government's reliance "misplaced" given that *Richmond* had nothing to do with statutory claims giving rise to compensation from the Judgment Fund. 567 U.S. at 198 n.9.

3. The Judgment Fund Satisfies Constitutional Requirements.

The USHOR emphasizes Congress's constitutional prerogatives (Br.4-7), citing the Appropriations Clause of Article I, Section 9, clause 7 ("No Money shall be drawn from the Treasury but in Consequence of Appropriations made by Law.") That argument ignores Congress' interwoven statutory actions: (a) giving the CFC Tucker Act jurisdiction to "render judgment upon any claim against the United

[17] *See* Brief for the Petitioners, *Salazar v. Ramah Navajo Chapter*, No. 11-551, 2012 WL 596117 (U.S.) (Appellate Brief) (Feb. 17, 2012).

States founded either upon. . . any Act of Congress . . . or implied contract," 28 U.S.C. § 1491; (b) authorizing the payment of CFC final judgments, 28 U.S.C. § 2517; and (c) providing that "[n]ecessary amounts are appropriated to pay final judgments . . . payable . . . under section[] 2517. . . of title 28," 31 U.S.C. § 1304(a)(3)(A).

The latter provision is the Judgment Fund, itself an "Appropriations made by Law," which "appears in Title 31, entitled 'Money and Finance' in Chapter 13—'Appropriations[;]' was first enacted in the Supplemental Appropriation Act of 1957[, and] was intended to establish a central, government-wide judgment fund from which judicial tribunals administering or ordering judgments, awards, or settlements may order payments ***without being constrained by concerns of whether adequate funds existed at the agency level to satisfy the judgment.***" *Bath Iron Works Corp. v. United States*, 20 F.3d 1567, 1583 (Fed. Cir. 1994) (emphasis added). Thus, "the Appropriations Clause is no bar to recovery in a case" giving rise "to compensation from the Judgment Fund." *Ramah*, 567 U.S. at 198 n.9 (citation omitted).

The Government observes (Br.42n.10) that "until the creation of the Judgment Fund in 1956, most money judgments against the United States required special appropriations from Congress for payment," and that "cases such as

Langston[18] and *Gibney*, which predate the creation of the Judgment Fund, did not require payment without a congressional appropriation."

The Government leaves unstated the conclusion it wishes the Court to draw from these observations. Over the 162-year history of the Court of Claims and its successors, Congress has steadily reduced its control over funds used to satisfy judgments, moving from individual appropriations to pay individual judgments; to annual appropriations that covered all judgments entered in the year; to a permanent appropriation subject to a dollar cap for individual judgments; to the system in place since 1977, under which the Judgment Fund is a permanent, unlimited appropriation for Tucker Act (and other) judgments. *See Slattery*, 635 F.3d at 1301-03. The Government's apparent notion that Congress's ***relinquishment*** of direct control over judgment funding acts as a ***constraint*** on the CFC's powers runs directly counter to the Court of Claims' contemporaneous reading of the 1977 amendment:

> In 1855 Congress would not even permit a final judgment, reserving to itself the right to second-guess the court. By 1866 the court [of claims] could enter a final judgment but Congress still reserved the right, though [largely] unused . . ., to challenge a court judgment by refusing to pay it. One hundred and eleven years later it cut the court from this financial apron string. The court had served its probationary period, if you can call it that, and ***after 122 years Congress formally announced that***

[18] *United States v. Langston*, 118 U.S. 389 (1886).

> ***it would not be necessary to maintain any oversight of the judgments. . . . In a sense, it is the ultimate compliment that a sovereign would leave its purse standing open "permanently and . . . indefinitely" in this way.***

2 W. Cowen, P. Nichols & M. Bennett, *The United States Court of Claims* 161-62 (1978), reprinted in 216 Ct. Cl. 4 (1978) (emphasis added). All three authors became Federal Circuit judges upon this Court's creation four years later.

4. The Judgment Fund Is Available Here.

The Judgment Fund provides "[n]ecessary amounts. . . to pay [all] final judgments" when "(1) *payment* is not otherwise provided for. . ." 31 U.S.C. §1304(a). USHOR invokes the "otherwise provided for" exception (Br.26), but it applies only to funding sources created for the specific purpose of paying ***judgments*** against the United States:

> [I]f other funds are not available to pay the judgment, the Permanent Judgment Fund is available for that purpose. . . . As the Government Accountability Office ("GAO") Redbook explains, ***"unless otherwise provided by law, agency operating appropriations are not available to pay judgments against the United States.***" United States Government Accountability Office, III Principles of Federal Appropriations Law, at 14–31 (3d ed. 2008).

Samish Indian Nation v. United States, 657 F.3d 1330, 1340-41 (Fed. Cir. 2011) (citations omitted, emphasis added), *vacated as moot*, 133 S.Ct. 423 (2012); *see also Wolfchild v. United States*, 101 Fed. Cl. 54, 84 (2011), *aff'd in part and rev'd in part on other grounds*, 731 F.3d 1280 (Fed. Cir. 2013) ("unless provision ***for***

payment of a judgment is supplied by another statute, any final judgment issued by this court is satisfied by payment from. . . the Judgment Fund" (emphasis added)); *McCarthy v. United States*, 670 F.2d 996, 1002 (Ct. Cl. 1982) ("our judgments, when awarded against the United States, are normally payable not from appropriations to maintain the agency that incurred the liability, but from appropriations made for the purpose of paying Court of Claims and other court judgments, now normally standing appropriations. 31 U.S.C. § 724a [the predecessor to Section 1304]").

"Most court judgments against the United States are paid from the Judgment Fund. . . ." III GAO, *Principles of Federal Appropriations Law* 14-61 (3d ed. 2008) ("GAO Redbook"). None of the limited exceptions (*see id*. at 14-39 through 14-44) applies here.

