IN THE UNITED STATES COURT OF FEDERAL CLAIMS

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY,	)	
Plaintiff,	)	Case No. 1:16-cv-00744C
v.	)	Judge Charles F. Lettow
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

MOTION FOR LEAVE TO FILE AMICUS CURIAE ON BEHALF OF MODA HEALTH PLAN, INC. AND HEALTH REPUBLIC INSURANCE COMPANY IN SUPPORT OF THE PLAINTIFF

Moda Health Plan, Inc. and Health Republic Insurance Company respectfully move this Court for leave to file the attached brief amicus curiae in this action. Amici have a strong interest in this case, given that they are plaintiffs in pending actions in this Court that, like this action, assert Tucker Act claims arising out of the Government's failure to make mandatory risk corridor payments pursuant to the Affordable Care Act.[1]

The Court of Federal Claims has broad discretion to accept the filing of a brief amicus curiae. *Fluor Corp. & Affiliates v. United States*, 35 Fed. Cl. 284, 285 (1995). In considering whether to exercise such discretion, the Court of Federal Claims considers such factors as "the usefulness of information and argument presented by the potential amicus curiae to the court," "the strength of information and argument presented by the potential amicus curiae's interests," "the timeliness of the motion," and "whether the parties oppose the motion." *Wolfchild v. United States*, 62 Fed. Cl. 521, 536 (2004).

[1] *See Moda Health Plan, Inc. v. United States*, No. 1:16-cv-00649 (Judge Wheeler); *Health Republic Insurance Company v. United States*, No. 16-259C (Judge Sweeney) (class action).

Applying these factors, the Court should grant the motion. First and foremost, the amicus brief will aid the Court in its resolution of this case. The brief addresses important regulatory background and case law not discussed by either Land of Lincoln or the United States in their respective memoranda in support of their cross Motions for Judgment on the Administrative Record. Some of this case law constitutes controlling legal precedent of the Federal Circuit and its predecessor, including, *e.g.*, case law addressing the circumstances under which the Judgment Fund is available to satisfy the Government's statutory obligations. Amici's counsel have many decades experience litigating before this Court, and submit that the brief's detailed explication of this case law will be of material assistance to the Court.

The amount of money at stake in the pending disputes over risk corridor payments also supports allowing the amicus brief. Many hundreds of millions of dollars are at issue. The questions presented are weighty, and merit detailed discussion and careful treatment.

Amici's interests also strongly support acceptance of the brief. As noted, they too have filed lawsuits in this Court seeking the recovery of risk corridor payments that the Government failed to make. The instant lawsuit presents certain issues common to all the lawsuits. This Court's resolution of those issues will at a minimum be considered carefully by the judges before whom amici's cases are pending.

The brief is being filed well in advance of the deadlines for the parties' oppositions to the cross-motions, and accordingly will not delay or impede the proceedings. Amici have acted in a timely manner in seeking leave to file their brief.

Plaintiff has consented to its filing, but the Government has not.

Amici's motion for leave to file their brief should be granted.

Respectfully submitted,

DATED: October 5, 2016

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CERTIFICATE OF SERVICE

I, Steven J. Rosenbaum, hereby certify that I caused a true and correct copy of this Motion for Leave to File Amicus Curiae Brief on Behalf of Moda Health Plan, Inc. and Health Republic Insurance Company in Support of the Plaintiff and the attached Amicus Brief to the following via ECF notification:

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PROPOSED ORDER

This Motion for Leave to File an Amicus Curiae Brief on Behalf of Moda Health Plan, Inc., et al. is **GRANTED** for good cause. The attached Amicus Brief is accepted as filed.

SO ORDERED.

ENTERED: _____, 2016

_____
J., CHARLES F. LETTOW

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

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AMICUS CURIAE BRIEF ON BEHALF OF MODA HEALTH PLAN, INC. AND HEALTH REPUBLIC INSURANCE COMPANY IN SUPPORT OF THE PLAINTIFF

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October 5, 2016

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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 American citizens. The ACA established a straightforward arrangement between the United States and health insurers: if the insurers would agree to offer Qualified Health Plans through the Health Benefit Exchanges established by the Act, the Government would pay the insurers a portion of any losses a plan suffered during each of the first three years of operation, pursuant to a straightforward formula set forth in the statute itself.

Many insurers, including plaintiff Land of Lincoln and amici, determined to participate, and incurred losses in calendar years 2014 and 2015 that required the Government to make these requisite "risk corridor" payments. But the Government has failed to do so, paying Land of Lincoln and each amici only 12.6 cents on the dollar owed for 2014, and publically announcing that the Government would not meet its obligations with respect to 2015, either. Land of Lincoln and amici have each filed lawsuits under the Tucker Act.[1]

The Government attempts to defend its behavior on four grounds: that the ACA purportedly limits the amount of risk corridor payments to be made by the Government to plans that suffered losses to the amount collected by the Government from plans that earned unexpectedly large profits; that appropriations riders adopted by Congress in 2015 and 2016, which proscribed the use of specified funds for making risk corridor payments, vitiated the Government's statutory obligation under the ACA to make those payments; that the Government

[1] *Health Republic Insurance Company v. United States*, No. 16-259C (Judge Sweeney); *Moda Health Plan, Inc. v. United States*, No. 16-649C (Judge Wheeler). Health Republic Insurance Company (HRIC) has brought its case as a class action, asserting a statutory obligation claim under the Tucker Act. Moda has raised both the statutory obligation claim and an implied contract claim. This brief addresses the statutory obligation (HRIC, Moda) and implied contract (Moda) claims at issue in the present case.

did not enter into implied contracts with the insurers; and that the Government is entitled to wait three years before making any payments. None of these excuses bears scrutiny.

I. INTRODUCTION.

The ACA significantly changed the United States market for health insurance through two mechanisms: (1) expanding Medicaid eligibility to all adults whose income is at or below 133 percent of the federal poverty level, ACA § 2001; and (2) creating "Health Benefit Exchanges" that facilitate the purchase of "Qualified Health Plans"[2] issued by private health insurance issuers, *id.* §§ 1311, 1321, 42 U.S.C. §§ 13031, 18041.[3] The ACA also provides for Government subsidies to low-income eligible individuals to assist in their purchase of private Qualified Health Plans.[4] By providing financial assistance to individuals purchasing "Qualified Health Plans" from health insurers through newly established "Health Benefit Exchanges," and by its adoption of other health insurance market reforms, the ACA created access to health insurance for millions of previously uninsured or underinsured Americans.

In addition to establishing and providing funding for these new Health Benefit Exchanges, the ACA implemented other significant health insurance market reforms. For

[2] A "Qualified Health Plan" is health insurance that: provides "essential health benefits" as defined in the ACA; complies with health care provider network adequacy standards; follows established limitations on cost-sharing; and has been certified by a Health Benefit Exchange. ACA § 1301, 42 U.S.C. § 18021.

[3] An individual is eligible to purchase a Qualified Health Plan through an Exchange if he or she: is a citizen or national of the United States or a lawfully present non-citizen; is not incarcerated; and meets certain residency requirements. ACA § 1312(f), 42 U.S.C. § 18032(f); see also 45 C.F.R. § 155.305(a).

[4] Specifically, tax credits to offset the cost of insurance premiums are available to citizens and lawfully present non-citizens with incomes between 100 percent and 400 percent of the federal poverty level, and who are not otherwise eligible for comprehensive health care coverage. ACA § 1401; § 155.305(f). In addition, subsidies to reduce enrollees' cost sharing are available to citizens and lawfully present non-citizens with household income between 100 percent and 250 percent of the federal poverty level, and who are not otherwise eligible for comprehensive health care coverage. ACA § 1402; § 155.305(g).

example, the ACA imposed prohibitions against health insurers denying coverage or setting different premiums based upon an individual's health status or medical history. ACA § 1201(2)(A); 42 U.S.C. §§ 300gg-1 - 300gg-5.

The ACA thus had several interlocking effects: it significantly revised practices governing health insurance; it created new programs that would result in the influx of large numbers of new enrollees; and it created a brand new market mechanism, Health Benefit Exchanges, for the procurement of health insurance.

Unsurprisingly, these revisions left insurers uncertain as to how to accurately set premium rates for Qualified Health Plans. Perhaps most importantly, insurers lacked reliable information regarding the number, and likely future health expenses of, the individuals who would enroll in their Qualified Health Plans, but were prevented from addressing that uncertainty by requiring higher premiums from sicker individuals.

The ACA anticipated these challenges. In order to encourage and induce insurers to offer Qualified Health Plans despite this considerable uncertainty — something insurers were under no legal obligation whatsoever to do — Section 1342 of the ACA established a temporary "risk corridors program." This risk corridors program would remain in effect for each of the first three years of ACA operations (calendar years 2014 through 2016), to help issuers weather the financial challenges caused by having to set premium rates for a population about which the insurers lacked important information.

The risk corridors program was also designed to discourage participating insurers from being excessively cautious in their cost estimates, ***which would have increased enrollee premiums, thereby increasing the Government's own costs of providing premium tax credits*** to low-income individuals purchasing Qualified Health Plans. Risk corridors were specifically

intended to "permit issuers to lower rates [they charge to enrollees] 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).

Under the risk corridors program, the Government is legally obligated to make specified payments to a participating insurer if its actual costs of providing enrollee health benefits exceeded premium revenues minus administrative costs during any year. While the insurer would still incur a loss, the temporary risk corridors program would cover a substantial portion of those losses.

