IN THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

LAND OF LINCOLN MUTUAL HEALTH INSURANCE CO.,
An Illinois Non-Profit Mutual Insurance Corporation,
Plaintiff-Appellant,
v.

UNITED STATES,
Defendant-Appellee;

No. 2017-1224
Appeal from the U.S. Court of Federal Claims in Case No. 16-744 (Lettow, J.)

MODA HEALTH PLAN, INC.,
Plaintiff-Appellee,
v.

UNITED STATES,
Defendant-Appellant;

No. 2017-1994
Appeal from the U.S. Court of Federal Claims in Case No. 16-649 (Wheeler, J.)

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
Plaintiff-Appellant,
v.

UNITED STATES,
Defendant-Appellee;

No. 2017-2154
Appeal from the U.S. Court of Federal Claims in Case No. 16-651 (Griggsby, J.)

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellant,
v.

UNITED STATES,
Defendant-Appellee.

No. 2017-2395
Appeal from the U.S. Court of Federal Claims in Case No. 16-967 (Bruggink, J.)

RESPONSE TO PETITIONS FOR REHEARING EN BANC

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PRELIMINARY STATEMENT

The panel majority correctly applied the precedents of the Supreme Court and this Court in rejecting the damages claims in these cases. The petitions should be denied.

Section 1342 of the Patient Protection and Affordable Care Act ("ACA") established a temporary risk-corridors program for the 2014, 2015, and 2016 calendar years. Although section 1342 directed the Department of Health & Human Services ("HHS") to establish and administer a program to collect payments from profitable insurers and make payments to unprofitable insurers, the ACA did not appropriate any funding for risk-corridors payments. Instead, Congress deferred the issue of funding to the annual appropriations process.

In anticipation of that appropriations process, and more than a year before any payments could be made to insurers, Members of Congress asked the Government Accountability Office ("GAO") to identify the sources of funding that would potentially be available for risk-corridors payments. The GAO opinion identified only two possible sources: (1) the amounts that HHS would collect from insurers under the risk-corridors program (referred to as "user fees"), and (2) a lump sum appropriation for the management of Centers for Medicare & Medicaid Services ("CMS") programs. The GAO emphasized that those sources would not be available unless Congress enacted language that appropriated those funds.

In response, Congress enacted legislation that appropriated the user fees, but explicitly barred HHS from using the only other potential funding source that the GAO had identified. Congress reenacted the same funding restriction in an unbroken series of appropriations acts that covered each of the three years that the risk-corridors program was in effect. Congress thus locked HHS into its previously announced intention to keep the program "budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (statement of the Chairman of the House Appropriations Committee).

The panel majority properly gave effect to Congress's express restrictions on funding for risk-corridors payments. The insurers' claims fail even assuming that Congress originally intended to make risk-corridors payments an obligation of the government without regard to appropriations. There is no doubt that appropriations legislation can alter or suspend a preexisting statutory obligation, as long as Congress's intent to do so is clear. *See*, *e.g.*, *United States v. Will*, 449 U.S. 200, 224 (1980); *United States v. Dickerson*, 310 U.S. 554, 554-55 (1940). And here, there is no doubt that Congress intended the restrictions in the annual appropriations acts to prevent the government from paying out more than it collected from insurers.

The insurers' reliance on *United States v. Langston*, 118 U.S. 389, 394 (1886), is misplaced because there, the Supreme Court declined to infer from an act that "merely appropriated a less amount" than an officer's full salary that Congress

intended to reduce his salary, which Congress had fully funded for many years. Here, there was no mere failure to appropriate funds. Congress explicitly barred HHS from using funds other than the amounts that insurers paid into the program. Insurers cannot circumvent Congress's power of the purse by demanding billions of additional dollars from the Treasury.

REASONS TO DENY THE PETITIONS

A. Statutory Claims

The panel majority correctly heeded Congress's express limits on funding for risk-corridors payments. The insurers' claims fail even assuming that Congress had originally intended to make risk-corridors payments an obligation of the government without regard to appropriations.

It is well settled that appropriations acts can alter or suspend a preexisting statutory obligation. The Supreme Court has emphasized that "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that ... it could accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" *United States v. Will*, 449 U.S. 200, 222 (1980) (quoting *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). And the Supreme Court has repeatedly found appropriations acts to do so. In *Will*, for example, the Supreme Court concluded that appropriations acts enacted "in Years 1, 3, and 4, although phrased in terms of limiting funds, nevertheless were intended by Congress to block the increases [in judges' salaries] the Adjustment Act otherwise would generate." *Id.* at 223. Similarly, in *Dickerson*, 310

U.S. at 554-55, the Supreme Court concluded that an appropriations act prohibiting the use of funds to pay military reenlistment allowances superseded permanent legislation providing that such allowances shall be paid. And in *United States v. Mitchell*, 109 U.S. 146, 148 (1883), the Supreme Court held that "by the appropriation acts which cover the period for which the appellee claims compensation, Congress expressed its purpose to suspend the operation of" a prior statute fixing salaries "and to reduce for that period the salaries of the appellee and other interpreters of the same class from $400 to $300 per annum."

Here, there is no doubt that Congress intended its appropriations acts to limit the government's risk-corridors payments to the amounts collected from insurers under the program. Although section 1342 directed HHS to establish a program under which HHS would collect "payments in" from profitable insurers and make "payments out" to unprofitable insurers for the 2014, 2015, and 2016 calendar years, the ACA did not appropriate any funding for risk-corridors payments. Moreover, under the terms of section 1342, no collections or payments could be made until calendar year 2015, because the amounts would depend on a retrospective analysis of insurers' data for the preceding calendar year.

Before making any appropriation, and a year before the first set of payments would be due, Members of Congress asked the GAO to identify the potential sources of funding for risk-corridors payments. *See Dep't of Health and Human Servs.—Risk Corridors Program*, B-325630, 2014 WL 4825237, at *1 (Comp. Gen. Sept. 30, 2014)

(noting the requests). The GAO examined HHS's appropriations act for fiscal year 2014 to determine whether its language—if reenacted in subsequent appropriations acts—would allow funds to be used for risk-corridors payments. *Id.* at *2-5. The GAO identified within the CMS Program Management appropriation two potential sources of funding that it believed would be available for risk-corridors payments, if the same language were reenacted for subsequent fiscal years. *Id.* at *3, *5. First, the GAO concluded that the appropriation for "user fees" would, if reenacted, allow HHS to use funds collected from insurers to make payments to insurers. *Id.* at *3-4. Second, the GAO concluded that a lump sum appropriation for the management of CMS programs could encompass risk-corridors payments, if it were reenacted by Congress in subsequent appropriations acts. *Id.* at *3, *5.

Congress then enacted the appropriations act for fiscal year 2015, which specifically addressed funding for the risk-corridors program. That legislation reenacted the user-fee language that would allow HHS to use funds collected from insurers to make risk-corridors payments. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, 128 Stat. 2130, 2477. But to ensure that the user fees would be the sole source of funding, Congress expressly barred the use of the only other source that the GAO had identified:

> None of the funds made available by this Act from [CMS trust funds], or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Id. § 227, 128 Stat. at 2491.

In other words, the first time that Congress needed to decide whether to appropriate funds for risk-corridors payments, it enacted legislation that capped those payments at amounts collected from insurers. Congress subsequently reenacted the identical funding restriction in an unbroken series of appropriations acts that covered all three years in which the risk-corridors program was in effect.[1] Congress thus bound HHS to its previously stated intention to keep the program "budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (statement of the Chairman of the House Appropriations Committee); *see* 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) (HHS's earlier announcement that it would "implement th[e] program in a budget neutral manner").

As the panel majority explained, these funding restrictions were "plainly" intended to "cap the payments required by the statute at the amount of payments in for each of the applicable years." Moda Addendum ("Add.") 31. "What else could Congress have intended?" *Id.* "It clearly did not intend to consign risk corridors

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[1] *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Continuing Appropriations Act, 2017, Pub. L. No. 114-223, div. C, 130 Stat. 857, 909; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, § 101, 130 Stat. 1005-06; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543; Continuing Appropriations Act, 2018, Pub. L. No. 115-56, div. D, §§ 101, 103, 104, 131 Stat. 1129, 1139-40; Further Additional Continuing Appropriations Act, 2018, Pub. L. No. 115-96, div. A, § 1001, 131 Stat. 2044, 2044.

payments 'to the fiscal limbo of an account due but not payable.'" *Id.* (quoting *Will*, 449 U.S. at 224). The majority correctly rejected the insurers' argument that Congress "simply intended to limit the use of a single source of funding while leaving others available." *Id.* The GAO identified only two potential funding sources—the user fees and the lump sum. Congress eliminated the lump sum, and thus made user fees the sole source of funding for risk-corridors payments.