C. Additional Funds Were Appropriated.

While not essential for the reasons just stated, Congress did appropriate funds to HHS that could be used to make RC payments. Congress on January 16, 2014 made a $3.6 billion lump sum FY 2014 CMS Program Management appropriation covering "other [CMS] responsibilities" through September 30, 2014. Appx236-237. GAO opined that CMS's "other responsibilities" "include the [RC] program," and thus "the CMS PM [Program Management] appropriation

for FY 2014 would have been available . . . for mak[ing] the payments specified in section 1342(b)(1)." Appx234-240.

GAO used the past perfect conditional tense — "would have been" — because GAO was writing on the last day of FY 2014, and HHS had not obligated those funds for RC purposes. But HHS could have. While an annual appropriation is only available for the fiscal year to which it applies, "the general rule is that the availability relates to the authority to obligate the appropriation, and does not necessarily prohibit payments after the expiration date for obligations previously incurred, unless the payment is otherwise expressly prohibited by statute." I GAO Redbook 5-3-5-4 (3d ed. 2004) (citations omitted).

"[A]n obligation arises when the definite commitment is made, even though the actual payment may not take place until a future fiscal year." GAO Redbook, Annual Update 7-1 (Mar. 2015). An "obligation" includes "both matured and unmatured commitments," with the latter "a liability which is not yet payable but for which a definite commitment nevertheless exists," *id.*, including "a legal duty on the part of the United States which could mature into a legally enforceable claim by virtue of actions on the part of the other party beyond the control of the United States." B-300480.2 (Comp. Gen.), 2003 WL 21361642 at * 3 (June 6, 2003).

The Government committed to make RC payments with respect to ACA operations beginning January 1, 2014. FY 2014 appropriations were available for obligation, because "the need arose . . . that year . . . even though the funds are not to be disbursed and the exact amount owed by the government cannot be determined until the subsequent fiscal year." I GAO Redbook 5-14 (3d. ed. 2004); *see also* B-325526 (Comp. Gen.), 2014 WL 3513027 at * 1-4 & n.3 (July 16, 2014) (DOD commitment to pay bonuses created a current "obligation" even though it was unknown whether service members would fulfill the conditions for payment, and disbursements might not be made until future fiscal years); B-300480.2 (Comp. Gen.), 2003 WL 21361642 at * 1-3 (Government's commitment to pay for enrollees created a current "obligation," even though the number of enrollees and their costs were not yet known).

Maine Community Health Options v. United States, No. 16-967C, 2017 WL 3225050 at * 8 (Fed. Cl. July 31, 2017), *appeal docketed*, No. 17-2395 (Fed. Cir. Aug. 7, 2017), erred in concluding that CMS FY 2014 funds could not be utilized because the obligation did not arise until HHS could "determin[e] [RC] amounts." That position is irreconcilable with the foregoing principles, that an obligation arises when a government undertaking "***could*** mature into a legally enforceable claim," and when "the exact amount. . . cannot be determined until the subsequent

fiscal year." B-300480.2 (Comp. Gen.), 2003 WL 21361642 at * 3; I GAO Redbook at 5-14.

Maine's related conclusion that the FY 2014 appropriation could not be utilized because it was not a "permanent" appropriation (2017 WL 3225050 at * 5 & n.3) misperceives the nature of annual and permanent appropriations. As just explained, a "regular" appropriation like the CMS FY 2014 appropriation indubitably can be used to make payments in future years, where (as here) the obligation arose during the year to which the appropriation relates. A permanent appropriation differs in that it can be used to meet obligations that first arise in future years, *see* GAO Redbook, Ch. 2 at 2-10 (4th ed. 2016), an attribute unnecessary here for the reason just stated.

In short, the contention that FY 2014 funds were not available because RC payments would not have taken place until 2015 (Gov.Br.34) is simply wrong. The related Government observation that a lump sum appropriation "expires" at the end of the fiscal year (*id.*) is misleading, because an appropriation need only have been "obligated" during the fiscal year: An "expired appropriation remains available for 5 years for the purpose of paying obligations incurred prior to the account's expiration and adjusting obligations that were previously unrecorded or under recorded." GAO Redbook, Ch. 2 at 2-29 (4th ed. 2016).

Judge Wheeler was thus clearly correct in concluding that the CMS FY 2014 appropriation was available, Appx25, and FY 2015 appropriations were also available, Appx27. Continuing resolutions in effect during the first two-and-a-half months of FY 2015 (October 1, 2014 through December 16, 2014) provided $750 million of lump sum CMS Program Management appropriations, *see* Appx27 n.13, all of which were available for RC obligations. *Id*.; *see also* II GAO Redbook 8-5 (3d ed. 2006) ("Obligations already incurred under [a continuing] resolution. . . may be liquidated" regardless of whether the subsequent permanent appropriation also funded the activity).[19]

III. THE APPROPRIATIONS RIDERS DID NOT VITIATE MODA'S STATUTORY RIGHTS.

A. The Appropriations Riders Did Not Affect the Government's Statutory Obligation to Make Full RC Payments.

A congressionally-imposed limitation on the use of agency appropriations may prevent agency compliance with a statutory mandate, but does not change the CFC's power to issue judgment for the Government's failure to honor its statutory payment obligations. *See* Section II.B.1 *supra*. And, while Congress may possess the legal power to amend pre-existing substantive statutory obligations, it must do so "expressly or by clear implication." *Prairie*, 782 F.3d at 689 (citations omitted).

[19] Given that FY 2014 appropriations were available to be obligated for RC payments, *see* pp. 37-38 *supra*, the fact that the FY 2015 continuing appropriations were limited to activities also covered by FY 2014 appropriations (*see* Gov.Br.35) means that they were likewise available.