Specifically, under the risk corridors program, if a participating plan's "allowable costs" — i.e., its actual costs of providing enrollee benefits covered by the plan, *see* ACA § 1342(c)(1) — for any year are between 103 and 108 percent of the "target amount" — i.e., the plan's premium revenue minus its administrative costs, *see id.* — the Government must pay the plan 50 percent of the amount by which the actual costs of providing enrollee health benefits exceeded 103 percent of premium revenues minus administrative costs. ACA § 1342(b)(1)(A). If a participating plan's actual costs of providing enrollee health benefits for any year are more than 108 percent of the plan's premium revenue minus its administrative costs, the Government must pay the plan 2.5 percent of the plan's premium revenue minus administrative costs, plus 80 percent of the amount by which the costs of providing enrollee benefits exceeded 108 percent of premium revenues minus administrative costs. *Id.* § 1342(b)(1)(B).

In short, if a plan's actual costs in a given year exceeded enrollee premium revenues minus administrative costs by the specified percentages, the Government must pay the insurer the specified portion of that excess, thus sharing in, and reducing the amount of, the insurer's loss.

Conversely, if a plan's actual costs of providing enrollee benefits are between 92 and 97 percent of its premium revenues minus administrative costs, the plan must pay the Government 50 percent of the amount by which premium revenues minus administrative costs exceed 97 percent of the actual plan costs of providing enrollee health benefits. *Id.* § 1342(b)(2)(A). If a plan's actual costs of providing enrollee benefits are less than 92 percent of its premium revenues minus administrative costs, the plan must pay the Government the sum of 2.5 percent of" premium revenues minus administrative costs, plus 80 percent of the amount by which premium revenues minus administrative costs exceed 92 percent of the actual plan costs of providing enrollee health benefits. *Id.* § 1342(b)(2)(B).

In short, if a plan's enrollee premiums exceed actual costs in a given year by the specified amount, the insurer pays the Government the specified portion of that excess, thus allowing the Government to share in the insurer's profit.

On its face, the Government's obligation under Section 1342 to make risk corridor payments to an insurer whose actual costs of providing enrollee health benefits for any plan year exceeded premium revenues (minus administrative costs) by the specified amounts is unfettered, and unrelated to whether, and the extent to which, the Government had received risk corridor payments from insurers that had been profitable in the applicable year.

The centrality of the risk corridor payments to the inducement of insurers to participate in the ACA is further highlighted by post-enactment Government action. As described on p. 2 *supra*, the ACA mandated that insurance plans meet the requirements of a "Qualified Health Plan," meaning, *inter alia*, that the plan provided "essential health benefits" as defined in the ACA, unless a preexisting plan was deemed a "grandfathered" plan because it: (a) was in effect on the date the ACA was enacted in March 2010, and (b) had not had any significant benefits or

cost sharing changes in the intervening years. ACA § 1251, 42 U.S.C. § 18011; ACA § 1255; *see also* 45 C.F.R. § 147.140. However, a public outcry arose when preexisting, non-ACA compliant plans began to terminate and disenroll their members, and the Government in November 2013 responded by announcing a "transitional" policy under which plans in effect on October 1, 2013 "will not be considered to be out of compliance with the [ACA's] market reforms," even if they did not meet the statutory definition of a "grandfathered" plan.[5] This transitional policy meant that many individuals with existing health insurance, who were assumed generally to be healthier than the uninsured population, maintained their existing insurance and did not enroll in the Qualified Health Plans available through the Exchanges.

CMS recognized that this transition policy would change the risk profile (i.e., increase the risk levels) upon which insurers had relied in determining their premium levels, and that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014," but expressed confidence that "the risk corridor program should help ameliorate unanticipated changes in premium revenue."[6] Although the original transitional policy was to last only a year, CMS has since twice extended it, until October 1, 2017.[7]

In short, the risk corridor payments were central to the entire health insurance scheme, and only became more important after the announcement of the transitional policy. Yet after hundreds of insurers had, in reliance on the availability of risk corridor payments, priced, sold,

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[5] CMS, Letter to State Ins. Comm'rs 1 (Nov. 14, 2013), https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf.

[6] *Id.*

[7] *See* CMS, Insurance Standards Bulletin Series – Extension of Transitional Policy through Calendar Year 2017 (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf; CMS, Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016 (Mar. 5, 2014), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf.

and administered coverage under Qualified Health Plans in the new Health Benefit Exchanges, the Government reneged on its statutory obligation and refused to make the risk corridor payment to which the insurers are entitled. In October 2015 — two years after issuers started selling Qualified Health Plan coverage — the Government announced that the aggregate risk corridor payments it would make to all insurers whose costs of providing enrollee health benefits had significantly exceeded premium revenues would be capped by the amount the Government had collected from insurers whose ACA premium revenues had exceeded the actual costs of providing enrollee health benefits.

Thus far, the Government has paid insurers only 12.6 percent of what they are owed for the 2014 benefit year, and it has announced that it anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridor obligations, and no funds will be available at this time for 2015 benefit year risk corridor payments.[8] As we now show, the Government is legally obligated to pay the risk corridor payments in full, and this Court should enter judgment in an amount equal to the difference between the risk corridor payments for 2014 and 2015 that the Government has actually made, and the risk corridor payments that the Government was required to make for those years, based upon the payment formulas set forth in Section 1342(b)(1) of the ACA.

[8] *See* CMS, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf; CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014 (Nov. 19, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf.

II. UNDER SECTION 1342, THE GOVERNMENT MUST PAY INSURERS THE RISK CORRIDOR PAYMENTS THEY ARE OWED REGARDLESS OF THE AMOUNTS THE GOVERNMENT HAS COLLECTED FROM PROFITABLE INSURERS.

The Government argues that the ACA's authors in Congress "planned the [risk corridor] program to be self-funding: insurers that have lower-than-expected costs for a given year are required to make contributions to the program, and those contributions are used to fund payments to insurers that have higher-than-expected costs." Gov't Mot. to Dismiss and Mot. for Judgment on the Admin. Record on Count One, at 23, Sept. 23, 2016 (ECF No. 22) (hereinafter "Gov't Br."). The Government's argument is completely inconsistent with both the text of the statute and the position taken by CMS itself when it published a final rule relating to the risk corridors program.

On its face, the Government's obligation under Section 1342 of the ACA to make risk corridor payments to eligible insurers is: (a) completely unfettered, and (b) unrelated to whether, and the extent to which, the Government had received risk corridor payments from insurers in the program in the applicable year:

> (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.

ACA § 1342, 42 U.S.C. § 18062 (emphasis added). This statutory language thus expressly provides that the Government "shall" make risk corridor payments, in statutorily-defined amounts, to qualified insurers pursuant to ACA § 1342(b)(1)(A) and (b)(1)(B), without any limit or conditions, including whether, or the extent to which, the Government had received any payments from profitable insurers whose plans met the criteria of ACA § 1342(b)(2)(A) or (b)(2)(B).

Following passage of the ACA, CMS acknowledged its obligation fully to comply with Section 1342 through formal notice and comment rulemaking. On March 23, 2012, CMS promulgated a final rule implementing the risk corridors program. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220 (Mar. 23, 2012) (codified at 45 C.F.R. Part 153). The regulation confirmed that "[Qualified Health Plan] issuers" to which risk corridor payments are owed by the Government "***will receive payment*** from [the U.S. Department of Health and Human Services ("HHS")]" in amounts consistent with the statutory provisions of Section 1342(b)(1), and that "[Qualified Health Plan] issuers" that owe

risk corridor payments to the Government "must remit charges to HHS" in amounts consistent with the statutory provisions of Section 1342(b)(2). 45 C.F.R. § 153.510 (emphasis added). Like Section 1342 itself, regulation 153.510 nowhere made the payments owed by the Government under Section 1342(b)(1) contingent on the payments received by the Government under Section 1342(b)(2).

On March 11, 2013, HHS published another final rule relating to Health Benefit Exchanges and Qualified Health Plans, which included certain benefit and payment parameters to be taken into consideration by insurers in establishing their premium rates for 2014, the first year of the Exchanges. In the preamble, CMS again acknowledged, consistent with the terms of the ACA itself, its obligation to make full risk corridor payments to insurers whose enrollee medical claims costs exceeded premium revenues minus administrative costs by the specified percentages, regardless of the amount collected by the Government from insurers whose premiums minus administrative costs exceeded enrollee medical claims costs by the specified percentages: "***The 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 (emphasis added).

This was the final CMS statement on the subject prior to the Health Benefit Exchanges coming into effect January 1, 2014. And just last month, CMS again confirmed the reading of Section 1342 as requiring payments to insurers regardless of the amounts received from profitable insurers, when it assured insurers that "HHS will record risk corridor payments ***due*** [to unprofitable insurers] ***as an obligation of the United States Government for which full payment is required***."[9] The General Accounting Office independently concluded that risk corridor

[9] CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-

payments were not limited to the amounts collected by the Government from insurers whose premiums minus administrative costs exceeded enrollee medical claims costs by the specified percentages receipts, but were payable from general appropriations.[10]

In support of its strained reading of the statute to provide the contrary, the Government's brief parses the statutory language to argue that Section 1342's instruction that the Government "shall" make a payment, in the amount specified by the statutory formula, does not bind the

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Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF#sthash.F6vymHRx.dpuf (emphasis added). On March 11, 2014, after the Qualified Health Plans had gone into effect on January 1, 2014, CMS stated in a preamble to the final rule for benefit and payment parameters for the next calendar year (2015) that it projected that net risk corridors payments would be "budget neutral" for 2014, and thus HHS "intend[ed]" to implement the risk corridors program in a "budget neutral manner." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787, 13,829 (Mar. 11, 2014) (eff. May 12, 2014). This was not inconsistent with previous HHS statements, as it was simply a prediction by HHS that the program would be budget neutral, not an indication that it would implement the risk corridors program in a budget neutral manner even if payments to HHS by Qualified Health Plans whose costs fell short were not sufficient to cover HHS's obligations to Qualified Health Plans whose costs exceeded premium revenues.

