IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,	:	Judge Griggsby
Plaintiff,	:	Case No. 16-651C
v.	:	
THE UNITED STATES OF AMERICA,	:	
Defendant.	:	

THE UNITED STATES' MOTION TO DISMISS

BENJAMIN C. MIZER
Principal Deputy Assistant Attorney General

RUTH A. HARVEY
Director
Commercial Litigation Branch

KIRK T. MANHARDT
Deputy Director

TERRANCE A. MEBANE
CHARLES E. CANTER
SERENA M. ORLOFF
FRANCES M. MCLAUGHLIN
L. MISHA PREHEIM
United States Department of Justice
Civil Division, Commercial Litigation Branch

Attorneys for the United States of America

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Federal Register

Rules

Miscellaneous

Pursuant to Rule 12(b)(1) of this Court's rules ("RCFC"), defendant, the United States, moves the Court to dismiss the Complaint of Blue Cross Blue Shield of North Carolina ("Blue Cross") for lack of subject matter jurisdiction. Should the Court determine that it has jurisdiction over Blue Cross's claims, the United States moves for dismissal under Rule 12(b)(6).

INTRODUCTION

Blue Cross brings this case seeking payments under section 1342 of the Affordable Care Act, 42 U.S.C. § 18062. Section 1342 directs the Secretary of Health and Human Services ("HHS") to establish and administer a three-year premium stabilization program known as "risk corridors" under which qualifying health plans either pay money to or receive money from HHS based on the ratio of their premiums to claims costs. Blue Cross participated in the program in 2014 and 2015 and claims to be entitled to more than $147 million in payments for 2014. Congress, however, has limited risk corridors payments to the amount of risk corridors collections, such that Blue Cross has received only a portion of the amount alleged to be due. Blue Cross seeks relief in this Court, but its claims fail as a matter of law.

First, Blue Cross has no claim to "presently due" money damages, as it must to establish jurisdiction under the Tucker Act. Section 1342 does not provide a deadline by which risk corridors payments must be made, and HHS, in its role as administrator of the program, established a three-year payment framework under which it operates the program in a budget neutral manner by making payments for any particular benefit year from charges collected across all three years of the program's life span. Under this framework, HHS does not owe Blue Cross, or any other issuer, final payment before the end of the program.

Second, Blue Cross's claims are not ripe. Because HHS's three-year framework has not yet run its course, HHS has not determined the total amount of risk corridors payments any issuer

will receive. Upon the conclusion of the three-year program, Blue Cross may receive the full amount of its claims. Even if it does not, it almost certainly will receive additional amounts. Because the final payment amounts are unknown and cannot be determined at this time, Blue Cross's claims are not justiciable.

Third, Count I fails on the merits. Section 1342 does not require HHS to make risk corridors payments beyond those funded from collections. And even if that intent were unclear when the Affordable Care Act was enacted in 2010, Congress removed any ambiguity when it enacted annual appropriations laws for fiscal years 2015 and 2016 that prohibited HHS from paying risk corridors amounts from appropriated funds other than collections. Thus, Blue Cross has, to date, received all the payments it is owed.

Fourth, Blue Cross's contract claims fail for the additional reason that risk corridors payments are a statutory benefit, not a contractual obligation. No contract requiring risk corridors payments could be formed as a matter of law because Congress neither established the risk corridors program as one based in contract nor conferred authority on HHS to bind the United States in contract for such payments. The sole express contract on which Blue Cross relies—an agreement known as a "QHP Agreement"—does not address risk corridors but instead relates to Blue Cross's obligation to protect consumers' personal information when operating on virtual insurance marketplaces facilitated by HHS. And no implied contract could arise because, in addition to the absence of any authority to bind the United States in contract for the payment of risk corridors, the express QHP Agreements define the relevant contractual parameters of Blue Cross's participation in the virtual insurance marketplaces. Thus, that participation could not also give rise to implied obligations as well.

Fifth, Blue Cross's takings claim fails because section 1342 does not require HHS to make risk corridors payments in excess of collections. Moreover, Congress—months before risk corridors payments could be made—enacted an appropriations rider that prohibited HHS from making risk corridors payments in excess of collections. Thus, issuers could not have had a reasonable expectation to annual payments in excess of collections. In any event, insurers have no vested property right under the Fifth Amendment to the expectation of a statutory benefit.

Finally, Blue Cross's claim for declaratory relief must be dismissed because this Court has no jurisdiction to award such relief.

STATEMENT OF THE ISSUES

1. Whether, as required by the Tucker Act, Blue Cross has an entitlement to "presently due money damages" under a government program that does not require final payment before the end of the three-year program.

2. Whether Blue Cross's claims for full payment are ripe for review before a final agency determination of how much will be paid.

3. Whether, on the merits, Blue Cross can receive payments in excess of collections under section 1342 notwithstanding congressional intent that risk corridors payments be funded solely from collections over the program's three year life-span.

4. Whether the statutory and regulatory provisions establishing the risk corridors program—which were not embodied in a written contract, contain no language of contractual intent, and were never accompanied by contractual budget authority—nevertheless create a contractual right to risk corridors payments in excess of collections.

5. Whether Blue Cross has a vested property interest in annual risk corridors payments that exceed the amount of collections.

6. Whether the Court has jurisdiction to award declaratory relief in this case.

STATEMENT OF THE CASE

I. In 2010, Congress Enacted the Risk Corridors Program as Part of the Affordable Care Act

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010) (the "ACA"), seeking to guarantee the availability of affordable, high-quality health insurance coverage for all Americans. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).[1] The Act's key reforms are threefold: (1) it prohibits health insurance companies from denying coverage or setting premiums based upon health status or medical history; (2) it requires individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service; and (3) it provides federal insurance subsidies in the form of premium tax credits and cost sharing reductions to make insurance more affordable to eligible consumers. *King*, 135 S. Ct. at 2486 (citing 42 U.S.C. §§ 300gg, 300gg–1(a), 18081, 18082, 18091; 26 U.S.C. §§ 5000A, & 36B); *see also* 42 U.S.C. § 18071.

A. The Health Benefit Exchanges

To implement these reforms, the Act created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where individuals and small groups can purchase health

[1] HHS is responsible for overseeing implementation of major provisions of the ACA and for administering certain programs under the ACA, either directly or in conjunction with other federal agencies and/or states. *See, e.g.*, 42 U.S.C. §§ 18041(a)(1)(A), (c)(1). HHS delegates many of its responsibilities under the ACA to the Centers for Medicare & Medicaid Services ("CMS"), which created the Center for Consumer Information and Insurance Oversight ("CCIIO") to oversee implementation of the ACA. HHS, CMS, and CCIIO are referred to in this motion as "HHS."

insurance coverage. 42 U.S.C. §§ 18031-18041. For consumers, the Exchanges provide a centralized location to shop for, select, and enroll in qualified health plans. Exchanges also are the only forum in which eligible consumers can purchase coverage with the assistance of federal subsidies. For issuers, the Exchanges provide organized, competitive marketplaces to compete for business in a centralized location, and they are the only commercial channel in which issuers can market their plans to the millions of individuals who receive federal insurance subsidies. The Exchanges also perform certain administrative functions, including eligibility verification, enrollment, and the delivery of federal insurance subsidies.

The Act contemplated that states would operate their own Exchanges ("State-Based Exchange") but provided that HHS would establish and operate Exchanges for any state that elected not to do so ("Federally-facilitated Exchange"). *See* 42 U.S.C. § 18041; 45 C.F.R. §§ 155.20, 155.105; Program Integrity; Exchange, SHOP, and Eligibility Appeals, 78 Fed. Reg. 54,070, 54,071 (Aug. 30, 2013).[2] All plans offered through an Exchange—whether State-Based or Federally-facilitated—must be "Qualified Health Plans" ("QHPs"), meaning that they provide "essential health benefits" and comply with other regulatory parameters such as provider network requirements, benefit design rules, and cost sharing limitations. *See* 42 U.S.C. § 18021; 45 C.F.R. parts 155 and 156.

To ensure that issuers operating on the Exchanges comply with these requirements, Congress required Exchanges to establish annual certification procedures. 42 U.S.C.

[2] States have three options regarding the establishment and administration of an Exchange: (1) they can elect to run their own Exchange using a state or federally-maintained information technology platform ("State-Based Exchange"); (2) they can let the federal government run their Exchange ("Federally-facilitated Exchange"); or (3) they can partner with the federal government to jointly administer their Exchange ("State Partnership Exchange"). 45 C.F.R. §§ 155.20; 155.105, 155.106, 155.200. HHS uses the term Federally-facilitated Exchanges to include State Partnership Exchanges.

§ 18031(d)(4); 45 C.F.R. part 156. HHS conducts the certification process for Federally-facilitated Exchanges and, as part of this process, requires issuers to attest that they will comply with federal and state insurance laws, including those governing QHPs, and to execute an agreement known as a "Qualified Health Plan Certification Agreement and Privacy and Security Agreement," or "QHP Agreement" for short. In the QHP Agreement, issuers agree to adhere to privacy and security standards when conducting transactions on the Federally-facilitated Exchange. 45 C.F.R. § 155.260(b)(2); *see, e.g.*, Compl. Exhibits 2-4. Notwithstanding these requirements, an issuer's decision to offer QHPs on an Exchange in any given year is not a contractual commitment to the United States; it is a business decision accompanied by regulatory consequences.