"This rule applies with *especial force* when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphasis added). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," their statutory instructions are presumed *not* to impact substantive law. *TVA v. Hill*, 437 U.S. 153, 190 (1978). "The intent of Congress to effect a change in the substantive law via provision in an appropriation act must be *clearly manifest*." *New York Airways*, 369 F.2d at 749 (emphasis added).

Three leading decisions apply the foregoing legal principles under closely analogous circumstances.

1. *Langston*.

A statute specified that the U.S. ambassador to Haiti would be paid an annual salary of $7,500. Congress later appropriated only $5,000 for this purpose. Langston sued for the $2,500 shortfall. The question was whether the statutory obligation remained binding and enforceable.

The Supreme Court noted that the relevant appropriations legislation did not have "any language to the effect that such sum [$5,000] shall be 'in full compensation' for those years; nor was there…an appropriation of money 'for additional pay,' from which it might be inferred that congress intended to repeal the act fixing his annual salary at $7,500." *Langston*, 118 U.S. at 393. Citing the

principles that "[r]epeals by implication are not favored," and that a court should give effect to a "reasonable construction" that allows two potentially incongruous laws to "stand together," the Supreme Court affirmed the Court of Claims, holding that the Government had a statutory obligation to pay the plaintiff-ambassador the full $7,500, given that the appropriations bill "contained no words that expressly, or by clear implication, modified or repealed the previous law." *Id*. at 393-94.

Congress here limited the availability of FY 2015 and 2016 CMS appropriations for purposes of making RC payments. But as in *Langston*, those appropriations provisions did not include any "words that expressly, or by clear implication, modified or repealed the previous law," or otherwise specified that a funding source or a capped appropriation "shall be 'in full compensation' for" the RC obligation for the year.

While the Government terms *Langston* a "difficult case" (Gov.Br.41), the Court of Claims resolved in precisely the same manner numerous comparable fact patterns, both pre- and post-*Langston*, *e.g.*, *Graham*, *Danforth*, *Strong*; *see especially Miller*, 86 Ct. Cl at 612 (plaintiff entitled to the $4,000 annual salary provided by 1912 statute even though Congress only appropriated $3,000 three years in a row, given that the appropriations acts "do not contain any repealing clause or any words which can be construed as an implied repeal of the Act of

1912 [and there] is no clause that the amount was in full payment of the salary of the position").

2. *Gibney*.

A special INS statute provided that certain employees should be paid overtime at specified rates, *see* p. 31 *supra*. Subsequent appropriations language provided "that none of the funds appropriated for the [INS] shall be used to pay compensation for overtime services other than as provided in [two general laws]." 114 Ct. Cl. at 48-49.

Gibney held this appropriations language "a mere limitation on the expenditure of a particular fund [that] had no other effect" on the statutory requirement to pay overtime. *Id*. at 50. The Court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation." *Id*. at 53. Judgment was entered for the plaintiff's full overtime pay. *Id*. at 47, 58.[20]

The RC appropriations riders are quite similar. *Compare Gibney*, 114 Ct. Cl. at 44 ("[N]one of the funds appropriated for the [INS] shall be used to pay compensation for overtime services other than as provided [under specific

[20] *Gibney* observed, immediately following the latter statement quoted above, that "it is not necessary in this case to rest the decision upon this point alone," followed by an alternative ground for decision, 114 Ct. Cl. at 53-55. "[W]here a decision rests on two or more grounds, none can be relegated to the category of obiter dictum." *Woods v. Interstate Realty Co.*, 337 U.S. 535, 537 (1949).

statutes]…."), *with* Pub. L. No. 113-235, § 227 ("None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for" RC payments).

Maine recites the *Gibney* facts (2017 WL 3225050 at * 9), but does not perform the critical task of comparing the appropriations language at issue in *Gibney* and here. As just shown, the provisions are essentially identical, which forecloses *Maine*'s conclusion that congressional intent here to vitiate the RC statutory obligation was "clear," *id.*, when *Gibney* held precisely the opposite.

In finding such clarity of intent, *Maine* appears to have focused not upon the RC appropriations riders language itself, but on contemporaneous statements in the congressional record and a Senate report (2017 WL 3225050 at * 5-6); *see also* Gov.Br.42-43. That approach would be questionable even as a matter of general statutory interpretation,[21] and is plainly inappropriate here, given that the applicable legal standard calls for a determination whether the appropriations language "clearly manifests" an intent to repeal a prior statutory obligation. *See*

[21] "Because it is presumed that Congress expresses its intent through the ordinary meaning of its language, every exercise of statutory interpretation begins with an examination of the plain language of the statute." *Alston v. Countrywide Fin. Corp.*, 585 F.3d 753, 759 (3d Cir. 2009) (citation omitted).

generally Star-Glo Associates, LP v. United States, 414 F.3d 1349, 1353 (Fed. Cir. 2005) ("it is inappropriate to rely upon legislative history to establish the existence of a statutory cap that is not contained in the text of the statute itself…").

Indeed, *Gibney* explicitly acknowledged that the floor debate indicated that the sponsoring "Senator was apparently under the impression that" the appropriations bill would negate the underlying statutory promise, but held that "we are not permitted to alter [the appropriation act's lack of] effect by accepting what he may have had in mind when he offered it." 114 Ct. Cl. at 55; *see also id*. (Whitaker, J. concurring) (some members of Congress "probably wanted" the appropriations language to suspend the Government's obligation to pay overtime, "but if so, they did not accomplish their purpose; they merely prohibited the use of certain funds to discharge the obligation under that Act," and "[t]his did not repeal the liability the Act created").