On April 11, 2014, CMS issued informal questions and answers suggesting that, for 2015, if risk corridors collections were insufficient to make risk corridors payments for a year, all risk corridors payments for that year would be reduced pro rata to the extent of any shortfall, and made up for in future years, *see* CMS, Risk Corridors and Budget Neutrality (Apr. 11, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. However, in May 2014, it immediately retreated from these April 2014 questions and answers by reaffirming that it had the legal authority to pay its entire risk corridors obligations regardless of the amount of payments the Government received through the program. Specifically, in a letter to the Government Accountability Office (GAO) dated May 20, 2014, HHS stated that CMS's general Program Management appropriation for fiscal year 2014 (Pub. L. No. 113-76, 128 Stat. 5 (Jan. 17, 2014)) gave it the authority to make full risk corridors payments. *See* Letter from William B. Schultz, Gen. Counsel, HHS, to Julia C. Matta, Assistant Gen. Counsel, GAO (May 20, 2014). Then, one week later, in the Final Rulemaking for Exchange and Insurance Market Standards for 2015 and Beyond, HHS reiterated that it was legally obligated to make risk corridors payments in full. While HHS "anticipate[d] that risk corridors collections will be sufficient to pay for all risk corridor payments," HHS explained that, "[i]n the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers" and thus "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014).

[10] GAO, B-325630, HHS — Risk Corridors Program (Sept. 30, 2014), http://gao.gov/assets/670/666299.pdf.

Government because it is contained in the subsection entitled "payment methodology." The Government argues that "shall pay" thus "merely describes the 'methodology' to be applied by HHS as it adjusts funds . . . ; it nowhere states that HHS or the United State must provide additional funds to insurers when funds available 'under the program' fall short of the statutory amounts." Gov't Br. at 23-24.

As an initial matter, the Government's interpretation of the statutory text is directly contrary to CMS's own statements, as summarized at pp.10-11, *supra*. As such, it is a *post-hoc* rationalization, advanced for purposes of litigation, and it is not entitled to any deference. *Parker v. Office of Pers. Mgmt.*, 974 F.2d 164, 166 (Fed. Cir. 1992) ("*[P]ost-hoc* rationalizations will not create a statutory interpretation deserving of deference.") (emphasis added).

Further, the Government's argument is inconsistent with the plain text of the statute. Section 1342 states that the Government "***shall*** establish and administer" a risk corridors program, in which "[t]he Secretary ***shall*** provide . . . that if . . . a participating plan's allowable costs for any plan year are more than 103 percent . . . of the target amount, the Secretary ***shall*** pay to the plan" the amount specified in the statutory formula. 42 U.S.C. § 18062 (emphasis added). The mere fact that "shall pay" appears in the "methodology" subsection does not change the plain meaning of those words.

Congress could not have been clearer that the Government was required to make these payments, in amounts specified under the statutory formula. Nothing in the statute suggests that this clear mandate is contingent on the Government collecting sufficient risk corridor payments from profitable insurers to pay the risk corridor payments owed to unprofitable insurers or upon sufficient appropriations. *Compare* § 1342, *with Prairie Cty. v. United States*, 782 F.3d 685,

686, 690 (Fed. Cir.) (statute specified that "[a]mounts are available only as provided in appropriation laws" (quoting 31 U.S.C. § 6906 (2006))), *cert. denied*, 136 S. Ct. 319 (2015).

The Government's argument that it may cap the amounts it pays out as risk corridor payments to the amount that it takes in is contrary to the plain language of the statute and not entitled to deference. No deference is due to an agency position that is "manifestly contrary to the statute." *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 53-54 (2011) (citations omitted). "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). To determine the intent of Congress, the court looks not only to the language of the statute itself, but also to its structure and purpose. *Delverde, SrL v. United States*, 202 F.3d 1360, 1363 (Fed. Cir. 2000).

The Government's interpretation of the statute is not only inconsistent with its plain text, but its structure and purpose as well. As CMS has explained, risk corridors were intended to "permit issuers to lower rates [they charge to enrollees] 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). In other words, the risk corridor payments were intended to protect insurers (in part) from the risk of underpricing their plans. Yet no protection would be provided, and no premium stabilization could be achieved, if such risk corridor payments were contingent upon the entirely speculative question whether other insurers would be so profitable as to result in payments by them to the Government sufficient to satisfy the payments owed by the Government to unprofitable insurers.

The stated purpose of risk corridors — to mitigate the risk that the Government was asking health insurers to undertake — is wholly undercut by an interpretation that would make a risk corridor payment to a given plan dependent not only on the Qualified Health Plan's own experience, but on the financial results of other insurers' Qualified Health Plans as well, about which a given plan would have no knowledge or control. Such an interpretation would reinforce, rather than reduce, the very uncertainty that the risk corridor payments were meant to ameliorate. Had plans known that the Government would not honor the full risk corridor payment obligation, plans would have priced their plans much higher, and the Government would have had to incur much higher costs in providing subsidies (through tax credits) to qualified enrollees. *See supra* page 2.

The Government's brief also tries to avoid the plain meaning of "shall pay" in the statutory text by observing that a different statute, the Medicare Part D risk corridors provision, provides that "'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,'" and suggests that the lack of similar language in Section 1342 means that Congress did not intend for Section 1342 to create a statutory obligation in the absence of sufficient appropriations. Gov't Br. at 24.

But as more fully explained in the next section, statutes requiring the Government to pay money to an individual or entity need not (and generally do not) expressly specify that they "represent an obligation" of the Government, in order that they be treated as such. Unlike Section 1342, the Medicare risk corridors provision does not provide that the Secretary "shall pay" but only that the Secretary "shall establish a risk corridor." 42 U.S.C. § 1395w-115(e)(3). This Court has repeatedly found that payments mandated by statute, using language almost

identical to Section 1342, are sufficient to support a claim under the Tucker Act, even if the statute does not expressly state that it constitutes budget authority or represents an obligation of the United States. *See, e.g.*, *N.Y. Airways, Inc. v. United States*, 369 F.2d 743 (Ct. Cl. 1966) (holding that government had a statutory obligation to pay the plaintiff; statute did not expressly specify that payments made pursuant to it were an "obligation" of the Government); *District of Columbia v. United States*, 67 Fed. Cl. 292 (2005) (same). Just because Congress chose to include such language in the Medicare Part D statute does not mean its omission in Section 1342 of the ACA, which was debated and enacted seven years later, negates Congress's clear instruction that the Secretary "shall pay" the amount calculated under the statutory formula.

III. THE 2015 AND 2016 APPROPRIATIONS RIDERS DID NOT VITIATE THE GOVERNMENT'S STATUTORY OBLIGATION TO MAKE FULL RISK CORRIDOR PAYMENTS.

The Government contends that two identical provisions in the 2015 and 2016 appropriations bills override the statutory text of ACA Section 1342, the statutory purpose, CMS's own assurances that it would make full payment, and the consequences of all the foregoing (*i.e.*, that issuers chose to participate in the new and uncertain ACA marketplace). The Government's position is inconsistent with the relevant text of those appropriations bills and well-established, binding precedent.

A. The 2015 and 2016 Appropriations Bills Do Not Alter the Government's Obligation to Make Full Risk Corridor Payments.

A long line of decisions, including decisions binding on this Court, makes clear that Congress's failure to appropriate funds for an agency to meet a statutory obligation "does not in and of itself defeat a Government obligation created by statute." *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (quoting *New York Airways*, 369 F.2d at 748); *see, e.g.*, *United States v. Langston*, 118 U.S. 389 (1886); *Prairie Cty. v. United States*, 782 F.3d 685, 689-

90 (Fed. Cir.), *cert. denied*, 136 S. Ct. 319 (2015); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949). A limitation on agency appropriations may mean that the agency cannot itself comply with the statutory mandate by making payment, but that does not change the jurisdiction of this Court to entertain claims against the United States to honor its statutory payment obligations and to provide relief, including an award from the permanent appropriation Congress has made for the Judgment Fund. 31 U.S.C. § 1304(a).

To the contrary, under longstanding precedent, "[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 are enforceable in the Court of Claims." *New York Airways*, 369 F.2d at 748. As the Government itself has noted in recent litigation, "[t]he mere absence of a more specific appropriation is not necessarily a defense to recovery from th[e] Fund."[11]

Indeed, it is a stringent standard for finding that a limitation on the use of an agency's appropriated funds vitiates a preexisting statutory right, and thus cuts off access to the Tucker Act. While Congress may have the legal authority prospectively to amend substantive preexisting statutory obligations, it must do so "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted). Moreover, and of direct relevance here, "[t]his 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," the statutory instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "The intent of Congress to effect a

[11] Defs.' Mem. in Supp. of their Mot. for Summ. J. at 11, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015).

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); *accord District of Columbia v. United States*, 67 Fed. Cl. 292, 335 (2005) (quoting *New York Airlines*).

Four leading decisions apply the foregoing principles under circumstances closely analogous to the case at hand: *United States v. Langston*, 118 U.S. 389 (1886); *Gibney v. United States*, 114 Ct. Cl. 38 (1949); *New York Airways*, 369 F.2d 743 (Ct. Cl. 1966); and *District of Columbia v. United States*, 67 Fed. Cl. 292 (2005). Although the first three constitute binding authority on this Court, none is mentioned in the Government's brief.

1. *United States v. Langston.*

In *United States v. Langston*, a statute specified that the ambassador to Haiti would be paid an annual salary of $7,500. But Congress only appropriated $5,000 for this purpose. Langston sued for the $2,500 difference. Because the Tucker Act was not yet in force when *Langston* was decided, this case proceeded as an appeal from a final judgment issued by the Court of Claims under the authority granted to it by Congress in 1866. Cong. Globe, 39th Cong., 1st Sess. 770-71 (1866). The question presented was whether the statutory obligation to pay $7,500 was legally binding and enforceable, notwithstanding Congress's failure to appropriate sufficient funds to pay the obligation.

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 principle that "[r]epeals by implication are not favored," as well as the principle that a court should give effect to a "reasonable construction" that allows two potentially incongruous laws to "stand together," the Supreme Court held 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.