B. The Risk Corridors Program

The ACA introduced millions of previously uninsured individuals into the insurance markets. The entry of these individuals—while creating valuable business opportunities for insurers—also created pricing uncertainties arising from the unknown health status of an expanded risk pool and the fact that insurers could no longer charge higher premiums or deny coverage based on an enrollee's health. *See* 42 U.S.C. §§ 300gg, 300gg-1; 45 C.F.R. §§ 147.104-147.110. To mitigate the pricing risk and incentives for adverse selection arising from these changes, the Act established three premium stabilization programs modeled on similar programs established under the Medicare Program. *See* Compl. ¶¶ 5, 7, 21. Informally known as the "3Rs," these programs began with the 2014 benefit year and consist of reinsurance, risk adjustment, and risk corridors. *See generally* 42 U.S.C. §§ 18061-18063.

The 3Rs program at issue in this case is the temporary risk corridors program established under section 1342 of the ACA, which seeks to reduce financial uncertainty for QHP issuers during the initial years of the Act by limiting financial losses and gains resulting from inaccurate rate-

setting. *See* Compl. ¶ 22. To do this, section 1342 requires the Secretary of HHS to "establish and administer a program of risk corridors" under which issuers offering individual and small group QHPs between 2014 and 2016 "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. § 18062(a). Under the "payment methodology" set forth in the ACA, if an issuer's "allowable costs" (essentially, claims costs) are less than a "target amount" (premiums minus administrative costs) by more than three percent, the plan must pay a percentage of the difference (referred to as a "charge" or "collection") to HHS. 42 U.S.C. § 18062(b)(2). Conversely, if an issuer's allowable costs exceed the target amount by more than three percent, the issuer receives a percentage of the difference (referred to as a "payment"). 42 U.S.C. § 18062(b)(1). The payment and charge percentage is set by statute: either 50% or 80%, depending on the degree of loss or gain realized by the issuer. 42 U.S.C. § 18062(b). HHS regulations incorporate this payment methodology in substantially similar terms. *See* 45 C.F.R. § 153.510(b)-(c).

All QHP issuers are statutorily required to participate in the risk corridors program; there are no risk corridors contracts, and a QHP need not have entered any agreement with HHS to owe risk corridors charges or receive payments.[3] Instead, HHS administers the risk corridors program solely pursuant to statutory requirements, regulations, and guidance. Under the regulations, after the close of each benefit year, issuers of QHPs must compile and submit premium and cost data and other information underlying their risk corridors calculations to HHS no later than July 31 of the next calendar year. 45 C.F.R. § 153.530(d). Using these data, HHS calculates the charges and payments due to and from each issuer for the preceding benefit year. *See* 45 C.F.R. § 153.530(a)-

[3] With respect to the risk corridors program, QHP is defined at 45 C.F.R. § 153.500 to include health plans offered outside the Exchanges that are the same plan or substantially the same as a QHP offered on the Exchanges, as defined at 45 C.F.R. § 153.20.

(c); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473-74 (March 11, 2013). Within 30 days of HHS's announcement of final charge amounts, issuers are required to remit payment to HHS. 45 C.F.R. § 153.510(d). Neither the ACA nor the implementing regulations set a deadline by which HHS must make payments to issuers. *See generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510.

II. In Early 2014, HHS Announced that It Would Implement the Risk Corridors Program in a Budget-Neutral Manner within a Three-Year Framework

Although Congress expressly appropriated funds in the ACA for many programs and authorized funding for others, Congress did not include in the ACA either an appropriation or an authorization of funding for risk corridors. In July 2011, HHS published a proposed rule noting that when the Congressional Budget Office ("CBO") performed a cost estimate contemporaneously with ACA's passage, it "assumed [risk corridors] collections would equal payments to plans in the aggregate." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,948 (July 15, 2011). In March 2012, HHS published a regulatory impact analysis again noting that "CBO . . . assumed collections would equal payments to plans and would therefore be budget neutral." Centers for Medicare & Medicaid Services, Regulatory Impact Analysis, Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) (Mar. 16, 2012); *see also* Centers for Medicare & Medicaid Services, Preliminary Regulatory Impact Analysis (CMS-9989-P2) (July 2011) ("CBO . . . assumed aggregate collections from some issuers would offset payments made to other issuers.").[4]

[4] A copy of this publication and other reference material not published in the Federal Register is provided in the Appendix.

On March 11, 2014, HHS issued a final rule stating that "[w]e intend to implement th[e] [risk corridors] program in a budget neutral manner, and may make future adjustments, either upward or downward to this program . . . to the extent necessary to achieve this goal." HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014); *see also id.* at 13,829 ("HHS intends to implement this program in a budget neutral manner."); Exchange and Insurance Market Standards for 2015 and Beyond Proposed Rule, 79 Fed. Reg. 15,808, 15,822 (Mar. 21, 2014) (same). On April 11, 2014, HHS released guidance explaining that in order to implement budget neutrality, it would make risk corridors payments only to the extent of collections and that any shortfall would result in a pro-rata reduction of all payments. Centers for Medicare & Medicaid Services, Risk Corridors and Budget Neutrality (Apr. 11, 2014) ("April 11 Guidance"), Appendix A144. That shortfall would then be paid from collections in the second and (if necessary) third years of the program. *Id.* Under this three-year framework, final payments under the risk corridors program are not due until the end of the program. *Id.* HHS reiterated and expanded upon this guidance in final rules issued in May 2014 and February 2015. *See* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

HHS did note, however, that although it would strive to achieve budget neutrality consistent with the CBO's projections, it interpreted section 1342 to require full payments to issuers and that, if necessary, at the conclusion of the program, it would use sources of funding other than risk corridors collections, subject to the availability of appropriations. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to

issuers. In [the event that risk corridors collections are insufficient to fund payments over the three-year life of the program], HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. at 10,779 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In the unlikely event that risk corridors collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); HHS Notice of Benefit and Payment Parameters for 2014 Final Rule, 78 Fed. Reg. at 15,473 ("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."). Similarly, on September 9, 2016, HHS issued an announcement stating, "As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required." Centers for Medicare & Medicaid Services, Risk Corridors Payments for 2015 (Sept. 9, 2016), Appendix at 241; *compare* April 11 Guidance.

III. For Fiscal Years 2015 and 2016, Congress Enacted Appropriations Riders Limiting the Total Risk Corridors Payments to the Amount of Risk Corridors Collections

Meanwhile, in February 2014, Members of Congress asked the Government Accountability Office ("GAO") for an opinion regarding the availability of appropriations to HHS to make payments to QHPs under the risk corridors program. *See* The Honorable Jeff Sessions,

the Honorable Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237, at *1 (Sept. 30, 2014) ("*GAO Op.*"). Prior to issuing its opinion, the GAO solicited the views of HHS, which identified collections from insurance issuers as the only source of funding and explained that collections could be spent pursuant to a provision of the CMS Program Management appropriation authorizing the expenditure of user fees. Letter of May 20, 2014, Appendix at A146. Shortly thereafter Members of Congress sent a similar inquiry to HHS regarding available budget authority to make risk corridors payments, and HHS again identified collections from insurance issuers as the only source of funding for risk corridor payments. Letter of June 18, 2014, Appendix at A149.

In its opinion released on September 30, 2014, the GAO recognized that "Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1)," *GAO Op.*, 2014 WL 4825237, at *2. The GAO agreed with HHS that risk corridors collections could be used to make risk corridors payments under the user fee authority in CMS's Program Management appropriation. *Id.* at *4. The GAO also looked to whether any other funds were legally available to be spent on the risk corridors program and concluded that, in the annual appropriations law then in effect (the "2014 Spending Law"), a lump sum appropriation of $3.7 billion to be transferred from CMS trust funds to the CMS Program Management account for "other responsibilities of [CMS]" was sufficiently broad to cover risk corridors payments. *Id*. at *3. The opinion noted, however, that because risk corridors payments would not begin until fiscal year 2015 and "[a]ppropriations acts, by their nature, are considered nonpermanent legislation," similar appropriation language would need to be enacted for fiscal years 2015, 2016, and 2017 for the Program Management account to supply a source of funding for the program. *Id*. at *5.

On December 9, 2014—months before any payments could be made under the risk corridors program—Congress passed the Consolidated and Further Continuing Appropriations

Act, 2015 ("the 2015 Spending Law") specifically addressing budget authority for the risk corridors program. Like the 2014 Spending Law, the 2015 Spending Law provided a lump sum amount for CMS's Program Management account for fiscal year 2015 to be transferred from CMS trust funds. Pub. L. No. 113-235, div. G, title II. Unlike the 2014 Spending Law, however, a rider to the Law expressly limited the availability of Program Management funds for the risk corridors program, as follows:

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

Id. § 227. The effect of the rider was to limit HHS's budget authority to make risk corridors payments to amounts derived from risk corridors collections. An accompanying Explanatory Statement indicated that the restriction was added "to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). The Explanatory Statement observed that, "[i]n 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral," and characterized that statement by HHS as "meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." *Id.*

On December 18, 2015, Congress enacted an identical funding limitation in the annual appropriations act for fiscal year 2016 (the "2016 Spending Law"). Pub. L. No. 114-113, div. H, title II, § 225. The Senate Committee Report to the 2016 Spending Law stated that the funding limitation "requir[es] the administration to operate the Risk Corridor program in a budget neutral manner by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as

payments for the Risk Corridor program." Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74, at 12 (2015).