Maine also purported to find clarity of intent to repeal the RC obligation in the absence of other agency funding once the riders were enacted, *see* 2017 WL 3225050 at *8. Even if that were true (which it is not, *see* pp. 37-41 *supra*), the same was indisputably true in *Gibney*, which held against the Government. As Judge Wheeler correctly observed in his second Section 1603 decision, *Molina Healthcare of California, Inc. v. United States*, No. 17-97C, 2017 WL 3326842 at *24-25 (Fed. Cl. August 4, 2017), because *Maine* never addressed whether the RC

program was budget neutral by design, it failed to apply the correct legal principle, which provides that in the presence of a money-mandating obligation like Section 1342, the absence of agency appropriations restrains the agency but not the CFC, *see* pp. 28-31 *supra*.

3. *New York Airways.*

The Civil Aeronautics Board (CAB) by statute fixed a monthly subsidy for helicopter companies. 369 F.2d at 744. But from FY 1962 through 1965, "Congress successively reduced the subsidy payments for helicopter operations under the immediately preceding year, making it clear that it did not want the budgeted amounts to be exceeded." *Id.* at 747. In the specific fiscal year at issue, Congress enacted an annual appropriations bill provision in an effort "to curtail and finally eliminate helicopter subsidies:"

> For payments to air carriers of so much of the compensation fixed and determined by the [CAB] under section 406 of the Federal Aviation Act of 1958 (49 U.S.C. 1376), as is payable by the Board, including not to exceed $3,358,000 for subsidy for helicopter operations during the current fiscal year, $82,500,000, to remain available until expended.

369 F.2d at 749, 751.

Reciting its longstanding rule "that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a

Government obligation created by statute," 369 F.2d at 748 (citations omitted), the Court entered judgment for the differences between the amounts statutorily required and provided by the appropriation, because a change in substantive law was not "clearly manifest" from the appropriation's text. *Id*. at 749.

The *New York Airways* appropriations language capped at a specified dollar amount all payments to the helicopter companies, while the RC riders simply limited the use of certain specific funds to make RC payments. *A fortiori, New York Airways* supports Moda's statutory entitlement to RC payments.

B. The Government's Precedents Are Distinguishable.

The three cases upon which the Government principally relies are entirely distinguishable.

United States v. Dickerson, 310 U.S. 554 (1940), involved a statute obligating the Government to make bonus payments to military re-enlistees. Appropriations bills from 1933 through 1937 expressly suspended this requirement: the statute "is hereby suspended as to reenlistments made during the fiscal year." 310 U.S. at 556. In 1938 and 1939, Congress employed slightly modified phraseology: "no part of any appropriation contained in this *or any other Act* for the fiscal year…, shall be available for the payment…during the fiscal year…*notwithstanding the applicable provisions of*" the bonus payments statute. *Id*. at 556-57 (emphasis added). The plaintiff re-enlisted in 1938 and sought a

bonus, but the Supreme Court held that year's appropriations language carried forward the longstanding suspension of the Government's statutory obligation. *Id*. at 561-62.

The *Dickerson* appropriations language is significantly different from the RC riders, prohibiting the use of funding both from the appropriations bill in which the rider was contained *and* "any other Act for the fiscal year," and providing that bonus payments were defunded "notwithstanding the applicable portions of" the underlying substantive law. That language was deemed a continuation of appropriations acts that had explicitly "suspended" the underlying statutory obligation.

As *New York Airways* explained, *Dickerson* involved "'a legislative provision under the guise of a withholding of funds' which suspended the legal obligation, rather than a simple withholding of funds unaccompanied by other expressed or implied purposes.'" 369 F.2d at 750 (quoting *Gibney*, 114 Ct. Cl. at 51).

Will involved a statute directing the President to make cost-of-living increases based on several considerations. In four consecutive fiscal years, appropriations bills blocked those pay increases through the following four provisions: "[n]o part of the funds appropriated in this Act *or any other Act* shall be used;" the salary increase that "would be made after the date of enactment of

this Act under [the provisions giving rise to the obligation]…*shall not take effect*;" "No part of the funds appropriated for the fiscal year ending September 30, 1979, by this *Act or any other Act* may be used to pay…"; "funds available for payment…shall not be used to pay any such employee or elected or appointed official any sum in excess of 5.5 percent increase in existing pay and such sum if accepted shall be in lieu of the 12.9 percent due for such fiscal year." *Will*, 449 U.S. at 205-08 (emphasis added). The Court held that each of these provisions "block[ed] the increases the [Act] otherwise would generate." *Id*. at 223.

The *Will* appropriations language clearly altered the prior statutory obligation, either by expressly stating that the underlying statute "shall not take effect" or by prohibiting the Government from using *any* appropriations source in the year at issue. Further, pay increases pursuant to the underlying statute were "discretionary decisions" made through an "uncertain…process." *Beer v. United States*, 696 F.3d 1174, 1181, 1183 (Fed. Cir. 2012) (en banc). In contrast, the RC appropriations riders only prevent the Government from making payments out of specified funding, and Moda's statutory rights arise under a strict, non-discretionary statutory formula.

Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United States, 48 F.3d 1166 (Fed. Cir. 1995), did not involve a money-mandating statute, *see id*. at 1169 (noting that the lower "court concluded that the Impact Aid program is not a

mandatory spending program"). This Court therefore never had occasion to address the central question presented here: whether appropriations language met the high standard for vitiating rights afforded by a money-mandating statutory obligation.