Like the appropriations bill at issue in *Langston*, Congress limited the availability of the 2015 and 2016 CMS appropriations for purposes of making risk corridor payments. But those appropriations provisions did not include any "words that expressly, or by clear implication, modified or repealed the previous law." Specifically, the 2015 and 2016 appropriations riders read in full:

> 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 payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

See Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2491 (Dec. 16, 2014); *see also* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2624 (Dec. 18, 2015).

This language simply prohibits CMS from using certain, specified funding sources from the two appropriations bills for risk corridor payments. Nothing in this provision precludes the Government from being required to use funds from another source (i.e., the permanent appropriation to the Judgment Fund) to meet its statutory obligation to make full risk corridor payments, or otherwise specifies that a funding source or a capped appropriation "shall be 'in full compensation' for" the risk corridor obligation for the year. *See Langston*, 118 U.S. at 393.

As in *Langston*, there is no language here altering or eliminating, "expressly or by clear implication," the Government's statutory obligation to make full risk corridor payments under

Section 1342 of the ACA. Thus, as in *Langston*, the Government remains liable in this Court for making the statutorily required risk corridor payments.

2. *Gibney v. United States.*

In *Gibney v. United States*, the Court of Claims considered whether appropriations language altered the payment mandate of a preexisting statute providing that "employees should be paid, for work beyond an eight-hour day on ordinary days, one-half day's additional pay for each two hours or major fraction thereof, and, for work on a Sunday or holiday, two additional days' pay." 114 Ct. Cl. at 48. The relevant appropriations language provided:

> That none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided in the Federal Employees Pay Act of 1945 (Public Law 106, 79th Cong., 1st sess.), and the Federal Employees Pay Act of 1946 (Public Law 390, 79th Cong., 2d sess.).

114 Ct. Cl. at 48-49.

The Court of Claims held that this appropriations language "was a mere limitation on the expenditure of a particular fund and had no other effect" on the statutory requirement to pay overtime. *Id.* at 50. The Court noted that it "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. The court accordingly entered judgment for the plaintiff for his full overtime pay, upon receiving a report from the General Accounting Office showing the amount that was due to the plaintiff in accordance with its opinion. *Id.* at 47, 58.

The language in the appropriations riders limiting risk corridors funding is analogous to the appropriations provision in *Gibney*. *Compare Gibney*, 114 Ct. Cl. at 44 ("[N]one of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided [under specific 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" risk corridor payments). Thus, just as the workers seeking overtime pay were entitled to an award of that pay notwithstanding the limitations imposed by the appropriations riders, insurers are entitled to an award of the risk corridor payments to which they are entitled under the ACA.

3. *New York Airways v. United States.*

New York Airways reaffirmed the holdings of both *Langston* and *Gibney*. In *New York Airways*, a statute authorized the Civil Aeronautics Board to fix a monthly subsidy for helicopter companies, which the Board did in 1964. 369 F.2d at 744. But from fiscal years 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. As a result, the Board lacked sufficient funding to meet its payment obligation to the plaintiff. In the specific fiscal year at issue in *New York Airways*, Congress enacted the following provision in an annual appropriations bill, 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 Civil Aeronautics Board 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.

New York Airways, 369 F.2d at 749, 751.

The plaintiff helicopter companies sought to recover the full subsidy that had been set by the Civil Aeronautics Board, asserting an entitlement to that amount notwithstanding the lesser

amounts provided for by several appropriations bills. The Court of Claims explained the longstanding rules that govern its analysis whether the appropriations language altered the Government's statutory obligation to make payments to the plaintiff:

> 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. *United States v. Vulte*, [233 U.S. 509 (1914)]; *Ralston v. United States*, 91 Ct. Cl. 91 (1940). . . .

New York Airways, 369 F.2d at 748. As the court explained, while the agency might be precluded from making payment, recovery was available in the Court of Claims:

> The failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims. *Gibney v. United States*, 114 Ct. Cl. 38, 51, 52 (1949); *Leonard v. United States*, 80 Ct. Cl. 147 (1935); *New York Central R.R. v. United States*, 65 Ct. Cl. 115, 128 (1928), *aff'd*, [279 U.S. 73 (1929)]; *Danford v. United States*, 62 Ct. Cl. 285 (1926); *Strong v. United States*, 60 Ct. Cl. 627, 630 (1925); *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892).

Id. As the court further elucidated:

> Whether the obligation to transport mail is derived from express contract with the Government, as in *Seatrain Lines, Inc. v. United States*, 99 Ct. Cl. 272 (1943), or by statute, as also in the instant case and in *New York Central R. R. v. United States*, 65 Ct. Cl. 115 (1928), *aff'd*, 279 U.S. 73, 49 S. Ct. 260, 73 L.Ed. 619 (1929), the failure of Congress or an agency to appropriate or make available sufficient funds does not repudiate the obligation; it merely bars the accounting agents of the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims.

Id. at 752.

The *New York Airways* court ruled in favor of the plaintiffs, holding that Congress did not alter the underlying statutory obligation because a change in substantive law was not "clearly manifest" from the text of the appropriations bill. *New York Airways*, 369 F.2d at 749. This

entitled the plaintiffs to judgments for the differences between the amounts that they received from the appropriations and the amount statutorily required under the subsidy scheme. *Id.* at 748-52.

The risk corridors appropriations riders are even less restrictive than the appropriations language in *New York Airways*. The latter outright capped all payments to the helicopter companies at a dollar total, whereas the former simply limits the use of certain specific sources to make risk corridor payments. Thus, *New York Airways* plainly supports Land of Lincoln's statutory entitlement to risk corridor payments.

4. *District of Columbia v. United States.*

This Court applied the principles established in *Langston*, *Gibney*, and *New York Airways* in *District of Columbia v. United States*. Congress had enacted legislation directing HHS to pay the District for repairs to buildings transferred from the United States Government to the District. Congress appropriated some funds for the repairs, but in an amount insufficient to cover the entire cost of those repairs. 67 Fed. Cl. at 334-35. Congress knew the appropriations would be insufficient, having been so informed by the District before the appropriations legislation was enacted. *Id.* at 299. The District filed a Tucker Act lawsuit in this Court, seeking to recover the excess of the actual costs of repair over the amounts appropriated for that purpose. *Id.* at 303.

This Court held the United States "liable for the full costs of repairs and renovations mandated by the [statute]," even though "this liability may not have been fully satisfied by initial appropriations in 1987." *Id.* at 346. As the Court explained:

> Merely because Congress has appropriated money and transferred funds to the District does not mean that the government's obligation has been fulfilled under the final system implementation plan or under the Act, or that the District is precluded from seeking additional funds owed to it. The referenced appropriation and transfer simply mean that the District has received some funds to pay for repairs and renovations.

67 Fed. Cl. at 335. But quoting *New York Airways*, this Court held that "[a]n appropriation with limited funding is not assumed to amend substantive legislation creating a greater obligation." *Id.* The court accordingly granted summary judgment to the plaintiff on its entitlement to recover the full costs of repairs and renovations. *Id.* at 349.

As in *District of Columbia*, Congress limited the appropriations available for risk corridor payments to amounts the Government contends are insufficient to pay out the entirety of the risk corridors obligations. But as this Court held in *District of Columbia*, Congress's decision to limit the amount of certain specified appropriations that would be available for risk corridor payments does ***not*** relieve the Government of its liability to meet its statutory obligation, or the availability of the Tucker Act as a remedy. To the contrary, the plaintiffs were entitled to judgment under the Tucker Act measured by the difference between the statutory obligation and the amount appropriated.

B. The Precedents Upon Which the Government Relies Are Clearly Distinguishable.

The Government relies heavily on three cases to support its argument that the appropriations riders suspended the statutory mandate to make full risk corridor payments to insurers: *United States v. Dickerson*, 310 U.S. 554 (1940); *United States v. Will*, 449 U.S. 200 (1980); and *Republic Airlines, Inc. v. U.S. Dep't of Transp.*, 849 F.2d 1315 (10th Cir. 1988). All three of these decisions are easily distinguishable.

1. The Appropriations Language in *Dickerson*, *Will*, and *Republic Airlines* is Dissimilar from the Language in the Risk Corridors Appropriations Riders.

While the Government argues that *Dickerson*, *Will*, and *Republic Airlines* show that a statutory obligation of the Government can be amended through language in appropriations bills, as explained above, if Congress wants to alter a preexisting statutory obligation it must do so

"expressly or by clear implication," *see, e.g.*, *Prairie Cty.*, 782 F.3d at 689-90, particularly if the relevant provision is enacted in an appropriations bill, in which case, the intent must be "clearly manifest," *New York Airways*, 369 F.2d at 749.

All three cases upon which the Government relies involve appropriations provisions entirely dissimilar from the appropriations language at issue in this case. *Dickerson*, *Will*, and *Republic Airlines* all involved appropriations language that clearly altered a statutory obligation, whereas the language in the 2015 and 2016 appropriations riders here did nothing more than limit the use of specific funding for risk corridor payments.

In *Dickerson*, a statute obligated Congress to make bonus payments to individuals who re-enlisted in the military. In each appropriations bill from 1933 through 1937, Congress expressly suspended this requirement with the following language: the statute that "provides for the payment of enlistment allowance to enlisted men for reenlistment . . . is hereby suspended as to reenlistments made during the fiscal year." 310 U.S. at 556. In appropriations bills for 1938 and 1939, Congress changed this language to read: "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 statute that required the bonus payments be made. *Id.* at 555 (emphasis added).

The plaintiff sued the government to receive a bonus for re-enlisting in 1938. The Supreme Court held that the 1938 appropriations language carried forward the longstanding suspension of the Government's statutory obligation to pay bonuses to individuals re-enlisting in the military. *Id.* at 561-62. This holding was based in part on the Court's conclusion, after a careful examination of the legislative history, that Congress intended the 1938 and 1939

appropriations language "as a continuation of the suspension [of the statutory obligation] enacted [by the appropriations bills] in each of the four preceding years." *Id.* at 561.