The insurers' observation that each funding restriction was "temporary" is irrelevant, because Congress repeatedly enacted the same restriction to ensure that it covered all three years of the program. Land of Lincoln's observation (Pet. 11) that the restrictions did not prevent HHS from using the $484 million collected from insurers to make payments to insurers is irrelevant, because HHS distributed those funds to insurers. The insurers are demanding billions of dollars beyond the amounts collected from insurers. Those demands are foreclosed by Congress's express restrictions on funding for risk-corridors payments.[2]

The insurers' assertion of a conflict with the Supreme Court's method of statutory interpretation does not bear even cursory scrutiny. The insurers contend that the panel majority should have considered the text of the appropriations acts in

[2] Land of Lincoln incorrectly states (Pet. 11) that the panel majority did not address the possibility that HHS could have used an additional $750 million to make risk-corridors payments *before* Congress enacted the first appropriations restriction on December 16, 2014. The panel majority explained that under the plain terms of section 1342, HHS could not have calculated or made risk-corridors payments until calendar year 2015. *See* Moda Add. 27-28.

isolation, and ignored Congress's back-and-forth with the GAO and the explanatory statement of the House Appropriations Committee Chairman. The Supreme Court, however, has repeatedly looked to legislative context and history to ascertain Congress's intent in enacting funding restrictions. In *Will*, for example, the Court relied on "floor remarks in both Houses" and committee reports in determining that Congress's intent was to block increases in judges' salaries that the underlying legislation would otherwise generate. 449 U.S. at 223-24. Likewise, in *Dickerson*, the Supreme Court relied on floor statements and other legislative history in determining that funding restrictions were intended to suspend reenlistment bonuses for the covered years. *See* 310 U.S. at 557-62. In rejecting the argument that it should not consider the legislative history, the Supreme Court explained that it would be "anomalous to close our minds to persuasive evidence of intention." *Id.* at 562. Moda's reliance (Pet. 10) on *Thompson v. Cherokee Nation of Oklahoma*, 334 F.3d 1075 (Fed. Cir. 2003), is misplaced, because this Court explicitly recognized that "legislative history can be used as an interpretive guide to determine whether language in an appropriations act constitutes a statutory cap." *Id.* at 1085 (citing *Dickerson*, 310 U.S. at 561).

The insurers' assertion of a conflict with *United States v. Langston*, 118 U.S. 389 (1886), is equally baseless. In *Langston*, the Supreme Court declined to infer from an act that "merely appropriated a less amount" than an official's full salary that Congress intended to reduce his salary, which Congress had fully funded for many

years. *Id.* at 394. Moreover, *Langston* predated the Judgment Fund, so an Act of Congress was required to pay the judgment. *See* Act of August 4, 1886, ch. 903, 24 Stat. 256, 275, 281-82.

Here, Congress did not "merely fail" to appropriate funding for risk-corridors payments; Congress appropriated the user fees but explicitly barred HHS from using the only other potential funding source that the GAO identified. When the context of an appropriations act reflects "a broader purpose" beyond "something more than the mere omission to appropriate a sufficient sum," *United States v. Vulte*, 233 U.S. 509, 515 (1914), the Supreme Court has consistently given effect to Congress's intent.[3]

This Court has heeded the Supreme Court's teachings. For example, although the insurers allege a conflict with *Greenlee County v. United States*, 487 F.3d 871 (Fed. Cir. 2007), that decision rejected the claimant's attempt to collect more funds than Congress had appropriated. This Court rejected similar claims in *Prairie County v. United States*, 782 F.3d 685 (Fed. Cir. 2015), and *Highland Falls-Fort Montgomery Central School District v. United States*, 48 F.3d 1166 (Fed. Cir. 1995).

As the panel majority recognized, the Court of Claims cases on which the insurers relied did not give courts license to disregard Congress's intent in enacting

[3] The insurers also cite *Tennessee Valley Authority v. Hill*, 437 U.S. 153 (1978), but that case simply found that acts appropriating funds for a dam were not intended to override the Endangered Species Act.

funding restrictions. *See* Moda Add. 30-31. The appropriations act at issue in *Gibney v. United States*, 114 Ct. Cl. 38, 50 (1949), expressly preserved the claimant's right to payment. And the appropriations act at issue in *New York Airways, Inc. v. United States*, 369 F.2d 743 (Ct. Cl. 1966) (per curiam), explicitly treated the underlying obligation as contractual. *See id.* at 752 ("Congress recognized the contract nature of the subsidy payments" by titling its enactment "Payments to Air Carriers (Liquidation of Contract Authorization))." (As discussed in Part B below, there are no contracts for risk-corridors payments.)

The insurers' reliance on a presumption against retroactivity is wholly misplaced. The legislation that appropriated funds for risk-corridors payments did not "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006). As discussed, the ACA did not appropriate any funding for risk-corridors payments. The first time that Congress appropriated such funds, and before any such payments could have been made, Congress appropriated the amounts that would be collected from insurers and barred HHS from using other funds. That is not retroactive legislation. In any event, the presumption of retroactivity is just a presumption, which is overcome when Congress's intent is clear. *See, e.g.*, *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976) (noting that Congress is free to "upset[] otherwise settled expectations" in a statutory program). And Congress clearly intended its appropriations acts to cap

payments to insurers at the amounts collected from insurers over the duration of the program.

Although the issue has no practical significance here, we respectfully submit that the panel majority was mistaken to conclude that Congress originally intended to make risk-corridors payments an obligation of the government without regard to appropriations. The panel majority misunderstood the government's position when it stated that the government "cites no authority for its contention that a statutory obligation cannot exist absent budget authority." Moda Add. 20. Although such an obligation "can" exist without budget authority, the touchstone is Congress's intent. Section 1342 is framed as a directive to HHS to establish a program to make payments. That directive is properly understood in light of the background appropriations statutes that prohibit an agency from making payments without budget authority or appropriation. Most notably, the Anti-Deficiency Act prohibits any officer or employee of the United States from "mak[ing] or authoriz[ing] an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation." 31 U.S.C. § 1341(a)(1)(A); *see also* 2 U.S.C. § 622(2) (defining types of budget authority). Although Congress can grant an agency budget authority in advance of appropriations or create an obligation of the government without regard to appropriations, Congress did not do so in section 1342. In this respect, section 1342 differed from the Medicare part D statute on which section 1342 was generally modeled. *See* 42 U.S.C. § 1395w-115(a)(2) ("This 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.”). Thus, section 1342 is not properly interpreted to make risk-corridors payments an obligation of the government without regard to appropriations.

B. Contract Claims

The insurers’ contract claims fail because insurers have no contracts for risk-corridors payments. The insurers have abandoned their express contract claims, which were rejected by every court to consider them. Instead, they seek to derive implied-in-fact contracts from the text of section 1342 or statements by HHS. These efforts are fruitless.

The precedents of the Supreme Court and this Court foreclose the insurers’ effort to derive an implied-in-fact contract from the text of section 1342. “[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that ‘a law is not intended to create private contractual or vested rights, but merely declares a policy to be pursued until the legislature shall ordain otherwise.’” *Brooks v. Dunlop Mfg.* 702 F.3d 624, 630 (Fed. Cir. 2012) (quoting *National R.R. Passenger Corp. v. Atchison, Topeka & Santa Fe Ry.*, 470 U.S. 451, 465-66 (1985)). “This well-established presumption is grounded in the elementary proposition that the principal function of the legislature is not to make contracts, but to make laws that establish the policy of the state.” *Id.* (quoting *Atchison*, 470 U.S. at 466). Accordingly, “the party asserting the creation of a contract must overcome this well-founded

presumption and [courts should] proceed cautiously both in identifying a contract within the language of a regulatory statute and in defining the contours of any contractual obligation." *Brooks*, 702 F.3d at 630-31 (quoting *Atchison*, 470 U.S. at 466).

Nothing in the language of section 1342 "'create[s] or speak[s] of a contract' between the United States and" insurers. *Brooks*, 702 F.3d at 631 (quoting *Atchison*, 470 U.S. at 467). Section 1342 "is a directive from the Congress to the [agency], not a promise from the [agency] to" third parties. *Hanlin v. United States*, 316 F.3d 1325, 1329 (Fed. Cir. 2003).