Highland Falls instead examined the relationship between the original, ***non***-money mandating statutory terms, which set forth one approach for addressing anticipated appropriation shortfalls, and subsequent appropriations statutes that plainly substituted a different methodology using "earmarked" funds. 48 F.3d at 1170-71. The Court accepted an agency interpretation that "gave effect" to both the statute and Congress's later enacted funding decisions. *Id*. at 1171.[22]

C. The Instant Case Implicates the Presumption Against Retroactivity.

Congress passed the RC appropriation riders only after insurers undertook material action (providing QHPs through the Exchanges) in return for the Government's statutory commitment to make RC payments. The *Dickerson*, *Will*,

[22] Two additional cited cases are of little relevance. In *United States v. Mitchell*, 109 U.S. 146 (1883), the underlying statutory obligation and the alteration of that obligation were both contained in appropriations acts, and involved the special case of Indian appropriations. *U.S. House of Representatives v. Burwell*, 185 F.Supp. 3d 165 (D.D.C. 2016), *appeal docketed*, No. 16-5202 (D.C. Cir. July 14, 2016), explicitly distinguished the enrollee subsidies before it from the RC payments at issue here, *id*. at 184-85, and left open whether the plaintiffs had claims cognizable in the CFC, *id*. at 183 & n.20.

and *Highland Falls* plaintiffs could not allege a similar *quid pro quo* exchange prior to enactment of the relevant appropriations riders.

Stripping Moda of its right to RC payments would "impair rights a party possessed when [it] acted" and impose new rules on a transaction already completed. *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quotation omitted). Such retroactive application of statutes is "disfavored," and "a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication." *Id*. (quotation omitted).

* * *

Efforts to amend Section 1342 to require budget neutrality were introduced, *see* Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014), but never enacted, and the President repeatedly threatened to veto any bill rolling back the ACA.[23] The riders' language falls far short of the "clearly manifest" standard for the repeal of a money mandating statute via an appropriations act.

[23]*See* Office of Mgmt. & Budget, H.R. 596 - Repealing the Affordable Care Act 2 (Feb. 2, 2015) ("If the President were presented with H.R. 596 [Repealing the ACA], he would veto it.") https://www.whitehouse.gov/sites/default/files/omb/legislative/sap/114/saphr596r_20150202.pdf; *see generally* Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA Today, Nov. 19, 2014 (noting that the President has threatened to veto twelve different bills that would have repealed all or part of the ACA).

IV. THE GOVERNMENT IS LIABLE FOR BREACH OF CONTRACT.

Implied in fact contract claims are cognizable under the Tucker Act, with judgments payable from the Judgment Fund. 28 U.S.C. § 1491(a)(1); *Slattery*, 635 F.3d at 1303, 1317, 1321. The contention that Section 1342 merely establishes a benefits program (Gov.Br.48) ignores the relationship and dealings between the Government and Moda. The Government received the performance promised by Moda — health coverage for tens of thousands of Americans — without adhering to its side of the bargain — making RC payments — even though the promise of such payments was essential to inducing Moda into the Exchanges.

"The general requirements for a binding contract with the United States are identical for both express and implied contracts," *Trauma Serv. Group v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997): "mutuality of intent to contract," "consideration," "lack of ambiguity in offer and acceptance," and "actual authority", "[of] the [G]overnment representative 'whose conduct is relied upon . . . to bind the [G]overnment in contract.'" *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995) (citation omitted). All these elements are present here.

A. There Was Mutuality of Intent.

Radium Mines, Inc. v. United States, 153 F. Supp. 403 (Ct. Cl. 1957), is the seminal case finding an implied-in-fact contract based on Government conduct, including published regulations. Agency regulations established a guaranteed

minimum price at which the United States would purchase uranium. The court rejected as "untenable" the Government's argument that the regulation was "a mere invitation to the industry to make offers to the Government." *Id*. at 405-06. Finding an intent to contract, the court noted that the regulation's purpose—

> was to induce persons to find and mine uranium. The Government had imposed such restrictions and prohibitions upon private transactions in uranium that no one could have prudently engaged in its production unless he was assured of a Government market. It could surely not be urged that one who had complied in every respect…could have been told by the Government that it would pay only half the 'Guaranteed Minimum Price,' nor could he be told that the Government would not purchase his uranium at all.

Id. at 406.

As in *Radium Mines*, the purpose of the RC payments was to induce insurers to offer affordable insurance to a population about which they lacked information. As Judge Wheeler explained, the Government—

> created an incentive program in the form of the Exchanges on which insurers could voluntarily sell QHPs. Insurers' performance went beyond filling out an application form; they needed to develop QHPs that would satisfy the ACA's requirements and then sell those QHPs to consumers. In return for insurers' participation, the Government promised risk corridors payments as a financial backstop for unprofitable insurers.

Appx37.

Moreover, the exchange of consideration, performance and benefits ran in both directions. The Government recognized that prudent insurers pricing a new product for an unknown population would normally add a "risk premium" to protect against uncertainties, *see* pp. 7, 15 *supra*. The Government included the RC Program to mitigate that uncertainty, and HHS repeatedly admonished insurers that the Program should enable them to keep premiums low, *see* p. 7 *supra*. Lower premiums resulted in far lower Government outlays for premium subsidies and tax credits, *see* p. 7 *supra*.

That the *Radium Mines* regulations provided that the Government would enter into a "purchase contract" when presented with uranium that met its qualifications was not the basis of the Court's decision. Rather, the "key" to *Radium Mines* "is that the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001); *see also Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982) (citing *Radium Mines* as an exemplary case "where contracts were inferred from regulations promising payment").

Many other decisions have also found mutuality of intent in situations comparable to Moda's. In *New York Airways*, 369 F.2d at 751, this Court's predecessor held:

> The actions of the parties support the existence of a contract at least implied in fact. The [CAB's]

> rate order was, in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer.

A Government program offering payments to companies that expanded naval stores operations likewise gave rise to a valid Tucker Act claim for underpayment, whether under an implied in fact contract or the regulations themselves. *Aycock-Lindsey Corp. v. United States*, 171 F.2d 518 (5th Cir. 1948). "When…the Secretary of Agriculture published bulletins and promulgated rules providing for the payment of subsidies to those naval stores producers who accepted the offer by voluntarily coming under, and complying with, the Act, there was revealed the traditional essentials of a contract, namely, an offer and an acceptance." 171 F.2d at 521. *Accord Grav v. United States*, 14 Cl. Ct. 390, 393 (1988) (statute requiring agency to make payments to qualified farmers, coupled with performance, created "mutuality of intent…in no uncertain terms" and gave rise to an implied-in-fact contract), *aff'd*, 886 F.2d 1305 (Fed. Cir. 1989).