The appropriations language at issue in *Dickerson* is significantly different than the language of the appropriations riders limiting the sources of funding for risk corridor payments. The *Dickerson* language prohibited funding for the statutory obligation from the appropriations bill in which it was contained *and* "any other Act for the fiscal year," and the provision expressly stated that bonus payments were defunded "notwithstanding the applicable portions of" the underlying substantive law. That language followed on the heels of, and was deemed to be a continuation of, appropriations acts that had explicitly suspended the underlying statutory obligation.

In contrast, the risk corridors appropriations language does not suspend the underlying statutory obligation; nor does it prohibit the use of funding from "any other Act;" nor does it specify that the funding limits were imposed "notwithstanding" the substantive risk corridors obligation. Rather, the risk corridors appropriations language is "a simple withholding of funds" from a few specified sources, "unaccompanied by other expressed or implied purpose[]" of altering the underlying statutory obligation. *See New York Airways*, 369 F.2d at 750 (explaining that the "language in the appropriation proviso in the *Dickerson* case" was "'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'" (quoting *Gibney*, 114 Ct. Cl. at 51)).

Unlike *Dickerson*, there is no indication in the legislative history or otherwise to support the view that the risk corridors appropriations language was intended to reflect a change or suspension in the statutory obligation. While some members of Congress may well support an

elimination of risk corridor payments, they have only been able to limit certain sources of appropriations available for these payments through the appropriations bills. They have not succeeded in eliminating or suspending the risk corridors statutory obligation itself, and indeed, the President has repeatedly threatened to veto any bill that rolls-back the ACA.[12] *Cf. Gibney*, 114 Ct. Cl. at 55 (Whitaker, J. concurring) (if Congress wanted the appropriations language to suspend the Government's obligation to pay overtime, "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").

The second case on which the Government relies, *United States v. Will*, involved plaintiffs-judges suing to obtain pay increases to which they argued that they were statutorily entitled. They based their claim on a statutory scheme in which the President was directed to make cost-of-living increases to judges and other federal employees based on several considerations. In four consecutive fiscal year appropriations bills, Congress blocked those pay increases for judges 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 following provisions of law [listing 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

[12] *See* Exec. Office of the President, Office of Mgmt. & Budget, Statement of Administration Policy: H.R. 596 - Repealing the Affordable Care Act 2 (Feb. 2, 2015) ("If the President were presented with H.R. 596 [Repealing the Affordable Care Act], he would veto it.") https://www.whitehouse.gov/sites/default/files/omb/legislative/sap/114/saphr596r_20150202.pdf ; *see generally* Peter Sullivan, *White House Issues Veto Threat on ObamaCare Repeal*, The Hill, Dec. 2, 2015 ("Both [Republicans and Democrats] have long known that [the President] would veto a bill to gut his signature domestic achievement . . . ."); Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA Today, Nov. 19, 2014 (noting that the President has threated to veto twelve different bills that would have repealed all or part of the ACA).

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) (citations omitted). The Court held that each of these provisions "block[ed] the increases the [Act] otherwise would generate." *Id.* at 223.

None of the four appropriations provisions at issue in *Will* are similar to the provisions limiting risk corridors appropriations. Like the language in *Dickerson*, the appropriations language in *Will* clearly indicated an alteration of the statutory obligation, because it either expressly stated that the underlying statute "shall not take effect," or prohibited the Government from using *any* appropriations source in the year at issue. In contrast, the risk corridors appropriations riders only prevent the Government from making payments out of certain specified sources of funding.

Further, *Will* did not involve a definitive statutory obligation, in which the precise amount the plaintiff was owed was established by statutory formula. Rather, as the Federal Circuit has explained, any payment to which the plaintiffs-judges were entitled in *Will* was determined through an "uncertain, discretionary process." *Beer v. United States*, 696 F.3d 1174, 1183 (Fed. Cir. 2012) (analyzing *Will*). As a result, the plaintiffs judges in *Will* did not have a clear right to a payment increase, unlike the insurers in this case, who have a clear-cut statutory right to specific payment amounts calculated by a non-discretionary statutory formula.

In the third case on which the Government relies heavily, *Republic Airlines*, the plaintiffs sought a subsidy to which they alleged an entitlement under Section 406 of the Federal Aviation Act of 1958. The Government contended that the following language in an appropriations bill relieved it of the obligation to pay the subsidy specified in Section 406:

> [N]otwithstanding any other provision of law, none of the funds appropriated by this Act shall be expended under Section 406 for

> services provided after ninety-five days following the date of enactment of this Act to points which, based on reports filed with the Civil Aeronautics Board, enplaned an average of eighty or more passengers per day in the fiscal year ended September 30, 1981: *Provided further*, That notwithstanding any other provision of law, payments under Section 406, exclusive of payments for services provided within the State of Alaska, shall not exceed a total of $14,000,000 for services provided during the period between March 31, 1982, and September 30, 1982, and, to the extent it is necessary to meet this limitation, the compensation otherwise payable by the Board under Section 406 shall be reduced by a percentage which is the same for all air carriers receiving such compensation . . . .

849 F.2d at 1317 (citation omitted).

The court ruled in favor of the Government, holding that this language "altered any 'entitlement'" the airlines may have had under Section 406. *Id.*

As an initial matter, *Republic Airlines* was decided by the Tenth Circuit and does not bind this Court. Moreover, *Republic Airlines* is not a Tucker Act case, and the plaintiffs in *Republic Airlines* were not seeking a monetary judgment for the Government's failure to meet a statutory payment obligation, but petitioning for review of an order of the Civil Aeronautics Board. Thus, the well-developed case law regarding the heavy scrutiny that applies when the Government seeks to rely upon an appropriations rider to avoid Tucker Act liability was simply not presented in *Republic Airlines*.

In addition, the language in the appropriations bill at issue in *Republic Airlines* is again dissimilar to the language limiting risk corridors appropriations. The *Republic Airlines* language caps all "payments under Section 406" at $14 million, "notwithstanding any other provision of law," and expressly directs the Government that to "the extent it is necessary to meet this limitation, the compensation otherwise payable by the Board under Section 406 shall be reduced by a percentage which is the same for all air carriers receiving such compensation." In contrast,

the risk corridors appropriations riders simply limit the sources of funding that the Government may use to fulfill its statutory obligation to make risk corridor payments.[13]

2. The Cases Cited by the Government Do Not Involve a Retroactive Alteration of a Statutory Obligation Designed to Induce Private Party Conduct Beneficial to the Government.

In addition to the stark differences in the appropriations language at issue in the cases upon which the Government relies, there is a key factual distinction between Land of Lincoln's claim and all three principal cases on which the Government relies. Congress limited the funding available for risk corridor payments only *after* the insurers had been induced to take quite material affirmative action in reliance on the Government's statutory commitment to make risk corridor payments. Specifically, relying on the Government's statutory obligation to pay insurers risk corridor payments if their costs exceeded their revenue by 3 percent, insurers agreed to offer Qualified Health Plans through the Health Benefit Exchanges established by the Act, priced their 2014 plans, obtained state regulatory approval of their 2014 plans and rates, and provided the underlying insurance coverage for almost a full year, *before* Congress enacted the 2015 appropriations riders in December 2014. The insurers had also obtained state regulatory approval for their 2015 plans and rates, and begun selling those plans to consumers once open enrollment began on October 1, 2014, before Congress enacted the 2015 appropriations rider in December 2014. The plaintiffs in *Dickerson*, *Will*, and *Republic Airlines* did not allege that they

[13] The Government cites several additional cases that are also easily distinguishable. *See Bickford v. United States*, 656 F.2d 636 (Ct. Cl. 1981) (underlying statute establishing the alleged obligation itself prohibited the payments the plaintiff sought); *Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United States*, 48 F.3d 1166 (Fed. Cir. 1995) (underlying statute containing the obligation expressly directed the Government to decrease payments if appropriations were insufficient); *United States v. Mitchell*, 109 U.S. 146 (1883) (both the underlying statutory obligation and the alteration of that obligation were contained in appropriations acts, and both involved the special case of Indian appropriations); *Mathews v. United States*, 123 U.S. 182, 185 (1887) (appropriations act explicitly amended the underlying statutory provision, and used additional language such that the case "does not come within [the] rule" created by *Langston*).

had been similarly induced to act by the statutory obligations established prior to the enactment of the relevant appropriations riders.

Any Government effort to strip insurers of their right to risk corridor payments, after they had chosen to deliver insurance for over a year pursuant to and in reliance upon a statutory scheme in which such risk corridor payments had been guaranteed, would constitute a retroactive application of law, because it "'would impair rights a party possessed when [it] acted . . . .'" *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994)). The Government's interpretation would also constitute a retroactive application of law because it would impose new rules on a transaction already completed. *See id.*

Retroactive application of statutes is "disfavored," and thus "it has become 'a rule of general application' that 'a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication.'" *Id.* (quoting *United States v. St. Louis, S.F. & Tex. Ry. Co.*, 270 U.S. 1, 3 (1926)). No such language or necessary implication is presented by the appropriations riders.

IV. ALTERNATIVELY, THE RISK CORRIDOR PAYMENTS ARE DUE UNDER A BINDING, IMPLIED-IN-FACT CONTRACT BETWEEN HHS AND QUALIFIED HEALTH PLANS.

The Government's contention that Section 1342 establishes a "benefits program" for Qualified Health Plans, and not an implied contract, turns the course of dealings and relationship between the parties on its head. The Government has received a benefit from Qualified Health Plans — health coverage for millions of Americans — without adhering to its side of the bargain — making risk corridor payments — even though the promise of such payments was essential to inducing health insurers into the new marketplaces.

"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). There must be "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 of these elements are met here.