IV. In Conformity with Its Three-Year Administrative Framework and the Appropriations Riders, HHS Applied a Pro-Rata Reduction to Risk Corridors Payments in the First Payment Cycle

On July 31, 2015, issuers submitted their risk corridors data for the 2014 benefit year pursuant to the schedule established by HHS. Centers for Medicare & Medicaid Services, Preliminary Risk Corridors Program Results (Aug. 7, 2015). On October 1, 2015, HHS announced that collections under the program for 2014 were expected to total $362 million, while payments calculated totaled $2.87 billion. Centers for Medicare & Medicaid Services, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015). HHS explained that, because payments exceeded collections, it could pay only 12.6% of these payments in the 2015 payment cycle. *Id.* Shortly thereafter, HHS released an individualized report of 2014 risk corridors charges and payments for each issuer. The same day, HHS released a guidance document explaining that it would make the pro-rated payments in late 2015, with "[t]he remaining 2014 risk corridors payments . . . made from 2015 risk corridors collections [in 2016], and if necessary, 2016 collections [in 2017]." Centers for Medicare & Medicaid Services, Risk Corridors Payments for the 2014 Benefit year (Nov. 19, 2015), Appendix at A151 ["November 19 Guidance"]. HHS also advised that, "[i]n the event of a shortfall for the 2016 program year, [HHS] will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments." *Id.*

In November 2015, HHS began collecting risk corridors charges for the 2014 benefit year. Centers For Medicare & Medicaid Services, Risk Corridors Payment and Charge Amounts for 2014 Benefit Year (Nov. 19, 2015), Appendix at A152. In December 2015, HHS began remitting

risk corridors payments to issuers, including Blue Cross. *Id.* HHS expects to pay additional installments of these payments in the 2016 payment cycle and the 2017 payment cycle. November 19 Guidance.

Issuers submitted their benefit year 2015 risk corridors data to HHS by August 1, 2016. *See* 45 C.F.R. § 153.530(d). HHS has not yet announced the final charge and payment amounts due from and to issuers for benefit year 2015. HHS expects to begin making payments to issuers in December 2016. *See* Centers for Medicare & Medicaid Services, Completing the Risk Corridors Plan-Level Data Form for the 2015 Benefit Year, Health Insurance Exchange Program Training Series (June 7 & 9, 2016) ("June Webinar"), at 7, Appendix at A183.[5]

ARGUMENT

I. The Court Lacks Jurisdiction Under the Tucker Act Because Blue Cross Has No Substantive Right to "Presently Due Money Damages"

A motion to dismiss for lack of subject matter jurisdiction is governed by RCFC 12(b)(1). When the movant challenges the jurisdictional facts alleged in the complaint, "[t]he plaintiff cannot rely solely on allegations in the complaint, but must bring forth relevant, adequate proof to establish jurisdiction." *Widtfeldt v. United States*, 122 Fed. Cl. 158, 162 (2015). The burden of proving that the court possesses subject matter jurisdiction lies at all times with the plaintiff. *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 176-77 (2009). If the court determines that the plaintiff has not met its burden, the court "cannot proceed at all in any cause" and must dismiss the action. *Ex parte McCardle*, 74 U.S. (7 Wall.) 506, 514 (1868); RCFC 12(h)(3).

[5] On September 9, 2016, HHS announced that, "based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments." Appendix at A241.

A. The Tucker Act's Waiver of Sovereign Immunity Is Limited to Monetary Claims That Are "Presently Due"

"The United States, as sovereign, is immune from suit save as it consents to be sued." *United States v. Sherwood*, 312 U.S. 584, 586 (1941). A waiver of sovereign immunity is a necessary prerequisite to the exercise of jurisdiction over the United States by any court. *See, e.g.*, *United States v. King*, 395 U.S. 1, 4 (1969). Such a waiver "must be unequivocally expressed in the statutory text" and "strictly construed, in terms of its scope," in favor of the United States. *Lane v. Pena*, 518 U.S. 187, 192 (1996). "Absent a waiver, sovereign immunity shields the Federal Government and its agencies from suit," without regard to any perceived unfairness, inefficiency, or inequity. *Dept. of Army v. Blue Fox, Inc.*, 525 U.S. 255, 260 (1999).

The Tucker Act, under which Blue Cross asserts jurisdiction, Compl. ¶ 11, waives sovereign immunity for certain non-tort claims against the United States founded upon the Constitution, a federal statute or regulation, or a contract. 28 U.S.C. § 1491(a)(1). The Tucker Act "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). "Thus, jurisdiction under the Tucker Act requires the litigant to identify a substantive right for money damages against the United States separate from the Tucker Act itself." *Todd v. United States*, 386 F.3d 1091, 1094 (Fed. Cir. 2004) (citing *Testan*, 424 U.S. at 398). In meeting this burden, it is not enough for a plaintiff to point to a law requiring the payment of money in the abstract. Instead, the law must "fairly be interpreted as mandating compensation for damages sustained as a result of *a breach of . . . duties [it] impose[s]*." *United States v. Mitchell*, 463 U.S. 206, 219 (1983) (emphasis added).

Further, the law must entitle the plaintiff to "actual, *presently due* money damages from the United States." *Todd*, 386 F.3d at 1093-94 (quoting *King*, 395 U.S. at 3) (emphasis added); *Johnson v. United States*, 105 Fed. Cl. 85, 94 (2012) ("Under the Tucker Act, the court's

jurisdiction extends only to cases concerning actual, presently due money damages from the United States.") (internal quotation omitted); *see also Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 689 (Fed. Cir. 1991) ("[T]he word 'claim' carries with it the historical limitation that it must assert a right to presently due money."), *superseded by statute on other grounds*, Pub. L. No. 102-572, Title IX, §§ 902(a), 907(b)(1), 106 Stat. 4506, 4516, 4519 (1992). Thus, where a plaintiff has received all the money it is currently due, the Court must dismiss the complaint for lack of jurisdiction. *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 179.

B. Additional Risk Corridors Payments Are Not Presently Due

With respect to risk corridors payments for benefit year 2015, it is undisputed that issuers were not required to submit the data necessary to calculate these payments before August 1, 2016, and that HHS has not announced final charge and payment amounts for 2015—much less made payments—for that benefit year. *See* Compl. ¶ 145; *see also* June Webinar, at 7. Blue Cross thus has no right to "actual, presently due money damages" for amounts that have not yet been announced by HHS and that, under Blue Cross's own theory of annual payment, are not yet due.

As for payments for the 2014 benefit year, Blue Cross's claim of Tucker Act jurisdiction rests on its mistaken assertion that "[t]he United States should have paid BCBSNC the full [benefit year] 2014 risk corridor payments due by the end of . . . 2015[.]" Compl. ¶ 87. But, as Blue Cross concedes, neither Congress nor HHS "impose[d] a deadline for HHS to tender full risk corridor payments to QHPs[.]" Compl. ¶ 81. *See also* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Section 1342 requires HHS to calculate risk corridors payments and charges based on claims and other costs for a "benefit year," but it neither requires HHS to pay risk corridors on an annual basis nor

sets a deadline for any such payments to be made (let alone sets a deadline that payments made in 2017 would not meet).

The very design of the risk corridors program and its inter-relationship with other 3Rs programs necessarily requires substantial flexibility in the timing of payments. For example, the ACA gives states responsibility for operating the reinsurance and risk adjustment programs unless they fail to do so, 42 U.S.C. §§ 18061(a), 18063(a), and requires that payments and charges in the federally-administered risk corridors program take into account "risk adjustment and reinsurance payments received" through these programs. 42 U.S.C. § 18062(c)(1)(B). Thus, if the statute had set a deadline for risk corridors payments (it did not), that deadline could have come no earlier than many months after the close of a plan year, so that the federal government could wait for (what Congress contemplated to be fifty different) state-operated reinsurance and risk adjustment programs to run their course and then include "risk adjustment and reinsurance payments received" in calculating risk corridor charges and payments. *Id.* Furthermore, the ACA permits a state to "allocate[] and use[]" reinsurance collections "in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period." *Id.* § 18061(b)(4)(A). If a state were to choose to operate its own reinsurance program and exercise that option, the Secretary would not be able to definitively determine a plan's risk corridors amount for any given year until after the conclusion of the three-year reinsurance program. In light of the statutory requirement that reinsurance receivables factor into risk corridors calculations, and the ACA's express permission to allocate reinsurance collections in any of the three years of that program, the Secretary has reasonably interpreted the risk corridor provision not to require payment before the conclusion of the program, when reinsurance receivables would definitively be known. Likewise, while HHS's regulation requires issuers to pay charges within

30 days of notification by HHS, it does not establish any deadline by which HHS must make payments to issuers. *See* 45 C.F.R. § 153.510(d).

In the absence of a contrary statutory provision, "agencies, not the courts, . . . have primary responsibility for the programs that Congress has charged them to administer." *McCarthy v. Madigan*, 503 U.S. 140, 145 (1992), *superseded by statute on other grounds*, Pub. L. No. 104-134, § 803, 110 Stat. 1321 (Apr. 26, 1996). Courts must defer to an agency's interpretation of ambiguous statutory provisions, so long as that interpretation is reasonable. *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). The Federal Circuit has stated that "the *Chevron* standard of deference applies" where, as here, "Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)).

By declining to specify when payments from HHS were due and delegating to HHS the responsibility to "establish and administer" the risk corridors program, 42 U.S.C. § 18062(a), Congress conferred "broad discretion" to HHS "to tailor [the] . . . program to fit both its needs and its budget." *Contreras v. United States*, 64 Fed. Cl. 583, 599 (2005), *aff'd*, 168 F. App'x 938 (Fed. Cir. 2006). HHS exercised this discretion by establishing a three-year payment framework. Under this framework, if risk corridors claims exceed collections for a given benefit year, as they did for year 2014, payments are temporarily reduced so as not to exceed HHS's budget authority for that year. However, further payments for that benefit year are made in subsequent payment cycles (as HHS's budget authority is replenished), with final payment not due until the final payment cycle

in 2017. *See* Compl. ¶ 142 (acknowledging HHS's multi-year payment cycle); April 11 Guidance; November 19 Guidance. Thus, HHS's three-year payment framework is well within the administrative authority delegated by Congress, and it is entitled to deference by the Court. *See, e.g.*, *W.E. Partners II, LLC v. United States*, 119 Fed. Cl. 684, 692 (2015) (deferring to agency framework for payments under statutory program because the "discretion afforded to the Treasury Department suggest Congress's intent to defer to the agency with the administration of this law"), *aff'd*, 636 Fed. Appx. 796 (Fed. Cir. 2016); *Meyers v. United States*, 96 Fed. Cl. 34, 54-55 (2010) (deferring to agency where statute authorized it to "establish" regulatory program and did "not [expressly] proscribe" the programmatic framework established).

The 2015 and 2016 Spending Laws confirm that HHS has discretion to administer the risk-corridors program using a three-year payment framework. As noted above, the Spending Laws enacted in 2014 and 2015 preclude HHS from using appropriated funds other than risk corridors collections to make risk corridors payments during fiscal years 2015 and 2016, respectively. And Congress expressly acknowledged the three-year span of the payment framework in the Explanatory Statement to the 2015 Spending Law. 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (characterizing the 2014 HHS regulation as "meaning that the federal government will never pay out more than it collects from issuers *over the three year period risk corridors are in effect*.") (emphasis added). In short, Congress was fully aware of HHS's interpretation, expressly referred to it in the Explanatory Statement, and enacted the Spending Laws contemplating the same result. The three-year framework thus permits HHS to pay out the maximum amount possible on claims for each program year while also conforming to the express statutory limitation on the use of funds for risk corridors payments in fiscal years 2015 and 2016. Indeed, by implementing the risk corridors program in a budget neutral manner during the years the Spending Laws are in effect,

HHS also is adhering to the restrictions in those laws, which prohibit HHS from making payments for 2014 and 2015 in amounts that exceed collections for those years. *Cf. Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005) (noting that appropriations limits "unequivocally control what may be spent on [covered] activities during the period of their applicability," and concluding agency reasonably interpreted underlying 1994 statute by considering Congress's post-1994 appropriations limitations).

Because HHS's three-year payment framework has not yet run its course, Blue Cross has no present right to full payment of its 2014 risk corridors receivable, let alone payment for its 2015 receivable (if any). As a result, Blue Cross does not seek "presently due money damages" in compensation for any discernable legal violation, but instead seeks relief for which it has no substantive right: immediate payment. The Tucker Act does not confer jurisdiction under such circumstances. *See, e.g.*, *Casitas Mun. Water Dist. v. United States*, 708 F.3d 1340, 1358 (Fed. Cir. 2013) (observing that "a compensable injury [under the Tucker Act] could not have occurred because [a legal violation] has not yet occurred"); *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 179 (holding that a plaintiff's mere "desire to receive a lump sum payment in lieu of" installment payments does not establish a legal violation by the United States or give rise to presently due money damages); *Wood v. United States*, 214 Ct. Cl. 744, 745 (1977) ("At best, plaintiff is claiming that he is not going to get [when the time comes] what is due him; such a claim is for future relief which we may not now entertain."); *cf. Barlow & Haun, Inc. v. United States*, 118 Fed. Cl. 597, 622 (2014) (dismissing claim where agency "had not actually failed to perform a presently due . . . obligation prior to plaintiffs filing suit"), *aff'd*, 805 F.3d 1049 (Fed. Cir. 2015). Blue Cross's Complaint should be dismissed for lack of jurisdiction.[6]

[6] Counts II, III, IV, and V are each dependent on an alleged right, under section 1342 or 45 C.F.R.

II. Blue Cross's Claims Are Not Ripe

Blue Cross's claims also should be dismissed because they are not ripe. "Ripeness is a justiciability doctrine that prevents the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements." *Shinnecock Indian Nation v. United States*, 782 F.3d 1345, 1348 (Fed. Cir. 2015) (citations and internal punctuation omitted); *see also Barlow & Haun, Inc.*, 118 Fed. Cl. at 614-15 ("[T]he court may find that it possesses jurisdiction over the subject matter of a claim but that the dispute is nevertheless nonjusticiable.").[7] Because "[t]he role of the federal courts is to provide redress for injuries that are 'concrete in both a qualitative and temporal sense,' . . . '[a]dherence to ripeness standards prevents courts from making determinations on the merits of a case before all the essential facts are in.'" *Shinnecock Indian Nation*, 782 F.3d at 1351-52 (quoting *Whitmore v. Arkansas*, 495 U.S. 149, 155 (1990)). "[A] claim is not ripe for adjudication if it rests upon 'contingent future events that may not occur as anticipated, or indeed may not occur at all' . . . [or] 'if further factual development is required.'"

§ 153.510, to receive risk corridors payments in full annually. *See* Compl. ¶ 178 (alleging breach of express contract for failure to fulfill obligations under section 1342 or 45 C.F.R.§ 153.510), ¶ 182 (alleging section 1342 and 45 C.F.R.§ 153.510 constituted an offer to enter an implied-in-fact contract), ¶ 202 (assuming existence of an express or implied-in-fact contract to make full risk corridors payments annually and alleging that failure to require full, annual payments breached implied duty of good faith and fair dealing), ¶ 213 (alleging vested property right to receive full risk corridors payments annually under section 1342, 45 C.F.R. § 153.510, express contract, or implied-in-fact contract). Accordingly, in addition to the reasons set forth more fully below, because annual payments are not required, those counts fail as a matter of law and should be dismissed.

[7] Although the constitutional basis for the justiciability doctrine derives from the "cases or controversies" requirement in Article III of the Constitution, this Court applies the doctrine on prudential grounds. *See, e.g.*, *CW Gov't Travel, Inc. v. United States*, 46 Fed. Cl. 554, 557-58 (2000) (collecting cases).

Id. at 1349 (quoting *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985); *Rothe Dev. Corp. v. Dep't of Def.*, 413 F.3d 1327, 1335 (Fed. Cir. 2005)).

Blue Cross's claims are not ripe because HHS has not yet finally determined the total amount of payments that Blue Cross (or any other issuer) will receive under the risk corridors program. HHS has not completed its data analysis for benefit year 2015, and benefit year 2016 is still underway. Whether sufficient funds will be available to make full payment of claims for any particular benefit year, and for all three years combined, is unknown. HHS may collect sufficient funds in future years to pay risk corridors claims in full. Alternatively, Congress may appropriate additional funds for the program in future years to pay all risk corridors amounts as calculated under section 1342(b). This Court does not address hypothetical situations that may be fully addressed by agency action, legislative action, or the passage of time. *See, e.g.*, *Shinnecock Indian Nation*, 782 F.3d at 1351-52 (affirming dismissal for lack of ripeness where "multiple possible . . . outcomes and factual developments could impact the Court of Federal Claims' adjudication" of plaintiff's claims). In short, it is too soon to determine whether Blue Cross will receive less than the full amount of its risk corridors claims, much less the extent of any such underpayment. This case is not ripe and should be dismissed.

III. If the Court Reaches the Merits, Count I Should be Dismissed for Failure to State a Claim upon Which Relief Can Be Granted

For the reasons set forth above, the Complaint should be dismissed for lack of jurisdiction and lack of a justiciable claim. If, however, the Court determines that it has jurisdiction and that the claims are justiciable, Count I should be dismissed under Rule 12(b)(6). RCFC 12(b)(6) requires a court to dismiss a claim that fails to state a claim on which relief can be granted. To avoid dismissal, a plaintiff must "provide the grounds of [its] entitle[ment] to relief" in more than mere "labels and conclusions." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation and

quotation marks omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A "formulaic recitation of the elements of a cause of action" is insufficient. *Twombly*, 550 U.S. at 555. Rather, the complaint must "plead factual allegations that support a facially 'plausible' claim to relief," *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009). The Court must dismiss a claim "when the facts asserted by the claimant do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002).

A. HHS's Pro-Rated Payments Are Rational Because the ACA Does Not Mandate Risk Corridors Payments In Excess of Amounts Collected

HHS's determination to operate the risk corridors program on a three-year, budget neutral basis, in which annual payments are limited by the amount of funds collected across all program years, must be upheld because Congress has not mandated that HHS make risk corridor payments in excess of collections. Rather, Congress planned the 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. Subsection (a) of section 1342 requires HHS to establish and administer a temporary "payment adjustment system" based on the ratio of a plan's allowable costs to the plan's aggregate premiums. HHS fulfills that role by collecting charges from plans whose allowable costs are less than the threshold and distributing those funds to plans whose allowable costs exceed the threshold. But nothing in section 1342 requires HHS to make up a shortfall in collections. To the contrary, section 1342 creates a program with only "payments in" and "payments out." 42 U.S.C. § 18062(b) (capitalization altered). Insurers are assessed charges or receive payments "under the program,"

42 U.S.C. § 18062(b)(1) and (2), and HHS distributes the monies accordingly. The statute contains no reference to any other source of funds.[8]

Blue Cross relies heavily on the language of subsection (b), which, in setting forth the "payment methodology," states that "the Secretary shall pay" amounts calculated in specified fashion. 42 U.S.C. § 18062(b)(1). But subsection (b) merely describes the "methodology" to be applied by HHS as it adjusts funds between plans "under the program"; it nowhere states that HHS or the United States must provide additional funds to insurers when the funds available "under the program" fall short of the statutory amounts. Under Blue Cross's interpretation, HHS would be the uncapped insurer of the insurance industry itself, under criteria—the ratio of a plan's allowable costs to its aggregate premiums—which are wholly dependent upon issuers' business judgment. Congress did not intend that result.

That Congress did not intend such a result is confirmed by the contrast between section 1342 and the preexisting risk corridors program under Medicare Part D. Although Congress specified that the ACA's temporary risk corridors program was generally based on the already-existing risk corridors program under Medicare Part D, *see* 42 U.S.C. § 18062(a), Congress omitted from the ACA the explicit statutory language that obligates the Secretary to make payments under the Medicare Part D risk corridors program in excess of amounts collected under that program. The Medicare Part D provision expressly provides: "This section constitutes budget

[8] Responding to a request for an opinion regarding the availability of appropriations to make risk corridors payments, the GAO concluded that, as a matter of appropriations law, the CMS Program Management appropriation then in effect would have been available to make risk corridors payments and also would have appropriated risk corridors collections to HHS to make risk corridors payments had any obligation to make payments existed in that fiscal year. *See GAO Op.*, 2014 WL 4825237, at *5. HHS had identified only collections as a source of funds for payments. *Id.* The GAO did not address whether HHS was required under section 1342 to make payments in excess of collections.

authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section." 42 U.S.C. § 1395w-115(a)(2). By contrast, there is no such language in section 1342.

Accordingly, when the CBO performed a cost estimate contemporaneously with the Affordable Care Act's passage, it omitted the risk corridors program from its scoring. *See* Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 2 (Mar. 20, 2010), http://www.cbo.gov/ftpdocs/113xx/doc11379/amendreconProp.pdf. The CBO's cost estimate was critical to ACA's passage, and was referenced in the text of ACA itself. *See* ACA § 1563(a), 124 Stat. 270-271; *see also* David M. Herszenhorn, *The Numbers Come Out Just Where Obama Wanted, With No Magic Involved*, N.Y. Times, Mar. 19, 2010, at A16. And that critical estimate of ACA's fiscal consequences was predicated on the understanding that the risk corridors program would not impose liability on the government for payments in excess of amounts collected under the risk corridors program.[9]

Thus, under the ACA's text and statutory structure, insurers' entitlement to risk corridors payments extends only to the extent of amounts collected under the program. Because section 1342 does not give insurers a right to risk corridors payments from the Secretary in excess of collections, Blue Cross's Tucker Act claims fail as a matter of law.

[9] HHS's various statements, described on pp. 9-10, addressed the agency's efforts to make risk corridors payments, subject to the availability of appropriations. The statements do not address the validity of claims against the United States under the Tucker Act.

B. Congress's Post-ACA Enactments Confirm That Insurers Do Not Have an Entitlement to Risk Corridors Payments In Excess of Collections

The appropriations riders that Congress enacted after the ACA's passage further reinforce the conclusion that the liability of the United States is limited to amounts collected under the risk corridors program. HHS announced its three-year framework for implementing budget neutrality in final rules and guidance issued in the spring of 2014. 79 Fed. Reg. at 13787; 79 Red. Reg. at 30,260; April 11 Guidance. In September 2014, the GAO released its opinion that, under the language of CMS's then-effective Program Management appropriation, monies transferred to the Program Management account from CMS trust funds would be available for risk corridors payments. *See GAO Op.*, 2014 WL 4825237, at *3. On December 9, 2014, in response to the GAO's conclusion and well before any risk corridors payments could be made, Congress passed the 2015 Spending Law with a rider prohibiting the use of appropriated funds other than collections to make risk corridors payments. The following year, Congress enacted an identical rider in the 2016 Spending Law. Pub. L. No. 114-113, div. H, title II, § 225. Congress's intent in each of the Spending Laws was clear: to ensure "that the risk corridor program will be budget neutral . . . over the three year period risk corridors are in effect," 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014), and to "requir[e] the administration to operate the Risk Corridor program in a budget neutral manner," Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74 at 12, (2015). The 2015 and 2016 appropriations riders thus confirm that Congress intends HHS to administer the risk corridors program as a self-funding program of redistribution among insurers.

Even if this were not the intent behind Section 1342 as originally enacted, "it is a well-established doctrine that Congress can authorize a deviation from pre-existing law by a provision in an appropriations act." *Bickford v. United States*, 228 Ct. Cl. 321, 329 (1981); *see, e.g.*, *United*

States v. Dickerson, 310 U.S. 554, 555-56 (1940) (Congress can "suspend or repeal [an] authorization contained in [its own acts] . . . by an amendment to an appropriation bill, or otherwise"); *Republic Airlines, Inc. v. U.S. Dep't of Transp.*, 849 F.2d 1315, 1320 (10th Cir. 1988) ("Congress can amend substantive legislation through a provision in an appropriations act."); *Envirocare of Utah Inc. v. United States*, 44 Fed. Cl. 474, 482 (1999) (appropriations laws are "'just as effective a way to legislate as are ordinary bills relating to a particular subject'") (citation omitted); GAO, GAO–04–261SP, *Principles of Federal Appropriations Law (Vol. I)* 2-62-63 (4th ed. Mar. 10, 2016) ("Congress may enact a subsequent appropriation that makes a smaller payment than was contemplated in the permanent legislation . . . as long as the intent to reduce the amount of the payment is clear.").

A long line of Supreme Court and appellate cases have held that provisions enacted in annual appropriations laws, such as the spending limits at issue here, can substantively amend money-mandating provisions in previously enacted laws, thereby eliminating or reducing a claimant's right to payment. In *Dickerson*, for example, the Supreme Court considered the effect of an annual appropriations law providing that "no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1938, shall be available for the payment of [an] enlistment allowance . . . notwithstanding . . . [previously enacted legislation mandating that such allowance 'shall be paid']." *Dickerson*, 310 U.S. at 556-57. The Court held that the plaintiff was not entitled to collect such an allowance, notwithstanding the prior statute, because the statutory context and the legislative history showed that "Congress intended [the appropriations law] to suspend the enlistment allowance" for the fiscal year at issue. *Id.* at 561-62.

Similarly, in *United States v. Will*, 449 U.S. 200 (1980), the Supreme Court held that appropriations language providing that "[n]o part of the funds appropriated for the fiscal year

ending September 30, 1979 . . . may be used to pay" salary increases mandated by earlier legislation "indicate[d] clearly that Congress intended to rescind these raises entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear intent of Congress . . . *was to stop for that year the application of the . . . Act*." *Id.* at 224 (emphasis added); *see also United States v. Mitchell*, 109 U.S. 146, 148 (1883) (holding that "by the appropriation acts which cover the period for which the appellee claims compensation, congress expressed its purpose to suspend the operation of [a prior statute fixing salaries] and to reduce for that period the salaries of the appellee and other interpreters of the same class from $400 to $300 per annum"); *Matthews v. United States*, 123 U.S. 182, 186 (1887) (appropriations law capping salaries "in full compensation" for services "repealed, by necessary implication[,] . . . previous enactments" setting higher compensation).

In *Highland Falls–Fort Montgomery Cent. Sch. Dist. v. United States*, 48 F.3d 1166, 1171-72 (Fed. Cir. 1995), the Federal Circuit likewise gave effect to congressional intent in an earmarked appropriation that limited and modified previously enacted statutory directions for the payment of money. Other circuits have reached similar conclusions. For example, in *Republic Airlines*, an annual appropriation law stated that "notwithstanding any other provision of law, none of the funds appropriated by this Act shall be expended under section 406 [of the Federal Aviation Act of 1958] for [certain] services provided after ninety-five days following the date of the enactment of this Act." 849 F.2d at 1317 (citing Pub. L. No. 97-102). The Tenth Circuit held that the appropriations restriction substantively amended the previously existing subsidy program under section 406 of the Act, thereby limiting the Civil Aeronautics Board's power to pay subsidies. *Id.* at 1319-22 (citing *Will*, 449 U.S. at 223; *American Fed'n of Gov't Employees, AFL–CIO v. Campbell*, 659 F.2d 157, 157 (D.C. Cir. 1980)). In so holding, the court rejected the

airlines' argument that "Congress intended in section 406(b) to create an entitlement which was to survive appropriations actions," concluding that the "appropriations act directly addressed, and limited, the subsidy payable by the Board under section 406 and, perforce, altered any 'entitlement' to which the Airlines refer." *Id.* at 1319. *See also City of Arcata v. Slater*, 133 F.3d 926, 1997 WL 812258, at *2 (9th Cir. 1997) [unpublished table op.] (holding that the "plain language" of the appropriations law stating that "none of the funds in this Act may be obligated or expended to operate" flight service station "defunds everything that [the prior act] obligates the FAA to do. Accordingly, the FAA's obligation to implement that section has been suspended") (citing *Burtch v. United States Dep't of the Treasury*, 120 F.3d 1087, 1090 (9th Cir. 1997)); *Am. Fed'n of Gov't Emp., AFL-CIO*, 659 F.2d at 161 ("the [appropriations act] in this case contains words that by clear implication, if not express statement, modified *pro tanto* the previous substantive law. Consequently, we conclude that Congress, by express reference to the earlier statute, effectively modified the prevailing rate statute to provide that wages for prevailing rate employees could not be increased by more than 5.5% for fiscal year 1979.").

In many of these cases, Congress prohibited payment from the appropriations act as a whole (or, in *Dickerson*, from any appropriations act for the fiscal year at issue), or Congress capped payments at a lesser amount than specified. In contrast, because the risk corridors program includes collections from issuers, Congress did not intend through the 2015 and 2016 Spending Laws to eliminate risk corridors payments under section 1342 entirely or reduce payments by a specific amount, but instead intended to limit payments to the extent of risk corridors collections. Moreover, because collections are themselves considered an appropriation as a matter of appropriations law, rather than prohibiting payments from the Spending Laws as a whole (as the riders at issue in many cases did), Congress included riders that limit risk corridors payments only

from the CMS Program Management appropriation, the only source of funding the GAO had determined to be legally available for risk corridors payments. The riders thus demonstrate Congress's intent that the risk corridors program be budget neutral.

The cases discussed above demonstrate that Congress can suspend or modify the extent of the government's obligation in an appropriations statute, and that Congress can demonstrate its intent to do so through the text of the appropriations statute itself, the surrounding context in which the appropriation was made, or the statute's legislative history. Here, in enacting the 2015 and 2016 Spending Laws, Congress demonstrated its intent that the risk corridors program be budget neutral for those fiscal years. Thus, even if Congress's intent to limit the United States' liability to the extent of risk corridors collections were unclear at the time the ACA was enacted, by the time any payments could be made, Congress had "directly spoken" to the issue by restricting the use of HHS funds to support the risk corridors program. *Highland Falls*, 48 F.3d at 1170. Issuers' remedy "must lie with Congress." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990).

C. Congress Could Limit the United States' Liability Through Appropriations Restrictions Because the Risk Corridors Program Does Not Impose Contractual Obligations on the United States

The Supreme Court has recognized a limitation on Congress's ability to curtail the government's contractual liability through the appropriations process. *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012); *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 646 (2005). The Court made clear, however, that this limitation is based on "longstanding principles of Government contracting law," *Ramah Navajo*, 132 S. Ct. at 2186, and the observation that "[a] statute that retroactively repudiates the Government's contractual obligation may violate the Constitution," *Cherokee Nation*, 543 U.S. at 646. Thus, this Court and the Court of Appeals have held that the rule of *Ramah Navajo* is confined to obligations based in contract and does not

apply to other statutory programs, such as the risk corridors program at issue here. *See, e.g.*, *Prairie Cty. Mont. v. United States*, 113 Fed. Cl. 194, 200 (2013) (observing that "'there is great room in benefits programs to find the government's liability limited to the amount appropriated'") (quoting *Greenlee Cty. v. United States*, 487 F.3d 871, 879 (Fed. Cir. 2007)), *aff'd*, 782 F.3d 685, 690 (Fed. Cir. 2015) ("[T]his case does not involve the same question as that addressed by the Supreme Court in *Ramah* and *Cherokee Nation*. *Absent a contractual obligation*, the question here is whether the statute reflects congressional intent to limit the government's liability.") (emphasis added), *cert. denied*, 136 S. Ct. 319 (Oct. 13, 2015).

As set forth more fully below, the limited contract-based doctrine of *Ramah Navajo* does not apply here because section 1342 provides for the creation of a benefits program. HHS has no contractual obligation to make risk corridors payments, and in the absence of such an obligation, Congress was free to "readjust[] rights and burdens" and even "upset[ ] otherwise settled expectations," *Usery v. Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976), by limiting the "government's liability . . . to the amount appropriated," *Prairie Cty. Mont.*, 113 Fed. Cl. at 200. *See also Richardson v. Belcher*, 404 U.S. 78, 80-81 (1971) (noting "the power of Congress to make substantive changes" to benefits programs such as risk corridors); *Kizas v. Webster*, 707 F.2d 524, 539 (D.C. Cir. 1983) (government benefits "are 'limited, as a general rule, by the governmental power to remove, through prescribed procedures, the underlying source of those benefits.'") (citations omitted, emphasis removed).

Congress has done so here. Accordingly, Count I must be dismissed for failure to state a claim upon which relief may be granted.

IV. Blue Cross's Contract and Takings Claims Fail to State a Claim

A. Counts II, III, and IV Must Be Dismissed Because HHS Has No Contractual Obligation to Make Risk Corridors Payments

In Counts II, III, and IV, Blue Cross alleges that, by making partial rather than full risk corridors payments in the 2015 payment cycle, HHS breached express and implied contracts and an asserted implied covenant of good faith and fair dealing. These claims fail because they rely on the existence of a contract between HHS and Blue Cross for the payment of risk corridors payments, but no such contract exists. Section 1342 establishes a statutory program, not a contractual undertaking. Insurance issuers do not "agree" with HHS to offer QHPs in exchange for a promise by HHS to make risk corridors payments. Rather, issuers of QHPs automatically are subject to the risk corridors program—along with numerous other regulatory benefits and burdens—and any amounts determined to be owed by or due to them arise wholly as a matter of statute and regulation. Blue Cross proffers several theories to avoid this conclusion, but none has merit.

1. Count II Fails Because the Express Agreements at Issue Are Wholly Unrelated to the Risk Corridors Program

In Count II, Blue Cross asserts breach of an express contract based on the QHP Agreements. As set forth above, Congress required Exchanges to establish annual certification procedures ensuring that plans sold on the Exchanges comply with QHP requirements. *See* 42 U.S.C. § 18031(d); 45 C.F.R. § 155.1010(a). HHS's certification process—which applies only to plans sold on Federally-facilitated Exchanges—requires issuers to (among other things) execute a QHP Agreement indicating their commitment to adhere to privacy and security standards under section 1411(g) of the ACA and, where necessary, the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), Pub. L. No. 104-191, 110 Stat. 1936 (Aug. 21, 1996),

when conducting transactions with the Exchanges. 45 C.F.R. § 155.260(b)(2); *see, e.g.*, Compl. Exhibits 2-4. In return, HHS agrees to take reasonable efforts to implement data-oriented systems and processes so as to support the QHP in its Exchange functions. But QHP Agreements do not create a contractual commitment to the United States to offer QHPs on an Exchange. Rather, the QHP Agreements merely require an issuer that has decided to issue QHPs (and to do so on a Federally-facilitated Exchange platform) to comply with specified electronic transmission standards.[10]

Notwithstanding the narrow focus of the QHP Agreements on the integrity of electronic transmissions, Blue Cross contends that the Agreements also give rise to an express contractual right to receive risk corridors payments. To evaluate that claim, the Court must begin with the plain language of the agreement. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (en banc). The Court need go no further: QHP Agreements do not mention risk corridors, section 1342, or 45 C.F.R. § 153.510, and nothing in them relates in any way to the risk corridors program. Rather, as indicated by their full title ("Qualified Health Plan Certification Agreement and *Privacy and Data Security Agreement*" (emphasis added)),[11] the Agreements are focused on the transmission of enrollee data through the Exchanges and the protection of personally identifying information in those transmissions.

[10] State-based Exchanges have their own certification processes. QHPs that operate on State-based Exchanges generally do not execute a QHP Agreement with HHS as a condition of certification. If, however, a State-based Exchange relies on the federal technology platform, issuers must sign a privacy and security agreement before they can connect to CMS's systems.

[11] The initial version of the QHP Agreements were known simply as "Qualified Health Plan (QHP) Agreements." After the first year that Exchanges offered coverage, the full title was changed to "Qualified Health Plan Certification Agreement and Privacy and Data Security Agreement," while the substantive provisions remained unchanged. *Compare* Compl. Exhibit 2 *with* Compl. Exhibits 3 and 4.

Consistent with this focus, in Section II of the Agreement—entitled "Acceptance of Standard Rules of Conduct"—an issuer agrees that, in order "to gain and maintain access to the 'CMS Data Services Hub Web Services,'" it will abide by rules relating to HIPAA compliance, secure transaction formats, transaction testing, and laws governing the use and storage of personally identifiable information.[12] QHP Agreement at § II.a. HHS, in turn, agrees to "undertake all reasonable efforts to implement systems and processes that will support QHP[] functions" and, in the event of system failure, to "work with QHP[s] in good faith to mitigate any harm caused by such failure." *Id.* § II.d. But Section II does not, as Blue Cross asserts, also require HHS to make risk corridors payments. The term "systems and processes," as used here, refers to systems and processes through which electronic data flows between issuers and the Federally-facilitated Exchanges via the CMS Data Services Hub Web Services ("Hub Web Services"); it cannot plausibly be read to relate in any way to the risk corridors program.[13] *See e.g.*, *Granite Constr. Co. v. United States*, 962 F.2d 998, 1003 (Fed. Cir. 1992) (contract provisions must be

[12] The CMS Data Services Hub Web Services is a CMS-operated electronic data system that connects issuers to the Exchanges. *Id.*

[13] The QHP Agreements specifically incorporate by reference, at II.b(3), a "Companion Guide" created for issuers and setting forth the detailed electronic data transmission requirements that issuers must follow to effectuate eligibility, enrollment, and federal insurance subsidy transactions with the Exchanges through the Hub Web Services. The official title of the Companion Guide is "CMS Standard Companion Guide Transaction Information: Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE), Companion Guide Version Number 1.5 (March 22, 2013). *See* Appendix at A98. As set forth in the Companion Guide, the systems and processes that use the Hub Web Services include the: "testing process" (at 3), "validation processes" (at 4-5), "Centers for Medicare and Medicaid Services (CMS) Enterprise File Transfer (EFT) System" (at 7, 33), "Federal Exchange Program System (FEPS) Enrollment Data Store (EDS)" (at 9-10), "enrollment process" (at 27-26), termination process (at 32-35), monthly reconciliation process (at 35), "HHS Reconciliation Process Flow" (at 33), "QHP Issuer Reconciliation Process Flow" (at 32) and the "comparison process" (at 34). The Companion Guide thus illustrates that the types of "systems and processes" referred to in the QHP Agreement are far afield from the risk corridors program.

read as a harmonious, integrated whole, rather than in isolation). In fact, if the term "systems and processes" were read to encompass the risk corridors program, it would also encompass any other ACA program that can plausibly be construed to "support" a QHP. Such a reading would necessarily transform the dozens of ACA programs operated by HHS from regulatory functions into contractual commitments. There is no limiting principle to such a construction, and nothing in the ACA, the QHP Agreements, or common sense supports it.

Blue Cross also relies on section V.g. of the QHP Agreements, which provides that the Agreements are governed by federal law. According to Blue Cross, this reference to federal law necessarily incorporates section 1342 (and presumably the vast corpus of other federal laws applicable to Blue Cross—whether ACA-related or not) by reference into the Agreement as a contractual commitment. Compl. ¶¶ 172-73. This theory suffers from precisely the same defects as Blue Cross's "systems and processes" theory: it finds no support in the contractual text and it has no limiting principle.

Unsurprisingly, courts also have uniformly rejected such a theory. A court may not "find that statutory or regulatory provisions are incorporated into a contract with the government unless the contract *explicitly* provides for the incorporation." *St. Christopher Associates, L.P. v. United States*, 511 F.3d 1376, 1384 (Fed. Cir. 2008) (citation omitted) (emphasis added). To so provide, "the incorporating contract must use language that is *express* and *clear*, so as to leave no ambiguity about the identity of the document being referenced, nor any reasonable doubt about the fact that the referenced document is being incorporated into the contract." *Northrop Grumman Info. Tech., Inc. v. United States*, 535 F.3d 1339, 1344 (Fed. Cir. 2008); *see also Precision Pine & Timber, Inc. v. United States*, 596 F.3d 817, 826 (Fed. Cir. 2010) ("To incorporate material by reference, a contract must use clear and express language of incorporation, which unambiguously

communicates that the purpose is to incorporate the referenced material, rather than merely acknowledge that the referenced material is relevant to the contract.") (citation omitted).

The QHP Agreements fail this test. Section V.g. states merely that Agreements "will be governed by the laws and common laws of the United States of America, including . . . such regulations as may be promulgated . . . by [HHS]." It uses no "clear and express" language incorporating Section 1342 by reference; indeed it uses no language of incorporation at all with reference to risk corridors. Section V.g. does not mention risk corridors, section 1342, or 45 C.F.R. § 153.510 or in any way imply that the Agreement has anything to do with risk corridors. *See, e.g.*, *Earman v. United States*, 114 Fed. Cl. 81, 104 (2013) (provision stating that a contract is governed by Federal laws, "which does not refer to any particular statutory or regulatory provision, cannot reasonably be read as incorporating the corpus of the [ ] statute into plaintiff's contract."); *Smithson v. United States*, 847 F.2d 791, 794 (Fed. Cir. 1988) (rejecting argument that provision that contract was "subject to" regulations promulgated by the Farmers Home Administration incorporated the agency's regulations). Blue Cross's suggestion that Section V.g. creates a contractual right to risk corridors payments must be rejected.[14]

Finally, interpreting the QHP Agreements to encompass risk corridors obligations would create an artificial policy distinction because QHP Agreements with HHS are a unique feature of certification on Exchanges that use HHS's platform. *See* Compl. Exhibit 2, at 1 (providing that the agreement is entered by HHS "as the Party . . . responsible for the management and oversight

[14] As noted above, the QHP Agreements incorporate the Companion Guide expressly and specifically into the Agreements. *See, e.g.*, Compl. Exhibit 2 § II.b.3. The use of specific incorporation language to incorporate the Companion Guide but not to incorporate section 1342 or 45 C.F.R. § 153.510 further indicates that the Agreements do not incorporate the provisions of the risk corridors program.

of the Federally-facilitated Exchange"). QHPs sold only on Exchanges that do not use HHS's platform (such as many State-Based Exchanges), though equally subject to the risk corridors program, do not enter QHP Agreements with HHS. Thus, embracing Blue Cross's theory that such Agreements create a contractual right to risk corridors payments from HHS would mean that issuers in operation on the Federally-facilitated Exchanges could enforce their rights in contract, while many of those operating on State-Based Exchanges could not.[15] Blue Cross identifies no reason why Congress would have designed the program in such a way and there is none. QHP Agreements do not require HHS to make risk corridors payments. Count II must be dismissed.

2. Count III Fails Because Section 1342 Establishes a Benefits Program, Not an Implied Contract

In Count III, Blue Cross alleges that it "entered into valid implied-in-fact contracts with the Government regarding the Government's obligation to make full and timely risk corridor payments to BCBSNC for CY 2014 in exchange for BCBSNC's agreement to become a QHP and participate in the North Carolina ACA Exchanges." Compl. ¶ 181. The elements of an implied-in-fact contract are the same as the elements of an express contract, namely: (1) mutuality of intent; (2) an unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the government's representative to bind the government in contract. *Hanlin v. United States*, 316 F.3d 1325, 1328 (Fed. Cir. 2003). Blue Cross has not alleged and cannot allege facts plausibly establishing these requirements.

[15] For example, the plaintiffs in *Health Republic* and *Moda* participated in State-based Exchanges (Oregon, and Oregon and Washington, respectively) and thus did not enter QHP Agreements with HHS as a condition of offering QHPs in these marketplaces. *See* Complaint, *Health Republic Ins. Co. v. United States*, No. 16-259C, Docket No. 1; Complaint, *Moda Health Plan, Inc. v. United States*, No. 16-649C, Docket No. 1.

a. Nothing in Section 1342 or 45 C.F.R. § 153.510 Indicates an Intent by the Government to Enter into a Contract for Risk Corridors

First, Blue Cross fails to offer any well-pleaded factual allegations indicating that the government intended to contract for risk corridors payments. "[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465–66 (1985) (internal quotations, citations omitted). Courts must presume that a statutory enactment constitutes a statement of policy rather than a binding commitment, because "the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state . . . [which], unlike contracts, are inherently subject to revision and repeal[.]" *Id.*; *see also Baker v. United States*, 50 Fed. Cl. 483, 489 (2001) ("[T]he United States cannot be contractually bound merely by invoking the cited statute and regulation.").

Blue Cross cannot overcome this presumption. It points to section 1342, 45 C.F.R. § 153.510, and HHS's purported "admissions regarding their obligation to make risk corridors payments" (most of which post-date the alleged formation of the implied contract) as allegedly indicating an offer by the government to make "full and timely" risk corridors payments. Compl. ¶¶ 182, 180-98. This does not suffice. Rather, "to overcome th[e] presumption [that general laws do not create private rights in contract], plaintiffs must point to specific language in [the statute or regulation] or to 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).

When courts have found an intent to contract with program participants, the statutes at issue clearly expressed Congress's intent for the government to enter into contracts. *See, e.g.*, *Grav v. United States*, 14 Cl. Ct. 390, 392 (1988) (finding an implied-in-fact contract where statute provided that "Secretary shall offer to enter into a contract"), *aff'd*, 886 F.2d 1305 (Fed. Cir. 1989); *Radium Mines, Inc. v. United States*, 153 F. Supp. 403, 405 (Ct. Cl. 1957) (opining that agency regulation could give rise to implied contract where it stated that "[u]pon receipt of an offer" the agency would "forward to the person making the offer a form of contract containing applicable terms and conditions ready for his acceptance"). In contrast, neither section 1342 nor 45 C.F.R. § 153.510 contain any contract language; they simply provide for the creation of a program and a formula for determining charges and payments.

Nor do HHS's acknowledgments of its risk corridors duties, Compl. ¶ 182, evince an intent to contract; they merely recognize HHS's understanding of its existing *statutory* duties. *See, e.g.*, 79 Fed. Reg. at 30,260 ("HHS recognizes that the *Affordable Care Act* requires the Secretary to make full payments to issuers."); 80 Fed. Reg. at 10,779 (same). An agency's acknowledgment of a statutory duty is not evidence of an intent to contract. *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 328 (2012). Thus, there is no support for Blue Cross's contention that Congress or HHS intended the risk corridors program to operate as a contractual obligation. *Cf. Hanlin*, 316 F.3d at 1329-30 (noting that statute and regulation "set forth the [agency's] authority and obligation to act, rather than a promissory undertaking" and "[w]e discern no language in the statute or the regulation that indicates an intent to enter into a contract"); *AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 (finding no intent to contract in Medicare Act and regulations where statute "only provides for payment" and regulation "provides for a review process"); *ARRA Energy Co. I*, 97 Fed. Cl. at 28 (dismissing implied-in-fact contract claim because statute "simply provides

that the government will make an outright payment to any applicant who meets specified conditions"). Absent any intent by the United States to contract for the payment of risk corridors, Count III must be dismissed.

b. The QHP Agreements Preclude Any Implied Contract

Blue Cross's implied contract claim also must fail because an implied contract cannot be grounded on an express contract. *Durant v. United States*, 16 Cl. Ct. 447, 452 (1998) ("Because plaintiffs' implied-in-fact contract argument is grounded on the same facts as the express contract, the existence of the express contract precludes the court from finding an implied in fact contract"); *accord Bank of Guam v. United States*, 578 F.3d 1318, 1329 (Fed. Cir. 2009) (citing cases). The QHP Agreements establish the relevant contractual parameters of Blue Cross's offering of QHPs on a Federally-facilitated Exchange, and those parameters require only that Blue Cross meet certain data transmission and security requirements before it can participate on a Federally-facilitated Exchange. Blue Cross cannot inject additional contractual obligations by recourse to an implied contract theory.

c. HHS Lacked Authority to Enter Contracts for Risk Corridors Payments

Regarding authority to enter an implied contract with issuers, Blue Cross again relies on HHS's representations and assurances. Compl. ¶ 194 ("[t]he Government repeatedly acknowledged its statutory and regulatory obligations . . . through its conduct and statements to the public and to BCBSNC and other similarly situated QHPs, made by representatives of the Government who had actual authority to bind the United States"). [16] Blue Cross fails to identify

[16] Not only were many of the representations relied upon by Blue Cross made two and three years after the time of purported contract formation, at all times, HHS's assurances were expressly grounded in the statute—not a contract—and often were accompanied by the qualifying language "subject to the availability of appropriations." *See, e.g.*, Compl. Exhibits 18 & 23 (relying on 2015

who authorized the alleged contracts or the source of their purported authority. *See* Compl. ¶¶ 182, 189, 194.

"A government agent possesses express actual authority to bind the government in contract only when the Constitution, a statute, or a regulation grants it to that agent in unambiguous terms." *McAfee v. United States*, 46 Fed. Cl. 428, 435 (2000). Moreover, budget authority is a prerequisite to contract formation with the United States. 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). Without such authorization (or appropriation), a valid contract for the payment of money cannot be formed. *See, e.g., Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 643 (2005) (recognizing that "without . . . special authority, a[n] . . . officer cannot bind the Government in the absence of an appropriation") (citations omitted). Nothing in the ACA or HHS's regulations grants authority to HHS to enter contracts for the payment of risk corridors.

In any event, the agency assurances relied on by Blue Cross do not advance its case. An agency simply cannot bind itself to the payment of money through its oral or written statements—absent express contracting authority bestowed by Congress. "If agents of the Executive were able, by their unauthorized . . . statements to citizens, to obligate the Treasury for the payment of funds, the control over public funds that the [Appropriations] Clause reposes in Congress in effect could be transferred to the Executive . . . in violation of the Constitution." *Richmond*, 496 U.S. at 428.

---

and 2016 letters from CCIIO containing the qualifying language: "[i]n the event of a shortfall for the 2016 program year, HHS will explore other sources of funding for risk corridor, *subject to the availability of appropriations*") (emphasis added).

3. Count IV (Breach of the Implied Covenant of Good Faith and Fair Dealing) Fails Because No Contract Exists for Risk Corridors Payments

Count IV alleges that HHS breached an asserted implied covenant of good faith and fair dealing by not making full risk corridor payments. Compl. ¶¶ 199-210. When a plaintiff "fail[s] to establish either an express or implied contract with [the United States], its dependent claim for a breach of implied covenant of good faith and fair dealing also must be dismissed." *HSH Nordbank AG v. United States*, 121 Fed. Cl. 332, 341 (2015). As set forth above, HHS has no contractual obligations with respect to risk corridors. Accordingly, Count IV should be dismissed.

B. Count V (Takings Without Just Compensation) Fails Because Blue Cross Has No Vested Property Right to Full, Annual Risk Corridors Payments

Count V asserts that the United States' "action in withholding . . . full and timely CY 2014, 2015 and 2016 risk corridor payments owed to BCBSNC constitutes a deprivation and taking of Plaintiff's property interests and requires payment to Plaintiff of just compensation under the Fifth Amendment of the U.S. Constitution." Compl. ¶ 217. Courts apply a two-part test when evaluating whether governmental action constitutes a taking without just compensation. "First, the court determines whether the claimant has identified a cognizable Fifth Amendment property interest that is asserted to be the subject of the taking. Second, if the court concludes that a cognizable property interest exists, it determines whether that property interest was 'taken.'" *Acceptance Insurance Cos., Inc. v. United States*, 583 F.3d 849, 854 (Fed. Cir. 2009) (collecting Federal Circuit cases). "If the claimant fails to demonstrate the existence of a legally cognizable property interest, the court's task is at an end." *Am. Pelagic Fishing Co. v. United States*, 379 F.3d 1363, 1372 (Fed. Cir. 2004).

At set forth above, Blue Cross has no contractual right to receive risk corridors payments. Its takings claim, therefore, must rest on its statutory or regulatory rights, if at all. An ordinary obligation on the part of the United States to pay money under a statutory benefits program, however, does not give rise to a takings claim. *Adams v. United States*, 391 F.3d 1212, 1224 (Fed Cir. 2004); *see also Nat'l Educ. Ass'n—Rhode Island v. Ret. Bd. of the Rhode Island Employees' Ret. Sys.*, 172 F.3d 22, 30 (1st Cir. 1999) (where an expectation of payment is insufficient to constitute an enforceable contract, it does not constitute property under the Takings Clause); *Kizas*, 707 F.2d at 539-40 ("A 'legitimate claim of entitlement' to a government benefit does not transform the benefit *itself* into a vested right.").

Apart from its generalized and conclusory allegation that it "had and has a reasonable investment-backed expectation of receiving the full and timely . . . risk corridor payments," Blue Cross pleads no facts to support its assertion that it "has a vested property interest in its . . . statutory and regulatory rights to receive statutorily-mandated risk corridors payments." Compl. ¶ 213. And indeed, as set forth above, the relevant statutory provisions do not obligate HHS to pay risk corridors amounts beyond the amounts collected under the program. In April 2014, moreover, HHS announced its three-year payment framework that expressly contemplated the possibility of less than full payments. By that time, Blue Cross could not have a reasonable expectation of full payment in the event payments exceeded collections, even assuming that expectations alone, rather than a vested property right, could give rise to a takings claim in this context.

Finally, just as HHS's statements recognizing general statutory mandates cannot constitute an offer to enter into a contract, they cannot create a vested property right in risk corridor benefits. *Cf. Yancey v. Dist. of Columbia*, 991 F. Supp. 2d 171, 179 (D.D.C. 2013) (no vested property right

in benefits based on erroneous statements by government employees). Accordingly, Blue Cross has no vested property rights to receive payments by a particular date. And in any event, because final payments are not due until the end of the risk corridor program, failure to make final payment before then cannot constitute a taking. Count V should be dismissed.

V. Blue Cross's Prayer for Declaratory Relief Should be Dismissed

Blue Cross asks the Court to award non-monetary and special relief, including a "declar[ation] . . . [that] the Government must make full and timely CY 2015 and CY 2016 risk corridor payments to Plaintiff if Plaintiff experiences qualifying losses during those years." Compl. at Prayer for Relief ¶ (6). The Court lacks jurisdiction to award such relief.

The Court's jurisdiction to grant equitable or declaratory relief is limited to cases in which such remedies are "incident and collateral to" and necessary "to complete the relief afforded by" a monetary or procurement judgment within the Court's primary jurisdiction. 28 U.S.C. § 1491(a)(2), (b)(2). The Court's authority to issue equitable or declaratory relief is limited to three statutorily defined circumstances: (i) "orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records" where "incident and collateral to" a money judgment, 28 U.S.C. § 1491(a)(2); (ii) actions brought under the Contract Disputes Act of 1979, *id.*; and (iii) bid protests, *id.* at § 1491(b)(2). *See, e.g.*, *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 181-82. None of these circumstances applies here.

Because the Court lacks jurisdiction over Blue Cross's monetary claims and such claims are currently non-justiciable, the Court "has no basis upon which to exercise jurisdiction over [the] claims for injunctive or declaratory relief." *Pucciariello v. United States*, 116 Fed. Cl. 390, 411-12 (2014) (citations omitted); *see also Nat'l Air Traffic Controllers Ass'n v. United States*,

160 F.3d 714, 716 (Fed. Cir. 1998); *Thorndike v. United States*, 72 Fed. Cl. 580, 582 (2006). The claim for declaratory relief should be dismissed.

CONCLUSION

For these reasons, Blue Cross's Complaint should be dismissed.

Dated: September 30, 2016

Respectfully submitted,

BENJAMIN C. MIZER
Principal Deputy Assistant Attorney General

RUTH A. HARVEY
Director
Commercial Litigation Branch

KIRK T. MANHARDT
Deputy Director

/s/ Charles E. Canter
CHARLES E. CANTER
TERRANCE A. MEBANE
SERENA M. ORLOFF
FRANCES M. MCLAUGHLIN
L. MISHA PREHEIM
United States Department of Justice
Civil Division, Commercial Litigation Branch
Telephone: (202) 616-2236
Facsimile: (202) 307-0494
Charles.Canter@usdoj.gov

Attorneys for the United States of America

CERTIFICATE OF SERVICE

I hereby certify that on this 30th day of September 2016, a copy of the foregoing, *The United States' Motion to Dismiss*, was filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing with be sent to all parties by operation of the Court's ECF system.

/s/ Charles E. Canter
CHARLES E. CANTER
United States Department of Justice