In *LaVan v. United States*, 382 F.3d 1340, 1346-47 (Fed. Cir. 2004), the Government was similarly held to have entered an "implied in fact contract governing the treatment of goodwill," based on a Federal Home Loan Bank Board Resolution and internal Board memorandum. This Court rejected the Government's argument, also advanced here (Gov.Br.47-48), that the agency was

merely performing a regulatory function, and did not require, as the Government urges here (Gov.Br.48), that there be any "contract" language in the Board resolution or any pertinent regulation. Appx35-36.

Moda does not assert a contractual obligation arising solely from the text of the statute (*cf.* Gov.Br.48-49), but from the combination of that text, HHS's implementing regulations, HHS's preamble statements before the ACA became operational, and the conduct of the parties, including that relating to the transitional policy. *Cf. United States v. Hughes House Nursing Home, Inc.*, 710 F.2d 891 (1st Cir. 1983) (Breyer, J.) (applying the statute of limitations applicable to claims arising under an express or implied contract to a Government dispute with a Medicare provider; "the Medicare statutes, rules and regulations create the basic 'contractual terms'").

Mutuality of intent to contract is lacking when "[t]he only effort to be expended by . . . plaintiffs [is] to fill in the blanks of a Government prepared form;" when there is "discretion . . . whether to award payments;" or when the parties must "negotiate and fix a specific amount" of payment. *Baker*, 50 Fed. Cl. at 491-93. None of these factors applies here.

The Government relies heavily (Gov.Br.47-48) upon *Brooks v. Dunlop Manufacturing Inc.*, 702 F.3d 624 (Fed. Cir. 2012), and *National R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Railway Co.*, 470 U.S. 451 (1985), but these

were due process claims, not Tucker Act lawsuits, and distinguishable on additional grounds:

- *Brooks* rejected a purported contractual right because the applicable statute merely "authorized a *qui tam* action and specified how any penalty would be divided," and the courts had "consistently recognized that amendments to *qui tam* statutes that interfere with a relator's pending action do not 'deprive him of rights guaranteed by the Constitution.'" 702 F.3d at 632.

- *Atchison* addressed a statutory scheme that provided for contracts between railroads and Amtrak (a non-government entity), *not* between railroads and the Government. 470 U.S. at 467, 470-71. The Government therefore retained its normal prerogatives as regulator, especially with respect to a sector (railroads) that it had "pervasive[ly]" regulated for decades. *Id*. at 468-69.

B. There Was Consideration.

Moda's provision of health benefits to enrollees was in consideration for the Government's payment of RC payments. The presence of consideration is unchallenged.

C. There Was Offer and Acceptance.

QHPs form the backbone of the Government's effort to provide affordable, comprehensive coverage through the ACA Exchanges. Moda was not legally required to accept the Government's offer to participate, but once it did, the

Government and Moda were committed to an intricate exchange of obligations. Moda had to—

- comply with "issuer participation standards," including standards on benefit design;
- set rates for an entire benefit year and justify any rate increases;
- utilize specified enrollment periods;
- terminate coverage only under Government standards; and
- establish a health care provider network that met federal standards (45 C.F.R. §§ 156.200-270).

In exchange, the Government committed that Moda would—

- be entitled to enroll all individuals who selected its QHPs;
- receive payment of any advance premium tax credits;
- receive payments to implement cost-sharing reductions for eligible individuals; and
- receive RC payments (45 C.F.R. §§ 155.400, 156.430, 156.440, 153.510).

Regulatory obligations are typically mandatory and imposed unilaterally. The obligations here were mutual, with an offer and inducement by the Government, followed by an entirely discretionary acceptance, and performance, by Moda, with benefits flowing in both directions. As in *Radium Mines, New York*

Airways, Aycock, Grav and Wells Fargo, the Government and Moda engaged in an offer and acceptance.

D. The Secretary of HHS Had Authority to Contract.

The notion that Section 1342 must have itself "vest[ed] HHS with any contracting authority" (Gov.Br.16) has been a dead letter for two hundred years. "The authority of the executive to use contracts in carrying out authorized programs is ... generally assumed in the absence of express statutory prohibitions or limitations." J. Cibinic & R. Nash, Federal Procurement Law 5 (3d ed. 1977). That precept goes back to the earliest days of the Republic:

> The United States is … capable of attaining the objects for which it was created, by the means which are necessary for their attainment. … It will certainly require no argument to prove that one of the means by which some of these objects are to be accomplished, is contract; the government, therefore, is capable of contracting, and its contracts may be made in the name of the United States…. Every contract which subserves to the performance of a duty, may be rightfully made….

United States v. Maurice, 26 F. Cas. 1211, 1216-17 (No. 15747) (C.C.D. Va. 1823) (Circuit Justice Marshall).

The Secretary of HHS was granted authority to administer the ACA, establish Exchanges carried out exclusively through private insurer QHPs, "establish" the RC Program, and "pay" RC payments. ACA §§1101, 1301-1304,

1321, 1342.[24] Authority to contract "is generally implied when such authority is considered to be an integral part of the duties assigned to a [g]overnment employee." *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989) (citing J. Cibinic & R. Nash, *Formation of Government Contracts* 43 (1982)). The scope of the Secretary's responsibilities place his authority to contract beyond serious dispute, *see* Appx38.