A. There was Mutuality of Intent.

In order for the Court to find that the Government has entered into an implied contract there must be "language . . . *or* . . . *conduct* on the part of the government that allows a reasonable inference that the government intended to enter into a contract." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011) (emphasis added). *Radium Mines* is the seminal case finding an implied contract based on conduct on the part of the Government, including through its published regulations. That case involved regulations of the Atomic Energy Commission which established a guaranteed minimum price at which the United States would purchase uranium. *See Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). 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 405-406. In finding an intent to contract, the Court noted that the purpose of the regulation

> 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.

Applying *Radium Mines* to this case, there can be no doubt that the purpose of the risk corridor payment was to "induce" insurers to offer affordable coverage to a population about which they lacked information. In enacting the ACA, the Government recognized that prudent insurers pricing a product for an unknown population would need to add a "risk premium" to protect against uncertainties. It included the risk corridors program to mitigate some of that uncertainty, and HHS expressly and repeatedly reminded insurers that the risk corridors program should enable them to keep premiums low. Thus, like *Radium Mines*, the Government by its conduct indicated an intent to enter into a binding contract to make the payments to plans that satisfied the requirements for a risk corridor payment.

The Government argues that *Radium Mines* "clearly expressed" an intent to enter into a contract. While the regulations quoted by the Court in that case did state that the Government would enter into a "purchase contract" when presented with uranium that met its qualifications, the express reference to a possible contract 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). The Supreme Court likewise cited *Radium Mines* as an example of cases "where contracts were inferred from regulations promising payment" for purposes of Tucker Act jurisdiction. *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

As the Supreme Court's observation in *Army & Air Force Exchange Service* illustrates, there is overlap between the cases finding that a statute is "payment-mandating" and those finding an implied contract. In *New York Airways*, for example, this Court described the mandatory payment in that case as creating an implied contract once the plaintiff had satisfied

the requirements for payment: "The actions of the parties support the existence of a contract at least implied in fact. The [Civil Aeronautics] Board'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." *New York Airways*, 369 F.2d at 751. Similarly, the U.S. Court of Appeals for the Fifth Circuit has explained, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature;" an entity accepts the Government's offer of payment by satisfying the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F. 2d 518, 521 (5th Cir. 1948).

By contrast, there is no mutuality of intent to contract 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. *See Baker*, 50 Fed. Cl. at 491-93. None of those factors apply here. The amount to be paid is fixed by statute, and the Government has never disputed or denied the amounts claimed, nor claimed that it has discretion as to whether to pay them. To the contrary, the Government has continued to recognize them as an obligation of the United States Government for which full payment is required.

Likewise, the cases cited by the Government in support of its argument that the Government must expressly state an intent to enter into a contract are distinguishable, as both involved "contract disputes" on issues corollary to the right of payment. *ARRA Energy* involved a dispute as to whether the plaintiff had submitted documentation sufficient to support its claim for payment. *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011). *AAA Pharmacy* involved a dispute over the timeliness of the Government's response to a pharmacy's appeal

from the denial of its Medicare billing privileges. *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321 (2012). Those cases do not undercut the central holding of *Radium Mines* and *New York Airways* that the Government's promise to make payment can induce behavior that constitutes a mutuality of intent to contract.

B. There was Consideration.

There is ample consideration to support the finding of an implied contract to timely pay risk corridor payments, and the Government does not argue otherwise. The provision of health benefits to enrollees is consideration for payment of the risk corridor payments. Indeed, the calculation of the risk corridor payments is premised on the costs incurred by Qualified Health Plans to provide those benefits. The Qualified Health Plans have all incurred expenses, and those owed risk corridor payments have incurred losses as a result of those expenses.

C. There is No Ambiguity in Offer and Acceptance.

There is no ambiguity in offer and acceptance of the implied contract. Qualified Health Plans are the backbone of the Government's effort to provide affordable, accessible, comprehensive coverage through the Health Benefit Exchanges established under the ACA, and there are extensive requirements imposed on both the Plans and the Government. A health insurance issuer is not required to create or offer a Qualified Health Plan product, but if it does both the Government and the Qualified Health Plan are committing to an intricate set of specific obligations including, for example, the following:

- the Qualified Health Plan must comply with certain "issuer participation standards" including standards on benefit design; standards regarding Health Benefit Exchanges processes and procedures; and implementation and reports on quality improvement strategy, including use of Government-designed enrollee satisfaction surveys (45 C.F.R. § 156.200);

- the Qualified Health Plan must agree to set rates for an entire benefit year, must submit rate and benefit information to the Exchange, and must submit a justification for a rate increase prior to implementation of the rate increase (45 C.F.R. § 156.210);
- the Qualified Health Plan must submit to HHS information regarding its claims payment policies and practices; periodic financial disclosures; data on enrollment; data on disenrollment; data on the number of claims that are denied; data on rating practices; and information on cost-sharing and payments with respect to out-of-network coverage (45 C.F.R. § 156.220);
- the Qualified Health Plan must use a provider network that meets federal standards (45 C.F.R. § 156.230);
- the Qualified Health Plan must enroll individuals during enrollment periods specified by the Government (45 C.F.R. § 156.260);
- the Qualified Health Plan may only terminate coverage or enrollment under standards established by the Government (45 C.F.R. § 156.270);
- the Qualified Health Plan must provide HHS with information regarding its prescription drug distribution and cost reporting (45 C.F.R. § 156.295); and
- the Qualified Health Plan must insure that individuals eligible for Government-imposed cost-sharing reductions pay only the cost-sharing required (45 C.F.R. § 156.410).

In exchange, the Government commits that only Qualified Health Plans, and not any other type of health insurance plan:

- may be purchased through a Health Benefit Exchange (45 C.F.R. § 155.400);
- will receive payment of "advance premium tax credits" that subsidize an individual's premium costs (45 C.F.R. § 156.440);

- will receive payments to implement cost-sharing reductions for eligible individuals (45 C.F.R. § 156.430); and
- will receive risk corridor payments (45 C.F.R. § 153.510).

Land of Lincoln, *amici* and other Qualified Health Plans accepted the Government's offer that if they complied with the numerous and extensive requirements to be Qualified Plans, and served the population for whom the Government sought to provide health coverage, then they would receive the statutory payments, including risk corridor payments. As in *Radium Mines* and *New York Airways*, the conduct of each party meets the offer and acceptance elements of an implied contract.

D. The Secretary of HHS Had Actual Authority to Contract.

Actual authority to contract can be express or implied; either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). "Authority to bind the Government is generally implied when such authority is considered to be an integral part of the duties assigned to a government employee." *Id.* at 324, citing J. Cibinic and R. Nash, *Formation of Government Contracts* 43 (1982).

Section 1342's instruction that the Secretary "shall establish" a risk corridors program and "shall pay" risk corridors payments to plans that incurred losses meeting the statutory threshold is an integral part of her statutory duties and is sufficient to support an implied contract. Similarly, in the cases where contracts have been inferred from statutes or regulations promising payment, the Government's actual authority to contract has not been questioned. *See, e.g., Radium Mines, supra*; *New York Airways, supra.*

The Government argues that there is no actual authority to contract because the Anti-deficiency Act prohibits government officials from involving the "government in a[n] . . .

obligation for the payment of money before an appropriation is made unless authorized by law." 31 U.S.C. § 1341(a)(1)(B).

That argument is irrelevant in this case, because the U.S. Government Accountability Office ("GAO") concluded in September 2014 that the Secretary *did* have such authority.[14] Specifically, the GAO concluded that the Secretary had authority to make risk corridor payments under CMS's "Program Management" appropriation. *Id.* at 3. The GAO also concluded that the Secretary had authority to make payments from the amounts HHS collected under the risk corridors program. *Id.* at 4-5. "Although GAO decisions are not binding, [courts] 'give special weight to [GAO's] 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) (quoting *Int'l Union, United Auto., Aerospace & Agric. Implement Workers v. Donovan*, 746 F.2d 855, 861 (D.C. Cir. 1984)).

Although later Congressional actions placed restrictions on CMS's Program Management appropriation in 2015 and 2016, that action took place *after* formation of the implied contract in 2014 when the Qualified Health Plans began providing benefits to their members. By the time Congress imposed restrictions on the Secretary's ability to spend the Program Management appropriation for risk corridor payments, the Qualified Health Plans had already been providing services -- and incurring losses -- for almost a year. Moreover, the Secretary's budget authority to make payments out of what HHS collects in risk corridors receivables (from plans that made an unexpectedly large profit) continues to this day, and was the basis for the 12.6% payment that HHS has already made. Thus, the Secretary had the budget authority as well as the actual legal authority to enter into an implied contract with the Qualified Health Plans.

[14] *See* GAO, B-325630, HHS — Risk Corridors Program (Sept. 30, 2014), http://www.gao.gov/assets/670/666299.pdf.

E. Congress Cannot Exercise Its Appropriation Authority to Curtail the Government's Contractual Liability.

As the Government fully concedes, Congress cannot curtail the government's contractual liability through the appropriations process. Gov't Br. at 30. *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012); *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 646 (2005). As the Supreme Court explained in *Salazar*, "[w]hen 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." 132 S. Ct. at 2189 (citing *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892); *Dougherty v. United States*, 18 Ct. Cl. 496, 503 (1883); 2 GAO, *Principles of Federal Appropriations Law* 6–17 (2d ed. 1992) [hereinafter "GAO Redbook"]). This line of cases applies "even if an agency's total lump-sum appropriation is insufficient to pay *all* the contracts the agency has made." *Cherokee Nation*, 543 U.S. at 637. " Although the agency itself cannot disburse funds beyond those appropriated to it, the Government's 'valid obligations will remain enforceable in the courts.'" *Salazar*, 132 S. Ct. at 2189, citing GAO Redbook at 6–17. Land of Lincoln's implied contract claim, and the implied contract claims of *amici* — which seek payment from the courts for amounts beyond what has been appropriated — fall neatly within this line of cases. The Government does not argue otherwise.