The Court of Claims' decisions on which the insurers relied are inapposite. The regulation in *Radium Mines, Inc. v. United States*, 153 F. Supp. 403, 405 (Ct. Cl. 1957), stated that "[u]pon receipt of an offer," the agency would "forward to the person making the offer a form of contract containing applicable terms and conditions ready for his acceptance." And in *New York Airways*, 369 F.2d at 752, "Congress recognized the contract nature of the subsidy payments" by titling its enactment "Payments to Air Carriers (Liquidation of Contract Authorization)."

The insurers' attempts to derive implied-in-fact contracts from statements by HHS are equally unavailing. HHS had no authority to enter into risk-corridors contracts and did not purport to do so. Federal law provides that "[a] law may be construed to make an appropriation out of the Treasury *or to authorize making a contract for the payment of money in excess of an appropriation* only if the law specifically states that an appropriation is made or that such a contract may be made." 31 U.S.C. § 1301(d)

(emphasis added). Nothing in section 1342 authorized HHS to make contracts for risk-corridors payments in excess of appropriations. Indeed, nothing in section 1342 gave HHS any contracting authority with respect to risk-corridors payments. And an implied-in-fact contract cannot arise without "actual authority" of the government's representative to bind the government. *Schism v. United States*, 316 F.3d 1259, 1278 (Fed. Cir. 2002) (en banc).[4]

The insurers' reliance on HHS regulations stating that insurers "will receive payment from HHS," 45 C.F.R. § 153.510(b), turns the Appropriations Clause on its head. Under the "straightforward and explicit command of the Appropriations Clause," "no money can be paid out of the Treasury unless it has been appropriated by *an act of Congress*." *OPM v. Richmond*, 496 U.S. 414, 424 (1990) (emphasis added). The Appropriations Clause is "particularly important as a restraint on Executive Branch officers," *U.S. Dep't of the Navy v. FLRA*, 665 F.3d 1339, 1347 (D.C. Cir. 2012), and it is implicit in any agency's payment regulation that implementation depends on appropriations. Thus, "[a] regulation may create a liability on the part of the government only if Congress has enacted the necessary budget authority." GAO, *Principles of Federal Appropriations Law* 2–2 (4th ed. 2016 rev.). Likewise, "[i]f a given

[4] The insurers' reliance on *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 185 (2012), is misplaced because the statute at issue there expressly directed the agency to enter into contracts with willing tribes.

transaction is not sufficient to constitute a valid obligation, recording it will not make it one." 2 GAO, *Principles of Federal Appropriations Law* 7-8 (3d ed. 2004).

Moreover, HHS's statements show that there was no meeting of the minds with respect to the key terms of the agency's risk-corridors payments. Indeed, the trial judge who ruled in favor of insurers recognized that "HHS stated repeatedly that it 'intend[ed] to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually.'" *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 454 (2017) (Wheeler, J.) (quoting 79 Fed. Reg. 30,240, 30,260 (May 27, 2014)). HHS thus made clear that "it intended to pay out only what it took in from profitable [insurers] over the program's three years." *Id.* "In other words, HHS announced that it would not make full annual payments." *Id.* (emphasis omitted). And HHS repeatedly recognized that its ability to make risk-corridors payments was subject to appropriations.[5]

Despite these statements, the insurers chose to offer plans on the Exchanges for the 2015 and 2016 calendar years. Moreover, they did so even after Congress enacted legislation in December 2014 that prohibited HHS from using funds other than amounts collected to make risk-corridors payments. Insurers had a strong profit

[5] *See* 79 Fed. Reg. at 30,260 (stating that if collections are insufficient to fund payments, "HHS will use other sources of funding for the risk corridors payments, *subject to the availability of appropriations*") (emphasis added); 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (same); CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) (Moda Appx546) (similar).

motive for doing so, because the Exchanges are the only commercial channel in which insurers can market their plans to the millions of individuals who receive federal subsidies. The insurers cannot now claim to have formed implied-in-fact contracts, the terms of which contradict HHS's statements and the express funding restrictions enacted by Congress.

CONCLUSION

The petitions should be denied.

Respectfully submitted,

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AUGUST 2018

CERTIFICATE OF SERVICE

I hereby certify that on August 31, 2018, I electronically filed the foregoing response with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Participants are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Alisa B. Klein
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CERTIFICATE OF COMPLIANCE

I hereby certify that this response complies with type volume and typeface requirements in Federal Rule of Appellate Procedure 35 because it has been prepared in 14-point Garamond, a proportionally spaced font, and contains 3897 words, excluding the parts exempted by Federal Circuit Rule 35(c)(2).

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