Indeed, such authority has been implied in far less compelling circumstances, *e.g.*, *Fifth Third Bank of W. Ohio v. United States*, 402 F.3d 1221, 1235-36 (Fed. Cir. 2005) (implied authority to contract when "the ability to offer supervisory goodwill as an asset for regulatory capital purposes and to allow extended amortization of goodwill was an essential tool for encouraging acquisition of failing thrifts"); *Advanced Team Concepts, Inc. v. United States*, 68 Fed. Cl. 147, 150-51 (2005) (implied authority to contract given that duties of "scheduling, hiring, and paying invoices" were central to an officer's work); *Zoubi v. United States*, 25 Cl. Ct. 581, 587-88 (1992) (contract inducing interpreter relocation was within project director's authority to "establish" a new project and "obtain the personnel necessary"); *State of Arizona v. United States*, 216 Ct. Cl.

[24] The Secretary shared this authority through delegations to the CMS Administrator, including the authority to "establish and administer a program of risk corridors." 76 Fed. Reg. 53,903, 53,903-04 (Aug. 30, 2011).

221, 231 (1978) (authority to contract implied by authority to manage correctional institutions).

The Government challenges authority by pointing to the Anti-Deficiency Act's prohibition against officials "entering into a contract for future payment of money in advance of, or in excess of, existing appropriation" (Gov.Br.50-51, citing *Cessna Aircraft Co. v. Dalton*, 126 F.3d 1442, 1449 (Fed Cir. 1997)). However, the GAO, whose opinions on such subjects are given "special weight," see p. 23 *supra*, concluded that appropriations ***had*** been made, both through the CMS "Program Management" appropriation, and through the amounts HHS collected from profitable insurers under the RC Program, *see* pp. 37-38 *supra*, the latter of which is also deemed an "appropriation," *see* Appx239. The riders restricting CMS Program Management appropriations came later and cannot implicate the Secretary's then-existing power.

Moreover, this issue is ultimately academic, given that "Anti-Deficiency Act's requirements…do not affect the rights in this court of the citizen honestly contracting with the Government." *Ramah*, 567 U.S. at 197 (citations omitted).

E. Moda's Breach of Contract Claim Stands on Its Own Merits.

Moda's breach of contract claim does not rise and fall with its statutory claim, *cf.* Gov.Br.56.

1. Congress Cannot Curtail Contractual Rights.

If Congress acts with sufficient specificity, it can through subsequent legislation curtail pre-existing statutory and regulatory rights, *see* Section II.A *supra* (although Congress did not do so here, *see id*.). That legal principle does not apply to rights arising under a Government contract. Statutory enactments having a material impact on pre-existing contractual rights give rise to a valid claim for breach. *Mobil Oil*, 530 U.S. at 614-19; *United States v. Winstar Corp.*, 518 U.S. 839, 870 (1996) (same); *Amber Resources*, 538 F.3d at 1370-74 (same).

2. Contractual Obligations Are Payable Even When Appropriations Are Explicitly Limited.

Congress can, if it does so explicitly, limit the total amount available to pay its statutory and regulatory obligations, *see* Section II.A *supra* (although Congress did not do so here, *see id*.). But a government contractor is entitled to judgment for the entire amount owed it, as long as the amount owed is less than the total amount appropriated. *Ramah* reiterated that long-established rule of law:

> When a Government contractor is one of several persons to be paid out of a larger appropriation sufficient in itself to pay the contractor, it has long been the rule that the Government is responsible to the contractor for the full amount due under the contract, even if the agency exhausts the appropriation in service of other permissible ends.

567 U.S. at 190-91; *see also Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 637 (2005) (contractor must be paid "even if an agency's total lump-sum

appropriation is insufficient to pay all the contracts the agency has made"). "Although the agency itself cannot disburse funds beyond those appropriated to it, the Government's valid obligations will remain enforceable in the courts." *Ramah*, 567 U.S. at 191 (quotation omitted).[25]

HHS had appropriations authority to use the $457 million in RC collections from profitable insurers to make RC payments to unprofitable insurers. Appx675, n.8. General CMS appropriations of $3.6 billion and $750 million were also available to make RC payments for FY 2014 and FY 2015, respectively, *see* pp. 37-41 *supra*. Either source was more than sufficient to pay in full the Government's RC obligations to Moda for 2014 and 2015. Leaving aside Moda's statutory rights, the Company is entitled to be paid in full pursuant to its contract claim.[26]

V. RC PAYMENTS ARE PAST DUE, AN ISSUE THAT WILL SOON BE MOOT.

Even if RC payments were not due until the RC program ended December 31, 2016, payments would be due by the end of 2017. The payment timing issue

[25] Similarly, the statutory language found sufficient to preclude a statutory claim in *Greenlee* and *Prairie* is insufficient to preclude a claim for breach of contract. The Supreme Court so held in *Ramah*, 567 U.S. at 190, as this Court recognized in *Arctic Slope Native Ass'n v. Sebelius*, 501 Fed. Appx. 957, 959 (Fed. Cir. 2012).

[26] *Land of Lincoln* ultimately based its "no breach" finding on the premise that the ACA itself limits RC payments to unprofitable insurers to the amounts collected from profitable insurers, 129 Fed. Cl. at 108, 113-14. Because that premise is incorrect, *see* pp. 14-25 *supra*, so is the holding. A contract claim was not asserted or addressed in *Maine*, *see* 2017 WL 3225050 at * 1.

will therefore soon be moot, *see* Gov.Br.16 ("the practical significance of the timing issue may be overtaken by the passage of time while the litigation is pending").