V. THE RISK CORRIDOR PAYMENTS ARE PRESENTLY DUE AND PAYABLE.

The Government argues that the money-mandating risk corridors statutory provisions are not "reasonably amenable to the reading" that the risk corridor payments are "presently due" for the 2014 and 2015 plan years. It is the Government's contrived "three-year payment" construct,

not the annual payments sought by Land of Lincoln and other Qualified Health Plans, that cannot reasonably be squared with the statute.

A. The "Presently Due" Issue Does Not Go to This Court's Jurisdiction.

The Government's argument that this Court lacks jurisdiction to hear Land of Lincoln's claim because money damages are not "presently due" must be rejected. It relies on *Todd v. United States*, 386 F.3d 1091 (Fed. Cir. 2004), which denied jurisdiction because money damages were not "presently due" under the specific facts of those cases.

However, in *Fisher v. United States*, the Federal Circuit clarified that in order to invoke this Court's jurisdiction on the basis of a "money-mandating" statute, a plaintiff need only identify a statute, regulation, and/or constitutional provision that: (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," and (2) is "*reasonably amenable* to the reading that it mandates a right of recovery in damages." *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (citations omitted). If the plaintiff also makes a "nonfrivolous assertion that it is within the class of plaintiffs entitled to recover under the money-mandating source, the Court of Federal Claims has jurisdiction. There is no further jurisdictional requirement that plaintiff make the additional nonfrivolous allegation that it is entitled to relief under the relevant money-mandating source." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008); *see also Albino v. United States*, 104 Fed. Cl. 801, 813 (2012) (jurisdiction exists "if a statute is reasonably amenable to a reading that is money-mandating and the plaintiff falls within the class of plaintiffs entitled to recover under the statute").

Since *Fisher*, this Court has repeatedly recognized that "presently due" is not the test for subject matter jurisdiction. *See, e.g., House v. United States*, 99 Fed. Cl. 342, 347 (2011) (applying *Fisher* to reject the Government's attempt to invoke a "presently due" jurisdictional

step, and finding jurisdiction because the statute at issue was money-mandating), *aff'd*, 473 F. App'x 901 (Fed. Cir. 2012); *Miller v. United States*, 119 Fed. Cl. 717, 729 (2015) ("[T]he holding in *Smith* has been eroded by the Federal Circuit's more recent decision in *Fisher*."); *Tippett v. United States*, 98 Fed. Cl. 171, 179 & n.10 (2011) (*Fisher* "altered the jurisdictional inquiry for Tucker Act suits").

Even if the proper jurisdictional test was "presently due" funds, however, the Government's argument still fails. Indeed, the case law relied upon by the Government does not support its argument. Gov't Br. at 14-15. For example, many of the claims held to be beyond the court's jurisdiction in the Government's citations sought non-monetary relief rather than money damages, the latter of which is a requirement for Tucker Act jurisdiction. *See Todd*, 386 F.3d at 1094 (no jurisdiction over lawsuit that effectively constituted a challenge to the Government's failure retroactively to change the status of an airport); *Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 687-88 (Fed. Cir. 1991) (no jurisdiction over lawsuit challenging Government contract termination without an accompanying claim for damages), *superseded by statute* 28 U.S.C. § 1491(a)(2), *as recognized in Alliant Techsystems, Inc. v. United States*, 178 F.3d 1260, 1268 (Fed. Cir. 1999); *United States v. Testan*, 424 U.S. 392, 407 (1976) (no Tucker Act jurisdiction over challenge to Government's employee classification decision).

Here, the claim is for money damages, and the Tucker Act provides jurisdiction for money damages claims founded upon, inter alia, "any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States…." 28 U.S.C. § 1491.

B. The ACA Requires Annual Risk corridor Payments in Their Full Amounts.

According to the Government, Section 1342 "neither requires HHS to pay risk corridors on an annual basis nor sets a deadline for any such payments to be made." Gov't Br. at 16. This

interpretation is incorrect based upon: the plain language of the risk corridors provisions in the ACA; the risk corridors provisions' legislative history; the very purpose and structure of the risk corridors provisions and the ACA, and the statutory construction rules established by the Supreme Court specifically in the context of the ACA.

1. The statute's plain meaning requires full, annual payments

"A court derives the plain meaning of the statute from its text and structure." *Norfolk Dredging Co. v. United States*, 375 F.3d 1106, 1110 (Fed. Cir. 2004) (citing *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001)). "In construing a statute, courts should not attempt to interpret a provision such that it renders other provisions of the same statute inconsistent, meaningless, or superfluous." *Abramson v. United States*, 42 Fed. Cl. 621, 629 (1998). Thus, "when reviewing the statute at issue in this case, the court must construe each section of the statute in connection with each of the other sections, so as to produce a harmonious whole." *Id.*

(a) Section 1342 and the broader ACA provide for an annual risk corridors program.

In the very first sentence of Section 1342, Congress mandated that HHS establish "a program of risk ***corridors*** for calendar years 2014, 2015, and 2016." 42 U.S.C. § 18062(a) (emphasis added). Absent contrary evidence, the use of the plural is deemed intentional, *see Dakota, Minnesota & Eastern R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) ("Congress's use of the plural is evidence of its intent"), which is revealing here because it indicates there are ***multiple*** risk corridors—one for each calendar year ("2014, 2015, and 2016")—and that there are separate payment obligations for each.

That there is a new risk corridor every year is no surprise, given that everything about the program is annual. The ACA mandates payment based on premiums and costs ***for each plan year*** from 2014-2016; all calculations are made on a plan year basis. *See* 42 U.S.C.

§§ 18062(c)(1)(A) ("The amount of allowable costs of a plan for any year …."), 18062(c)(2) ("The target amount of a plan for any year …."); *see also* 42 U.S.C. § 18062(b) (calculating risk corridor "[p]ayments out" and "[p]ayments in" based on ratio of allowable costs to target amounts "for any plan year").

Indeed, Qualified Health Plan issuers must submit their data to HHS annually for the preceding year, so that HHS may calculate annual risk corridor amounts based on that data. 45 C.F.R. § 153.530(d). All Qualified Health Plans are certified for an Exchange one year at a time. *See*, *e.g.*, 45 C.F.R. § 155.1045 (mandating that accreditation for Qualified Health Plans occur before each year the plan is offered). Payment into the risk corridors by Qualified Health Plans is annual as administered by HHS; risk corridor payments out to Qualified Health Plans issuers are also annual to the extent HHS has money to make the payments. Other aspects of the ACA requiring payments between insurers and the Government (risk adjustment and reinsurance) are both paid annually even though neither program's establishing statute mandates annual Government payments.[15]

[15] The Risk Adjustment Program transfers funds from issuers with low actuarial risk to plans with high actuarial risk in order to offset insurer losses from a higher proportion of high-cost enrollees. Issuers are required to report data annually, and CMS determines risk adjustment charges and payments using this data for each benefit year. CMS transferred $4.6 billion among insurance companies nationwide in 2014, and is in the process of collecting and paying risk adjustment charges for the 2015 benefit year. *See* CMS, The Three Rs: An Overview, https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html; CMS, Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year (June 30, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf

The Reinsurance Program spreads the cost of very large insurance claims across all coverage providers in order to reduce the uncertainty of insurance risk in the individual market by partially ofsetting issuers' claims associated with high-cost enrollees. Reinsurance charges are collected and payments made annually. CMS paid $7.9 billion in Reinsurance payments in 2014, and expects to pay a similar amount for the 2015 Benefit Year. *Id.*

HHS has not made full, annual risk corridor payments solely because Congress specifically withheld the funds that would have allowed it to do so, not because it ever took the position that the statute provided for such payments only at the end of three years. The Government now contends HHS should be able to "administer" the mandatory risk corridor payment program by paying only what it can, when it can. But that was not HHS' pre-litigation understanding or position on the payment regime.

As noted, certain insurers who earn larger than expected profits are required to make risk corridor payments to HHS. HHS long ago decreed that the deadline for payments from insurers who owed such payments to HHS, and the deadline for payments by HHS to insurers like Land of Lincoln and Amici who are owed risk corridor payments, should be exactly the same, and should call for annual payments. Specifically, in 2011, HHS openly admitted that "***QHP [Qualified Health Plan] issuers who are owed these [risk corridors] amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers."*** Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012) (emphasis added).

Qualified Health Plan issuers are required to pay in their risk corridor amounts 30 days after the Government provides its final calculations with respect to a given year. 45 C.F.R. § 153.510(d). HHS knows it should pay risk corridor amounts out at the same time. Indeed, it did make its payments with respect to 2014 in 2015, albeit only 12.6% of the total owed amount. And, it will make payments in 2016 (although it has announced that the payments will go

towards its 2014 and not its 2015 obligations).[16] In short, the Government's own behavior indicates that annual payments are required.

The Government offers no real explanation for how or when the mandatory payment will be made, other than it is supposedly only due sometime after 2017, at which time Congress would perhaps have changed its mind and appropriated the money so HHS can itself meet its payment obligations. But this turns the world on its head. As established in Sections III and IV *supra*, the entire point of the Tucker Act is to provide aggrieved plaintiffs the ability to obtain a judgment (from a permanent appropriation, *see* 31 U.S.C. § 1304) for a payment the Government is statutorily obligated to make, but has not. Neither the Tucker Act nor the Judgment Fund provide for delays in the disbursement of sums owed. The Government cannot justify an inexcusable delay in Land of Lincoln's and Amici's receipt of the payments to which they are entitled by statute and contract, based on a hope and prayer that other money might become available at some unspecified date in the future.

(b) The ACA risk corridors program is "based on" the Part D Medicare program, which requires full, annual payments.

Supporting the requirement of full, annual ACA risk corridor payments is the comparable payment scheme established by Medicare Part D, which Congress required HHS to use as the basis of the ACA risk corridors program. *See* 42 U.S.C. § 18062(a). Medicare Part D, which provides coverage for prescription drugs, establishes its own risk corridors program. 414,2 U.S.C. § 1395w-115(e).

As discussed above, rather than directly specifying that the Secretary "shall pay" the risk corridor amounts, Medicare Part D instead specifies that the Secretary "shall establish a risk

[16] *See* CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF.

corridor," *see supra* pages 14-15. But Part D is very specific about the payment timetable, providing that each "risk corridor" is specific to the plan year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) ("***For each plan year*** the Secretary shall establish ***a risk corridor*** for each prescription drug plan and each MA–PD plan. The ***risk corridor for a plan for a year*** shall be equal to a range as follows . . . ."); 42 C.F.R. § 423.336(a)(2)(i) ("***For each year***, CMS establishes ***a risk corridor*** for each Part D plan. The ***risk corridor for a plan for a coverage year*** is equal to a range as follows . . . .") (emphasis added). CMS has interpreted these provisions as requiring payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) ("CMS at its discretion makes either lump-sum [risk corridor] payments or adjusts monthly [risk corridor] payments ***in the following payment year*** ….") (emphasis added).

This is precisely the annual payment mechanism required for the ACA. Where "Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the [administrative or judicial] interpretation given to the incorporated law, at least insofar as it affects the new statute." *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978).[17] Thus, just as Part D does, the ACA requires HHS to establish a program to make and receive payments in the year following each risk corridor year. HHS clearly understood this requirement as it applies to profitable Qualified Health Plan issuers that owe risk

[17] *See also Am. Fed. of Gov't Emps., AFL-CIO v. United States*, 46 Fed. Cl. 586, 599-600 (2000) (applying interpretation given to statute with "the same purposes" as statute at issue in the present case), *aff'd*, 258 F.3d 1294 (Fed. Cir. 2001); *Leroy v. Sec'y of Dep't of Health & Human Servs.*, No. 02–392V, 2002 WL 31730680, at *14 (Fed. Cl. Oct. 11, 2002) (applying definition of specific statutory term from previous Act that was referenced in newer Act, the latter of which did not define the term); *James v. Santella*, 328 F.3d 1374, 1377-78 (Fed. Cir. 2003) (applying interpretation given to language from previous statute that was incorporated into newer statute); *Cohen v. United States*, 105 Fed. Cl. 733, 752-53 (2012) (analyzing and applying interpretations of Copyright Act provisions regarding minimum statutory damages that were incorporated into amendments to the Patent Act), *aff'd*, 528 F. App'x 996 (Fed. Cir. 2013).

corridor payments to HHS, who must provide an annual Qualified Health Plan on the Exchanges, submit their risk corridor data for that Qualified Health Plan by the following July 31, and then pay any owed amounts based on that data 30 days after notification of any charges owed to the Government. 45 C.F.R. § 153.510(d).[18] Precisely the same payment deadline applies to risk corridor payments owed by HHS to Land of Lincoln and Amici.

(c) The Government identifies no plain language in any statute supporting its "three-year payment framework."

The Government's primary counter-position relies on the assumption that payments for each risk corridor may be collectively spread across the three-year length of the ACA risk corridors program, and/or set off against payments and charges from other risk corridor years. *See* Gov't Br. at 1, 18-19, 43. For this interpretation, however, the Government identifies no actual statutory language permitting such a result, nor any reason that (in light of the risk corridors program's clear annual purpose and structure) such a payment framework would be consistent with the statute's plain meaning. *Id.* There is none.

Furthermore, absent an evident statutory purpose to the contrary, courts read statutes and regulations to preserve common law principles. *See United States v. Texas*, 507 U.S. 529, 534 (1993). It is axiomatic under the common law that, in the absence of a specific timetable, payments must be made within a reasonable time. *Goodman v. Praxair, Inc.*, 494 F.3d 458, 465 (4th Cir. 2007) (observing, in context of statute of limitations discussion, that the elapse of a "commercially reasonable time for payment" is one event that could establish a breach of contract); *see also Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013) (when

[18] For the 2014 plan year, the Government notified Qualified Health Plan issuers of their charge amounts on November 19, 2015, thus requiring them to pay those charges by December 19, 2015. *See* CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, at 1 (Nov. 19, 2015).

there is not a specified timetable for performance, performance must occur within a reasonable time). The Government has identified nothing suggesting it is reasonable to wait three years to pay amounts it owes, when such risk corridor payments were understood *ab initio* to be critical to the stability and integrity of the ACA Health Benefit Exchanges.

2. The legislative history also demonstrates that HHS must make full, annual risk corridor payments.

While there is little legislative history on the ACA,[19] the risk corridors program of the ACA is, as noted above, required by statute to be "based on" Part D. 42 U.S.C. § 18062(a) ("Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]."). Therefore, Part D's statutory language, implementing regulations and legislative history are relevant to the present dispute. *See, e.g.*, *Cohen*, 105 Fed. Cl. at 753 (analyzing older law's legislative history when interpreting new law that incorporated portions of the older law); *American Federation of Government Employees, AFL-CIO*, 46 Fed. Cl. at 598-600 (same).

The legislative history of Part D continuously emphasized the annual nature of risk corridor payments. Congressional testimony noted that "[t]he Federal Government has large-scale experience with the use of risk corridors;" that such a program "can limit both the downside risk and upside gain for an insurance organization"; and that risk corridors are annual in nature. *Expanding Coverage of Prescription Drugs in Medicare: Hearing before the Comm. on Ways and Means, H. of Representatives*, 108th Cong., 2003 WL 23996388, at *115-17 (Apr. 9, 2003) (Statement of Cori E. Uccello and John M. Bertko, American Academy of Actuaries). Following debate, Congress reported that it agreed to enact a risk corridors program that

[19] "Congress wrote key parts of the Act behind closed doors, rather than through 'the traditional legislative process.'" *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) (citation omitted).

proceeded in phases, with the first risk corridor in 2006-2007 and then a subsequent phase from 2008-2011, in which the corridors would be broadened and plans would be at full risk for a greater portion of their gains and losses. 149 Cong. Rec. H. 11877, 12000 (Nov. 20, 2003) (H.R. Rep. No. 108-391 (2003) (Conf. Rep.)). All amounts for these risk corridors calculations were annual. *Id.*

HHS then demonstrated its understanding of Congress's intent with respect to the Part D risk corridors program by requiring annual payments from all parties. 42 C.F.R. § 423.336(c). It is this history that informed Congress when enacting the ACA, and further supports the fact that the risk corridors program only works if it is annual in nature.

3. The purpose of the risk corridors program is to prevent exactly what has now occurred due to the Government's failure to pay.

The risk corridors program's purpose (as demonstrated by Section 1342 and the ACA's other interrelated provisions) also supports the conclusion that risk corridor amounts must be paid annually. As the Government admits, risk corridors are meant to provide "premium stabilization" in the highly risky, early years of the ACA exchanges. Gov't Br. at 1. If risk corridor amounts are not paid annually, then the program will fail to provide any stabilization at all. Given risk corridors' annual structure and underlying purpose, no reasonable interpretation permits anything other than risk corridor payments in each year following the plan year. *See King v. Burwell*, 135 S. Ct. 2480, 2492-93 (2015) ("the statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market . . . , and likely create the very 'death spirals' that Congress designed the Act to avoid").

VI. LAND OF LINCOLN'S RISK CORRIDORS CLAIMS ARE RIPE FOR THE 2014 AND 2015 PLAN YEARS.

The Court should also reject the Government's argument that "Land of Lincoln's claims are not ripe because HHS has not yet finally determined the total amount of payments that Land

of Lincoln (or any other issuer) will receive under the risk corridors program." Gov't Br. at 20-21. As an initial matter, this presumes that the Government need not pay full risk corridor amounts annually, which, for the reasons discussed above, is incorrect. However, the Government's argument also fails because it misapplies the law on ripeness.

As the Federal Circuit instructs:

> Whether an action is "ripe" requires an evaluation of "both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." As to the first prong, an action is fit for judicial review where further factual development would not "significantly advance [a court's] ability to deal with the legal issues presented." As to the second prong, withholding court consideration of an action causes hardship to the plaintiff where the complained-of conduct has an "immediate and substantial impact" on the plaintiff.

Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc., 527 F.3d 1278, 1294-95 (Fed. Cir. 2008) (internal citations omitted). "These two prongs are typically [and respectively] referred to as fitness and hardship." *CBY Design Builders v. United States*, 105 Fed. Cl. 303, 331 (2012).

With respect to fitness, the Government does not contest that Land of Lincoln incurred compensable risk corridor losses for both the 2014 and 2015 plan years they have not received in full, and will not receive from CMS in light of the appropriations riders. While the Government claims that it has not yet calculated the exact scope of the 2015 losses, these arguments do not change that Qualified Health Plans have ***already suffered*** their compensable risk corridor losses, that the Plans have ***already complied*** with their statutory obligations for both 2014 and 2015, that the Government ***already owes*** the risk corridor amounts for 2014 and 2015 (even if it has not finally calculated the latter), and that HHS is ***forbidden from using appropriations*** to pay these amounts. Thus, no "further fact development" might eliminate Land of Lincoln's current claims nor affect the Court's ability to deal with the legal issues presented.

Land of Lincoln and other Qualified Health Plans similarly satisfy the hardship prong. The Government does not dispute that it owes risk corridor payments, and that the amounts owed are significant. That is, in and of itself, more than enough to establish hardship. *See Coal. for Common Sense in Gov't Procurement v. Sec'y of Veteran Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006) (finding claim ripe where government would lose "hundreds of millions of dollars" annually if currently-pending stay continued, and plaintiff would have to pay "millions" if stay was lifted).

CONCLUSION

For the foregoing reasons, the Court should rule in favor of plaintiff Land of Lincoln.

Respectfully submitted,

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