Nonetheless, payments were in fact due annually, for the reasons detailed in *Health Republic Insurance Co. v. United States*, 129 Fed. Cl. 757, 772-78 (2017). The Government's theory that no payment is due until the end of the RC program is:

- inconsistent with the text of the ACA, which instructs HHS to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016" 42 U.S.C. § 18062(a), not a program for calendar years 2014 through 2016, and similarly requires HHS to make RC calculations of "payments in" and "payments out" for each year of the program, 42 U.S.C. § 18062(b)(1), (b)(2), (c)(1), (c)(2), not for the entire program;
- inconsistent with Congress's intent to model the ACA RC program on the Medicare Part D RC program, 42 U.S.C. §18062(a), which makes RC payments on an annual basis. *See* 42 U.S.C. §1395w-115(e)(3)(A), 42 C.F.R. §423.336(c)(2009);
- inconsistent with HHS's own proposed regulation, which provided for annual payments. 76 Fed. Reg. 41,930, 41,943 (July 15, 2011); and

- inconsistent with HHS's actual practice, which has been to calculate and disburse RC payments annually (albeit using only RC collections from profitable insurers). Appx508-539.

CONCLUSION

The CFC judgment should be affirmed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing brief for the appellees with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system on this 21st day of August 2017. I further certify that service of the brief was made on counsel for the appellant, listed below, by the CM/ECF system.

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CERTIFICATE OF COMPLIANCE

1. This brief complies with the type-volume limitations of Federal Circuit Rule 32(a) because the brief contains 13,996 words, excluding the parts of the brief exempted by Fed. R. App. 32(f).

2. This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman.

Dated: August 21, 2017

/s/ Steven J. Rosenbaum
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ADDENDUM OF STATUTES AND REGULATIONS

Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119

Section 1342. Establishment of risk corridors for plans in individual and small group markets (42 U.S.C. § 18062).

(a) IN GENERAL.—The Secretary shall establish and administer a program of Risk Corridors for calendar years 2014, 2015, and 2016 under which a Qualified Health Plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

(b) PAYMENT METHODOLOGY.—

(1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

45 CFR Part 153, Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, as promulgated in 77 Fed. Reg. 17,220 (Mar. 23, 2012)

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Subpart F—Health Insurance Issuer Standards Related to the Risk Corridors Program

§ 153.500 Definitions.
The following definitions apply to this subpart:

Administrative costs mean, with respect to a QHP [Qualified Health Plan], total non-claims costs incurred by the QHP issuer for the QHP, as described in § 158.160(b) of this subchapter.

Allowable administrative costs mean, with respect to a QHP, administrative costs of the QHP, up to 20 percent of the premiums earned with respect to the QHP (including any premium tax credit under any governmental program).

Allowable costs mean, with respect to a QHP, an amount equal to the sum of incurred claims of the QHP issuer for the QHP, within the meaning of § 158.140 of this subchapter (including adjustments for any direct and indirect remuneration); expenditures by the QHP issuer for the QHP for activities that improve health care quality as set forth in § 158.150 of this subchapter; expenditures by the QHP issuer for the QHP related to health information technology and meaningful use requirements as set forth in § 158.151 of this subchapter; and the adjustments set forth in § 153.530(b).

Charge means the flow of funds from QHP issuers to HHS.

Direct and indirect remuneration means prescription drug rebates received by a QHP issuer within the meaning of § 158.140(b)(1)(i) of this subchapter.

Payment means the flow of funds from HHS to QHP issuers.

Premiums earned mean, with respect to a QHP, all monies paid by or for enrollees with respect to that plan as a condition of receiving coverage, including any fees or other contributions paid by or for enrollees, within the meaning of § 158.130 of this subchapter.

Risk corridors means any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount.

Target amount means, with respect to a QHP, an amount equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

§ 153.510 Risk corridors establishment and payment methodology.
(a) *General requirement.* A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.

(b) *HHS payments to health insurance issuers.* QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:

(1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

(2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(c) *Health insurance issuers' remittance of charges.* QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:

(1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and

(2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

§ 153.520 Attribution and allocation of revenue and expense items.
(a) *Attribution to QHP*. Each item of revenue or expense in allowable costs or the target amount with respect to a QHP must be reasonably attributable to the operation of the QHP, with the attribution based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.
(b) *Allocation across plans*. Each item of revenue or expense in allowable costs or the target amount must be reasonably allocated across a QHP issuer's plans, with the allocation based on a generally accepted accounting method, consistently applied. To the extent that an issuer utilizes a specific method for allocating expenses for purposes of § 158.170 of this subchapter, the method used for purposes of this paragraph must be consistent.

(c) *Disclosure of attribution and allocation methods*. A QHP issuer must submit to HHS a report, in the manner and timeframe specified in the annual HHS notice of benefit and payment parameters, with a detailed description of the methods and specific bases used to perform the attributions and allocations set forth in paragraphs (a) and (b) of this section.

(d) *Attribution of reinsurance and risk adjustment to benefit year*. A QHP issuer must attribute reinsurance payments and contributions and risk adjustment payments and charges to allowable costs for the benefit year with respect to which the reinsurance payments or contributions or risk adjustment calculations apply.

(e) *Maintenance of records*. A QHP issuer must maintain for 10 years and make available to HHS upon request the data used to make the attributions and allocations set forth in paragraphs (a) and (b) of this section, together with all supporting information required to determine that these methods and bases were accurately implemented.

§ 153.530 Risk corridors data requirements.
(a) *Premium data*. A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters.

(b) *Allowable costs*. A QHP issuer must submit to HHS data on the allowable costs incurred with respect to each QHP that the QHP issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters. For purposes of this subpart, allowable costs must be—

(1) Increased by—

(i) Any risk adjustment charges paid by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part; and

(ii) Any reinsurance contributions made by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part.

(2) Reduced by—

(i) Any risk adjustment payments received by the issuer for the QHP under the risk adjustment program established pursuant to subpart D of this part;

(ii) Any reinsurance payments received by the issuer for the QHP under the transitional reinsurance program established pursuant to subpart C of this part; and

(iii) Any cost-sharing reduction payments received by the issuer for the QHP.

(c) Allowable administrative costs. A QHP issuer must submit to HHS data on the allowable administrative costs incurred with respect to each QHP that the QHP issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters.