IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MODA HEALTH PLAN, INC. Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	))))))))))	Case No. 1:16–cv–00649–TCW Judge Thomas C. Wheeler

PLAINTIFF'S CROSS MOTION FOR PARTIAL SUMMARY JUDGMENT AS TO LIABILITY

Pursuant to RCFC 56, Plaintiff Moda Health Plan, Inc. ("Moda") moves for partial summary judgment as to liability with respect to both Count One of the Complaint, which challenges the Government's violation of its statutory obligations to make specified payments to Moda, and Count Two of the Complaint, which challenges the Government's violation of its implied contractual duty to make specified payments to Moda. As demonstrated in the accompanying Memorandum, no material facts are in dispute with respect to liability issues.

Moda is not seeking summary judgment as this time with respect to damages.

Respectfully submitted,

/s/ Steven J. Rosenbaum
Steven J. Rosenbaum
Counsel of Record
(srosenbaum@cov.com)
Caroline M. Brown
Philip J. Peisch
Covington & Burling LLP
One City Center
850 Tenth Street, N.W.
Washington, D.C., 20001
(202) 662-5568
(202) 778-5568

October 25, 2016

Counsel for Plaintiff

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MODA HEALTH PLAN, INC. Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)))))))))	Case No. 1:16–cv–00649–TCW Judge Thomas C. Wheeler

PLAINTIFF'S MEMORANDUM IN OPPOSITION TO DEFENDANT'S MOTION TO DISMISS, AND IN SUPPORT OF PLAINTIFF'S CROSS MOTION FOR PARTIAL SUMMARY JUDGMENT AS TO LIABILITY

Steven J. Rosenbaum
Counsel of Record
(srosenbaum@cov.com)
Caroline M. Brown
Philip J. Peisch
Covington & Burling LLP
One CityCenter
850 Tenth Street, N.W.
Washington, D.C., 20001
(202) 662-5568
(202) 778-5568

October 25, 2016

Counsel for Plaintiff

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes

Other Authorities

INTRODUCTION

The Patient Protection and Affordable Care Act of 2010, Pub. L. No. 111-148, 124 Stat. 119 ("ACA"), extended health insurance to millions of uninsured and underinsured Americans. The ACA set forth a straightforward arrangement: if a health insurer would agree to provide "Qualified Health Plans" through the "Health Benefit Exchanges" established by the Act, the Government would, *inter alia*, pay "Risk Corridor" payments covering a portion of any losses the insurer suffered during each of the first three years of operation.

Plaintiff Moda Health Plan, Inc. ("Moda") decided to participate and incurred losses in 2014 and 2015 that required the Government to make such Risk Corridor payments to it. But the Government failed to do so, paying Moda only 12.6 cents on the dollar for 2014, and announcing that it will not meet its obligations with respect to 2015. This lawsuit followed.

The Government in its motion to dismiss attempts to defend its behavior on four grounds: that the ACA purportedly limits the amount of Risk Corridor payments owed to plans that suffered losses to the amount collected by the Government from other, profitable plans; that appropriations riders adopted by Congress in 2015 and 2016 vitiated the Government's statutory obligation under the ACA to make those payments; that the Government did not enter into an implied contract with Moda; and that the Government is entitled to wait literally years before making any payments. None of these excuses bears scrutiny. To the contrary, the undisputed facts establish Moda's entitlement to summary judgment as to liability.

STATEMENT OF THE ISSUES PRESENTED

1. Is the Government liable for its failure to meet its statutory obligation to make full Risk Corridors payments to Moda under a money-mandating statute? (Count I)

2. Is the Government liable for its breach of an implied-in-fact contract to make full Risk Corridors payments to Moda? (Count II)

STATEMENT OF THE CASE

A. The ACA and the Risk Corridors Program.

The ACA significantly expands access to health insurance through two mechanisms: (1) expanding Medicaid eligibility to all adults whose income is at or below 133 percent of the federal poverty level, ACA § 2001, and (2) creating "Health Benefit Exchanges" in each state that facilitate the purchase of "Qualified Health Plans"[1] issued by private health insurance issuers to qualified individuals.[2] ACA §§ 1311, 1321, 42 U.S.C. §§ 18031, 18041. The ACA also provides for Government subsidies to low-income individuals to assist in their purchase of Qualified Health Plans.[3] At the federal level, these programs are administered by the U.S. Department of Health and Human Services ("HHS") and its Centers for Medicare and Medicaid Services ("CMS"). *Cutler v. HHS*, 797 F.3d 1173, 1177 (D.C. Cir. 2015).

The ACA adopted other significant health insurance market reforms, including a prohibition against health insurers denying coverage or setting different premiums based upon an individual's health status or medical history. ACA § 1201(2)(A); 42 U.S.C. §§ 300gg-1 - 300gg-5. The ACA thus has interlocking effects: it significantly altered the pricing of health insurance;

[1] A "Qualified Health Plan" is health insurance that, among other things: provides "essential health benefits" as defined in the ACA; complies with network adequacy standards; follows limits on cost-sharing; and has been certified by an Exchange. ACA § 1301, 42 U.S.C. § 18021.

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

[3] Tax credits are available to persons not otherwise eligible for comprehensive health care coverage with incomes between 100 percent and 400 percent of the federal poverty level, while subsidies are available to such persons with household income between 100 percent and 250 percent of the federal poverty level. ACA §§ 1401, 1402; 45 C.F.R. § 155.305(f), (g).

it created programs that would result in large numbers of new enrollees; and it created a brand new market mechanism, Health Benefit Exchanges, for the procurement of health insurance.

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

In order to encourage and induce insurers to offer Qualified Health Plans despite this considerable uncertainty — ***something insurers were under no legal obligation to do*** — Section 1342 of the ACA established a temporary "Risk Corridors Program." This Program would remain in effect for each of the first three years of ACA operations (calendar years 2014 through 2016), to help issuers weather the financial challenges caused by having to set premium rates despite lacking important risk information. The Risk Corridors Program was also specifically intended by the Government to encourage and "permit issuers to lower rates [they charge to enrollees] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets," HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013). Such a risk premium would have increased the Government's own outlays for premium subsidies and tax benefits, *see* p. 2-3 & n. 3 *supra*.

Under the Risk Corridors Program, the Government is legally obligated to make payments to a participating insurer if its actual costs of providing enrollee health benefits exceed premium revenues minus administrative costs during any year. While the insurer will still incur a loss, the Risk Corridors Program will cover a substantial portion of those losses.

Specifically, if a participating plan's "allowable costs" — *i.e.*, its actual costs of providing enrollee benefits covered by the plan, *see* ACA § 1342(c)(1), 42 U.S.C. § 18062(c)(1) — for any year are between 103 and 108 percent of the "target amount" — *i.e.*, the plan's premium revenue minus its administrative costs, *see id.* — the Government must pay the plan 50 percent of the amount by which allowable costs exceeded 103 percent of the target amount. *Id.* § 1342(b)(1)(A). If a participating plan's allowable costs for any year are more than 108 percent of the target amount, the Government must pay the plan 2.5 percent of the target amount, plus 80 percent of the amount by which allowable costs exceeded 108 percent of the target amount. *Id.* § 1342(b)(1)(B). In short, if a plan is unprofitable, the Government must make payments to the insurer, thus significantly reducing the insurer's loss.

Conversely, if a plan's allowable costs are between 92 and 97 percent of its target amount, the plan must pay the Government 50 percent of the amount by which the target amount exceed 97 percent of allowable costs. *Id.* § 1342(b)(2)(A). If a plan's allowable costs are less than 92 percent of its target amount, the plan must pay the Government the sum of 2.5 percent of the target amount, plus 80 percent of the amount by which the target amount exceeds 92 percent of allowable costs. *Id.* § 1342(b)(2)(B). In short, if a plan is profitable, the insurer must make payments to the Government, thus allowing the Government to share in the insurer's profit.

On its face, the Government's obligation under Section 1342(b)(1) to make Risk Corridor payments to unprofitable insurers in the specified amounts is unfettered, and entirely disconnected from whether, and the extent to which, the Government has under Section 1342(b)(2) received Risk Corridor payments from profitable insurers.

B. HHS's Assurances of Full Risk Corridors Payments.

Following passage of the ACA, HHS in March 2012, through formal notice and comment rulemaking, promulgated final rules implementing the Risk Corridors Program. The regulations,

among other things, confirmed that unprofitable "[Qualified Health Plan] issuers" to which Risk Corridor payments are owed by the Government "will receive payment from HHS" in amounts consistent with the statutory provisions of Section 1342(b)(1). Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,251-52 (Mar. 23, 2012) (codified at 45 C.F.R. pt. 153). As with the statute, the regulatory requirement that the Government make Risk Corridors payment to unprofitable insurers is not contingent on the extent to which the Government receives Risk Corridor payments from profitable insurers.

The following year, on March 11, 2013, HHS published a final rule that included benefit and payment parameters for calendar year 2014, the first operational year of the Exchanges. In the preamble, HHS acknowledged its obligation to make full Risk Corridors payments to unprofitable insurers, regardless of the amount (if any) it collected from profitable insurers: "***The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.***" 78 Fed. Reg. at 15,473 (emphasis added).

C. Moda's 2014 Qualified Health Plans.

Shortly after the issuance of HHS's March 2013 rule, Moda submitted its Qualified Health Plans and premium rates to state regulators in Alaska and Oregon.[4] In July 2013, Moda obtained approval of the Qualified Health Plans rates from those state regulators,[5] and as required by HHS regulations, Moda began selling Qualified Health Plans on October 1, 2013, with coverage effective January 1, 2014, *see* 45 C.F.R. § 155.410(b), (c).

[4] Health plans' terms and premiums generally must be reviewed and approved annually by state insurance regulators. *See, e.g.*, Alaska Stat. Ann. § 21.51.405; Or. Admin. R. § 836-053-0475.

[5] *See* Francesconi Decl., Exhs. 1-4 at A7-22 (2014 Alaska and Oregon approvals).

D. HHS Action Placing Additional Reliance upon the Risk Corridors Program.

As described on p. 2 & n. 1 *supra*, the ACA mandated that all insurance plans meet a host of new requirements effective January 1, 2014, unless a preexisting plan constituted a "grandfathered" plan because it: (a) was in effect on the date the ACA was enacted in March 2010, and (b) had not had any significant benefits or cost sharing changes in the intervening years. ACA § 1251, 42 U.S.C. § 18011; ACA § 1255; *see also* 45 C.F.R. § 147.140. Thus, it was contemplated that Qualified Health Plans enrollees beginning in 2014 would include both previously uninsured individuals and those previously enrolled in non-ACA compliant plans.

However, due to public outcry when preexisting, non-ACA compliant plans began to terminate and disenroll their members, the Government in November 2013 announced a "transitional policy" under which plans in effect on October 1, 2013 "will not be considered to be out of compliance with the [ACA's] market reforms" even if they did not qualify as a "grandfathered" plan.[6] This transitional policy meant that many individuals with existing health insurance, who were assumed generally to be healthier than the uninsured population, because they had previously passed medical underwriting standards and gained access to health care, maintained their existing insurance and did not enroll in Qualified Health Plans.

[6] Letter from Gary Cohen, Dir., Ctr. for Consumer Info. and Ins. Oversight ("CCIIO"), to State Ins. Comm'rs 1 (Nov. 14, 2013), https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf (Francesconi Decl., Exh. 5 at A24). CMS "encouraged" States "[s]tate agencies responsible for enforcing the specified market reforms . . . to adopt the same transitional policy with respect to this coverage," *id.*, which Alaska and Oregon did, *see* Memo from Or. Dep't of Consumer and Bus. Servs., Updated Guidance for Transitional Health Benefit Plans Permitted by 2014, Senate Bill (SB) 1582 (Apr. 11, 2014), http://dfr.oregon.gov/industry/health-ins-regulation/Documents/transitional-plan-guidance-201404.pdf (Francesconi Decl., Exh. 6 at A26); Alaska Dep't of Commerce, Cmty., and Econ. Dev., Bulletin 16-04 (Mar. 24, 2016), https://www.commerce.alaska.gov/web/portals/7/pub/bulletins/b16-04.pdf (Francesconi Decl., Exh. 7 at A36).

This significantly skewed the Qualified Health Plan risk pool toward sicker individuals. For example, in Oregon in 2014, 17.8 percent of all individual plan enrollees, and 30.3 percent of all small group plan enrollees, were covered by plans that were allowed to stay in existence, in lieu of Qualified Health Plans, as a result of the Government's transitional policy. HHS recognized that this transitional policy would change the risk profile of enrollees in Qualified Health Plans (*i.e.*, increase their average health risk level, and thus increase the average costs of providing them health insurance), and that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014." However, HHS expressed confidence that "the risk corridor program should help ameliorate unanticipated changes in premium revenue."[7] Although the transitional policy was to last only a year, CMS has since twice extended it, until October 1, 2017.[8]

E. Moda's 2015 Qualified Health Plans.

In 2014, after Exchanges had been operational for several months, Moda submitted its 2015 Qualified Health Plans, and their premium rates, to state regulators in Alaska, Oregon and Washington. In August and September 2014, Moda obtained approval of the Qualified Health

[7] Kevin Counihan, Dir., CCIIO, CMS, *Transitional Adjustment for 2014 Risk Corridors Program* (Apr. 17, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_TransitionalAdjGuidance_5CR_041715.pdf (Francesconi Decl., Exh. 8 at A39).

[8] *See* Gary Cohen, Dir., CCIIO, *Insurance Standards Bulletin Series – Extension of Transitional Policy through October 1, 2016*, CMS (Mar. 5, 2014), https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/transition-to-compliant-policies-03-06-2015.pdf (Francesconi Decl., Exh. 9 at A43); Kevin Counihan, *Insurance Standards Bulletin Series – Extension of Transitional Policy through Calendar Year 2017*, CMS (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf (Francesconi Decl., Exh. 10 at A51).

Plans rates from these state regulators.[9] On November 15, 2014, Moda began selling Qualified Health Plans in these states, with coverage effective January 1, 2015, *see* § 155.410(e).

F. The Appropriations Riders, and HHS's Subsequent Limited Payments.

After Moda's 2014 Qualified Health Plans had been in operation for nearly the entire year, and Moda had already sold 2015 Qualified Health Plans, Congress in December 2014 inserted a rider into a 2015 appropriations bill that read: "None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used" for Risk Corridors payments. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2491 (2014). The same provision was subsequently included in the appropriations bill for 2016. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2624 (2015). Congress did not then, or ever, repeal or amend Section 1342.

On October 1, 2015, HHS announced that for 2014, it owed $2.87 billion in Risk Corridor payments to unprofitable plans, and was owed $362 million in Risk Corridors collections from profitable plans. HHS stated that it would only pay unprofitable plans a pro rata share of the $362 million. Because $362 million represented 12.6 percent of the $2.87 billion owed, HHS would thus only pay 12.6% of 2014 Risk Corridor payments.[10]

---

[9] *See* Francesconi, Exhs. 11-16 at A58-97 (2015 approvals for Alaska, Oregon, and Washington).

[10] *See* CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf (Francesconi Decl., Exh. 17 at A98); *see also* Kevin J. Counihan, Dir., CCIIO, CMS, to Robert Gootee, Pres. & CEO, Moda (Oct. 8, 2015) (Francesconi Decl., Exh. 18 at A100).

Moda submitted documentation establishing that HHS owed it $1,686,016 in Alaska Risk Corridor payments, and $87,740,414.38 in Oregon Risk Corridor payments, for 2014. HHS only paid Moda 12.6% of this amount, or $212,739 for Alaska, leaving a shortfall of $1,473,277, and $11,070,968 for Oregon, leaving a shortfall of $76,669,446.[11]

On October 8, 2015, CMS sent a letter to Robert Gootee, President and CEO of Moda, explaining its proration policy. In that letter, CMS made a point "to reiterate" to Mr. Gootee that it "recognizes that the [ACA] requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required." Declaration of James Francesconi ("Francesconi Decl."), Exh. 18 at A102.

On Sept. 9, 2016, HHS announced that it will not pay *any* of the Risk Corridors payments it owes them for 2015, because "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."[12] Moda is entitled to $101,842,405 in Risk Corridor payments for 2015: $31,531,143 for Alaska; $93,362,051 for Oregon; and $11,360,460 for Washington. Francesconi Decl., Exh. 20 at A136-38.

ARGUMENT

A motion to dismiss may only be granted "'when the facts asserted do not give rise to a legal remedy.'" *Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 198 (2013) (quoting

[11] CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014*, tbl. 2 (Nov. 19, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf (Francesconi Decl., Exh. 19, A102).

[12] CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF (Francesconi Decl., Exh. 21, A140).

Indian Harbor Ins. Co. v. United States, 704 F.3d 949, 954 (Fed. Cir. 2013)). "'The court assumes all well-pled factual allegations are true and indulges in all reasonable inferences in favor of the nonmovant.'" *Id.* at 198-99 (quoting *Terry v. United States*, 103 Fed. Cl. 645, 652 (2012)).

Summary judgment is appropriate "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." RCFC 56(a); *see also, e.g.*, *Celotex Corp. v. Catrett*, 477 U.S. 317, 325 (1986). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Santa Fe Pac. R.R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002).

Both the Government's and Moda's motions hinge on a legal question: Whether, as a matter of either statutory obligation or implied contract, Moda is entitled to recover the 2014 and 2015 Risk Corridors payments it is owed under the formula established by ACA Section 1342, but which the Government has not made. As Moda now demonstrates, the answer is yes. The Government's motion to dismiss should be denied, and Moda's motion for partial summary judgment as to liability granted.

I. THE GOVERNMENT IS LIABLE FOR FAILURE TO MEET ITS STATUTORY OBLIGATION UNDER A MONEY-MANDATING STATUTE (COUNT I).

A. ACA Section 1342 Is a Money-Mandating Statute Giving Rise to Tucker Act Remedies.

Under the Tucker Act, 28 U.S.C. § 1491, a plaintiff may recover money damages when the Government fails to meet its obligations under a money-mandating statute or regulation. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United State*s, 67 Fed. Cl. 292 (2005) (citing § 1491(a)(1)). Statutes that provide that the Government "shall" make a payment are money-mandating. *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007); *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003).

ACA Section 1342 provides that when certain easily determinable financial metrics are met, the Government "shall pay to the [insurance] plan an amount" established by the statutory Risk Corridor payment formula. § 1342(b)(1). The implementing regulations similarly provide that an unprofitable insurer "will receive payment from HHS," based solely on a calculation of the excess of the plan's enrollee medical claims costs over its premium revenues less administrative costs. 45 C.F.R. § 153.510. Thus, Section 1342 and its implementing regulation are money mandating, and the Judgment Fund is available to make payment of the Risk Corridor shortfalls owed to Moda. *See* 31 U.S.C. § 1304; *see also*, *e.g.*, *Slattery v. United States*, 635 F.3d 1298, 1317 (Fed. Cir. 2011) (en banc) ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims.")

B. The Government Must Pay Moda the Risk Corridors Payments Owed Regardless of the Amounts Collected from Profitable Insurers.

The Government contends that Moda is not entitled to Risk Corridor payments because the ACA's authors purportedly intended the Risk Corridors program to be "self-funding," arguing that "Risk Corridors payments are limited to the amounts HHS collects from profitable insurers in a given year. (United States' Mot. to Dismiss at 22, (ECF No. 8) (hereinafter "Gov. Br.")). This is inconsistent with the statute's text and intent, and the position repeatedly espoused by HHS.

1. The Plain Text of Section 1342 and Section 153.510 Require that the Government Make Full Risk Corridors Payments.

On its face, the Government's obligation under ACA Section 1342 to make risk corridor payments to unprofitable insurers is: (a) unfettered, and (b) unrelated to whether, and the extent to which, the Government receives Risk Corridors payments from profitable insurers in the applicable year:

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of Risk Corridors for calendar years 2014, 2015, and 2016 under which a Qualified Health Plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary ***shall provide*** under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary ***shall pay*** to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary ***shall pay*** to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

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

Indeed, following passage of the ACA, HHS acknowledged through formal notice-and-comment rulemaking its obligation fully to comply with Section 1342. On March 23, 2012, CMS promulgated a final rule implementing the Risk Corridors Program that reads in part:

> [Qualified Health Plan] issuers ***will receive payment*** from HHS in the following amounts, under the following circumstances:
>
> (1) When a [Qualified Health Plan]'s allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the [Qualified Health Plan] issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
>
> (2) When a [Qualified Health Plan]'s allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the [Qualified Health Plan] issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

77 Fed. Reg. at 17,251 (45 C.F.R. § 153.510(b)) (emphasis added). Like Section 1342 itself, regulation 153.510 nowhere makes the payments owed by the Government to unprofitable plans contingent on the payments received by the Government from profitable plans.

A year later, on March 11, 2013, HHS published another final rule relating to Health Benefit Exchanges and Qualified Health Plans, which included certain benefit and payment parameters for insurers in establishing their premium rates for 2014, the first year of the Exchanges. In the preamble, HHS openly acknowledged that "***[t]he risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.***" 78 Fed. Reg. at 15,473 (emphasis added). This was the final HHS statement on the subject prior to the Health Benefit Exchanges coming into effect January 1, 2014.

Even after CMS announced its proration policy, it continued to assure plans that they were entitled to and would receive full Risk Corridors payments. On October 8, 2015, CMS sent

a letter to Moda Health's CEO "to reiterate" that HHS "recognizes that the [ACA] requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required." Francesconi Decl., Exh. 18 at A102. And, just last month, HHS issued a letter to insurers in which it described "risk corridors payments ***due*** [to unprofitable insurers] ***as an obligation of the United States Government for which full payment is required***."[13] Francesconi Decl., Exh. 21 at A142. (emphasis added).

Moreover, the General Accounting Office ("GAO"), during the first year of Health Exchange operations, concluded that Risk Corridor payments are ***not*** limited to the amounts

[13] On March 11, 2014, after the Qualified Health Plans had gone into effect on January 1, 2014, HHS stated in a preamble to the final rule for benefit and payment parameters for the next calendar year (2015) that it projected that net Risk Corridors payments would be "budget neutral" for 2014, and thus HHS "intend[ed]" to implement the Risk Corridors Program in a "budget neutral manner." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787, 13,829 (Mar. 11, 2014) (eff. May 12, 2014). This was simply a prediction, not an indication that HHS would implement the program in a budget neutral manner even if payments to HHS by profitable insurers were not sufficient to cover HHS's obligations to unprofitable insurers.

On April 11, 2014, HHS issued informal questions and answers suggesting that, for 2015, if Risk Corridors collections were insufficient to cover Risk Corridors payments for a year, all Risk Corridors payments for that year would be reduced pro rata to the extent of any shortfall, and made up for in future years. *See* CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. However, in May 2014, it retreated from these April 2014 questions and answers by reaffirming, in a letter to GAO, that it had the legal authority to pay its entire Risk Corridors obligations regardless of the amount of payments the Government received through the program. *See* Letter from William B. Schultz, Gen. Counsel, HHS, to Julia C. Matta, Assistant Gen. Counsel, GAO (May 20, 2014), *available at* https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/letters/20140619HHS-GAOResponse.pdf (Francesconi Decl., Exh. 23 at A146). One week later, in the preamble to a final rulemaking, HHS reiterated that it was legally obligated to make Risk Corridors payments in full, stating that while it "anticipate[d] that risk corridors collections will be sufficient to pay for all risk corridor payments," "[i]n the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014).

collected by the Government from profitable insurers, but were payable from general appropriations.[14] "Although GAO decisions are not binding, [courts] 'give special weight to [GAO's] opinions' due to its 'accumulated experience and expertise in the field of government appropriations.'" *Nevada v. Dep't of Energy*, 400 F.3d 9, 16 (D.C. Cir. 2005) (quoting *UAW v. Donovan*, 746 F.2d 855, 861 (D.C. Cir. 1984)).

In support of its strained contrary reading, the Government attempts to parse the statutory language to argue that Section 1342's instruction that the Government "shall" make a payment, in the amount specified by the statutory formula, does not bind the Government because it is contained in the subsection entitled "payment methodology." Gov. Br. at 22-23. This argument is inconsistent with the plain text of the statute. Section 1342 states that the Government "***shall*** establish and administer" a Risk Corridors Program, in which "[t]he Secretary ***shall*** provide . . . that if . . . a participating plan's allowable costs for any plan year are more than 103 percent . . . of the target amount, the Secretary ***shall*** pay to the plan" the amount specified in the statutory formula. § 1342 (emphasis added). The mere fact that "shall pay" appears in the "methodology" subsection does not alter the plain meaning of this language.

The Government observes that a different statute, dealing with the Medicare Part D prescription drugs risk corridors provision, provides that "'[t]his section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.'" The Government argues that the lack of similar language in ACA Section 1342 means that Congress did not intend for Section 1342 to create a statutory obligation in the absence of sufficient appropriations. Gov. Br. at 24.

[14] GAO, B-325630, HHS — Risk Corridors Program (Sept. 30, 2014), http://gao.gov/assets/670/666299.pdf (Francesconi Decl., Exh. 24 at A150).

But the commitment in ACA Section 1342 is actually stronger than the Medicare Part D statute, which provides only that the Secretary "shall establish a risk corridor," 42 U.S.C. § 1395w-115(e)(3), not that it "shall pay" the Risk Corridor payment, as expressly required by the language of ACA Section 1342. Moreover, the Federal Circuit's predecessor and this Court have repeatedly found that payments mandated by statute, using language almost identical to Section 1342, are sufficient to support a Tucker Act claim, even if the statute does not expressly state that it constitutes budget authority or represents an obligation of the United States. *See, e.g.*, *N.Y. Airways, Inc. v. United States*, 369 F.2d 743 (Ct. Cl. 1966) (government had statutory obligation to pay; statute did not expressly specify that payments were an "obligation" of the Government); *District of Columbia*, 67 Fed. Cl. 292 (same). We return to this topic in Section I(C) *infra*.

2. The Government's Interpretation of Section 1342 Is Inconsistent with the Purpose and Intent of the Risk Corridors Program.

The Government's interpretation of the ACA is also inconsistent with its structure and purpose. As CMS has explained, Risk Corridor payments are intended to "permit issuers to lower rates [they charge to enrollees] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets," 78 Fed. Reg. at 15,413. In other words, the Risk Corridors payments are intended to protect insurers from the risk of underpricing their plans. Yet no protection would be provided if Risk Corridor payments were contingent upon the speculative question of whether other insurers would be sufficiently profitable to result in payments to HHS sufficient to satisfy the amounts owed to unprofitable insurers.

No deference is owed the Government's current interpretation. "If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council,*

Inc., 467 U.S. 837, 842-43 (1984); *accord N.Y. Life Ins. Co. v. United States*, 190 F.3d 1372, 1379-80 (Fed. Cir. 1999). No deference is due to an agency position that is "manifestly contrary to the statute." *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 53-54 (2011). The plain text and intent of Section 1342 forecloses the Government's reading.

Even if the statute or its intent were ambiguous (which it is not), *Chevron* deference would not apply, given that such deference is owed to an agency's interpretation only if it is both reasonable (which it is not, *see* pp. 11-16 *supra), **and*** promulgated through notice-and-comment rulemaking or a similar process, *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361, 1365 (Fed. Cir. 2005), which it was not, *see* 45 C.F.R. pt. 153, Subpart F.

Moreover, even the lesser deference articulated under *United States v. Mead Corp.*, 533 U.S. 218 (2001), and *Skidmore v. Swift & Co.*, 323 U.S. 134 (1944), which is based on the persuasiveness of an agency's interpretation, requires three prerequisites,[15] none of which is present here: (1) there is no evidence that "the agency has conducted a careful analysis" of the statutory issue; (2) the agency's position espoused in this litigation has not "been consistent and reflects agency-wide policy," but rather is entirely ***inconsistent*** with HHS's previous statements that Risk Corridors payments are not capped by the amount collected from profitable insurers, *see* pp. 4-5, 9 *supra*, and thus represents a *post hoc* rationalization to which no deference is owed, *see Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 473-74 (1988); *Parker v. Office of Pers. Mgmt.*, 974 F.2d 164, 166 (Fed. Cir. 1992); and (3) the agency's position does not constitutes a reasonable conclusion as to the proper construction of the statute, *see* pp. 11-17 *supra*.

[15] *See Cathedral Candle*, 400 F.3d at 1365, *Stephenson v. Office of Pers. Mgmt.*, 705 F.3d 1323 (Fed. Cir. 2013).

C. The 2015 and 2016 Appropriations Riders Did Not Vitiate the Government's Statutory Obligation to Make Full Risk Corridor Payments.

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

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

A long line of judicial decisions, including decisions binding on this Court, makes clear that Congress's failure to appropriate funds for an agency to meet a statutory obligation "does not in and of itself defeat a Government obligation created by statute." *Greenlee Cty.*, 487 F.3d at 877 (quoting *N.Y. Airways***,** 369 F.2d at 748); *see also, e.g., United States v. Langston*, 118 U.S. 389 (1886); *Prairie Cty., Mont. v. United States*, 782 F.3d 685, 689-90 (Fed. Cir. 2015); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949).

A limitation on agency appropriations may mean that the agency cannot itself comply with the statutory mandate by making payment, but that does not change the jurisdiction of this Court to entertain claims against the United States for its failure to honor its statutory payment obligations and to provide relief, including an award from the permanent appropriation Congress has made for the Judgment Fund, 31 U.S.C. § 1304(a). To the contrary, "[t]he failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims." *N.Y. Airways*, 369 F.2d at 748. As the Government itself noted in recent litigation, "[t]he mere absence of a more specific appropriation is not necessarily a defense to recovery from th[e] [Judgment] Fund." Defs.' Mem. in Supp. of their Mot. for Summ. J. at 11, *U.S.*

House of Representatives v. Burwell, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015).

Indeed, the legal standard for finding that statutory language limiting the use of appropriated funds would vitiate a preexisting statutory right, and thus cuts off access to the Tucker Act, is quite stringent. While Congress may possess the legal authority prospectively to amend preexisting substantive statutory obligations, Congress must do so "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted).

Moreover, and of direct relevance here, "[t]his rule applies with ***especial force*** when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphasis added). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," the statutory instructions included in them are presumed ***not*** to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). As the Federal Circuit's predecessor emphasized, "[t]he intent of Congress to effect a change in the substantive law via provision in an appropriation act must be *clearly manifest*." *New York Airways*, 369 F.2d at 749 (emphasis added); *accord District of Columbia*, 67 Fed. Cl. at 335.

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

a) United States v. Langston.

In *Langston*, a statute specified that the U.S. ambassador to Haiti would be paid an annual salary of $7,500. However, Congress only appropriated $5,000 for this purpose. Langston sued

for the $2,500 shortfall. Because the Tucker Act was not yet in force, this case proceeded as an appeal from a final judgment issued by the Court of Claims under the authority granted to it by Congress in 1866. Cong. Globe, 39th Cong., 1st Sess. 770-71 (1866). The question presented was whether the statutory obligation to pay $7,500 was legally binding and enforceable, notwithstanding Congress's failure to appropriate sufficient funds to pay it.

The Supreme Court noted that the relevant appropriations legislation did not have "any language to the effect that such sum [$5,000] shall be 'in full compensation' for those years; nor was there . . . an appropriation of money 'for additional pay,' from which it might be inferred that congress intended to repeal the act fixing his annual salary at $7,500." *Langston*, 118 U.S. at 393. Citing the principles that "[r]epeals by implication are not favored," and that a court should give effect to a "reasonable construction" that allows two potentially incongruous laws to "stand together," the Supreme Court held that the Government had a statutory obligation to pay the plaintiff-ambassador the full $7,500, given that the appropriations bill "contained no words that expressly, or by clear implication, modified or repealed the previous law." *Id.* at 393-94.

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

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to Risk Corridors).

See Pub. L. No. 113-235, § 227; *see also* Pub. L. No. 114-113, § 225.

This language simply prohibits HHS from using certain, specified funding sources for Risk Corridor payments. Nothing in this provision precludes the Government from being required to use funds from another source (*e.g.*, the Judgment Fund) to meet its statutory obligation to make full Risk Corridor payments, or otherwise specifies that a funding source or a capped appropriation "shall be 'in full compensation' for" the risk corridor obligation for the year. *See Langston*, 118 U.S. at 393. As in *Langston*, there is no language here altering or eliminating, "expressly or by clear implication," the Government's statutory obligation to make full Risk Corridor payments under Section 1342 of the ACA.

b) Gibney v. United States.

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

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

Id. at 48-49.

The Court of Claims held that this appropriations language "was a mere limitation on the expenditure of a particular fund and had no other effect" on the statutory requirement to pay overtime. *Id.* at 50. The Court noted that it "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend

a statutory obligation." *Id.* at 53. The court accordingly entered judgment for the plaintiff for his full overtime pay, upon receiving a GAO report showing the amount due. *Id.* at 47, 58.

The language in the appropriations riders limiting Risk Corridors funding is quite similar to the appropriations provision in *Gibney*. *Compare Gibney*, 114 Ct. Cl. at 44 ("[N]one of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided [under specific statutes] . . . ."), *with* Pub. L. No. 113-235, § 227 ("None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for" Risk Corridor payments). Thus, just as the workers seeking overtime pay were entitled to an award of that pay notwithstanding the limitations imposed by the appropriations riders, Moda is entitled to an award of the Risk Corridor payments to which it is entitled under the ACA.

c) New York Airways v. United States.

New York Airways reaffirmed both *Langston* and *Gibney*. In *New York Airways*, a statute authorized the Civil Aeronautics Board to fix a monthly subsidy for helicopter companies, which the Board did in 1964. 369 F.2d at 744. But from fiscal years 1962 through 1965, "Congress successively reduced the subsidy payments for helicopter operations under the immediately preceding year, making it clear that it did not want the budgeted amounts to be exceeded." *Id.* at 747. As a result, the Board lacked sufficient funding to meet its payment obligation to the plaintiff. In the specific fiscal year at issue in *New York Airways*, Congress enacted the following provision in an annual appropriations bill, in an effort "to curtail and finally eliminate helicopter subsidies":

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

369 F.2d at 749, 751.

The plaintiff helicopter companies sought to recover the full subsidy that had been set by the Civil Aeronautics Board, asserting an entitlement to that amount notwithstanding the lesser amounts provided by the several appropriations bills. The Court of Claims explained the longstanding rules that govern its analysis whether appropriations language alters the Government's statutory obligation to make payments to the plaintiff:

> It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute. *United States v. Vulte*, [233 U.S. 509 (1914)]; *Ralston v. United States*, 91 Ct. Cl. 91 (1940). . . .

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

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

Id. As the court further elucidated:

> Whether the obligation to transport mail is derived from express contract with the Government, as in *Seatrain Lines, Inc. v. United States*, 99 Ct. Cl. 272 (1943), or by statute, as also in the instant case and in *New York Central R. R. v. United States*, 65 Ct. Cl. 115 (1928), *aff'd*, 279 U.S. 73, 49 S. Ct. 260, 73 L. Ed. 619 (1929), the

> failure of Congress or an agency to appropriate or make available sufficient funds does not repudiate the obligation; it merely bars the accounting agents of the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims.

Id. at 752.

The *New York Airways* court ruled in favor of the plaintiffs, holding that Congress did not alter the underlying statutory obligation, because a change in substantive law was not "clearly manifest" from the text of the appropriations bill. *Id.* at 749. This entitled the plaintiffs to judgment for the differences between the amounts they received from the appropriations and the amounts statutorily required. *Id.* at 748-52.

The Risk Corridors appropriations riders are even less restrictive than the appropriations language in *New York Airways*. The latter capped outright all payments to the helicopter companies at a specified dollar amount, whereas the former simply limit the use of certain specific sources to make Risk Corridor payments. Thus, *New York Airways* plainly supports Moda's statutory entitlement to Risk Corridor payments.

d) District of Columbia v. United States.

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

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

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

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

As in *District of Columbia*, Congress limited the appropriations available for Risk Corridor payments to amounts the Government contends are insufficient to pay out the entirety of the obligations. But as in *District of Columbia*, Congress's decision to limit the amount of certain specified appropriations that would be available for Risk Corridor payments does *not* relieve the Government of its statutory obligation, or the availability of the Tucker Act.

2. The Government's Precedents Are Clearly Distinguishable.

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

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

As explained at pp. 19-20 *supra*, if Congress wants to alter a preexisting statutory obligation, it must do so "expressly or by clear implication," *see, e.g.*, *Prairie Cty.*, 782 F.3d at 689-90, particularly if it acts through an appropriations bill, in which case the intent must be "clearly manifest," *N.Y. Airways*, 369 F.2d at 749. *Dickerson*, *Will*, and *Republic Airlines* all involved appropriations language that clearly altered a statutory obligation, unlike the 2015 and 2016 appropriations riders, which simply limited the availability of specific funding.

Dickerson involved a statute obligating the Government to make bonus payments to individuals who re-enlisted in the military. In each appropriations bill from 1933 through 1937, Congress expressly suspended this requirement, with language providing that this pre-existing statute that "provides for the payment of enlistment allowance to enlisted men for reenlistment . . . is hereby suspended as to reenlistments made during the fiscal year." 310 U.S. at 556. In appropriations bills for 1938 and 1939, Congress changed this language to read: "no part of any appropriation contained in this ***or any other Act*** for the fiscal year . . . , shall be available for the payment . . . during the fiscal year . . . notwithstanding the applicable provisions of" the statute that required the bonus payments be made. *Id.* at 556-57 (emphasis added).

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

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

In contrast, the Risk Corridors appropriations language does not suspend the underlying statutory obligation; prohibit the use of funding from "any other Act"; or specify that the funding limits are imposed "notwithstanding" the substantive Risk Corridors obligation. Rather, the Risk Corridors appropriations language is "a simple withholding of funds" from a few specified sources, "unaccompanied by other expressed or implied purpose[]" of altering the underlying statutory obligation. *See N.Y. Airways*, 369 F.2d at 750 (explaining that the appropriations language *Dickerson* case was "'a legislative provision under the guise of a withholding of funds' which suspended the legal obligation, rather than a simple withholding of funds unaccompanied by other expressed or implied purposes'" (quoting *Gibney*, 114 Ct. Cl. at 51)).

While some members of Congress may support an elimination of risk corridor payments, they have only been able to limit through the appropriations bills the use of certain sources of appropriations. They have not succeeded in eliminating or suspending the Risk Corridors statutory obligation itself. Indeed, the President has repeatedly threatened to veto any bill that rolls back the ACA.[16] *Cf. Gibney*, 114 Ct. Cl. at 55 (Whitaker, J. concurring) (if Congress

[16] *See* Office of Mgmt. & Budget, H.R. 596 - Repealing the Affordable Care Act 2 (Feb. 2, 2015) ("If the President were presented with H.R. 596 [Repealing the ACA], he would veto it.") https://www.whitehouse.gov/sites/default/files/omb/legislative/sap/114/saphr596r_20150202.pdf (continued…)

wanted the appropriations language to suspend the Government's obligation to pay overtime, "they did not accomplish their purpose; they merely prohibited the use of certain funds to discharge the obligation under that Act," and "[t]his did not repeal the liability the Act created").

The second case on which the Government relies, *United States v. Will*, involved plaintiff judges suing to obtain pay increases, predicated upon a statutory scheme under which the President was directed to make cost-of-living increases to judges and other federal employees based on several considerations. In four consecutive fiscal year appropriations bills, Congress blocked those pay increases through the following four provisions: "[n]o part of the funds appropriated in this Act ***or any other Act*** shall be used;" the salary increase that "would be made after the date of enactment of this Act under the following provisions of law [listing the provisions giving rise to the obligation] . . . ***shall not take effect;***" "No part of the funds appropriated for the fiscal year ending September 30, 1979, by this ***Act or any other Act*** may be used to pay . . ."; "funds available for payment . . . shall not be used to pay any such employee or elected or appointed official any sum in excess of 5.5 percent increase in existing pay and such sum if accepted shall be in lieu of the 12.9 percent due for such fiscal year." *Will*, 449 U.S. at 205-08 (emphasis added) (citations omitted). The Court held that each of these provisions "block[ed] the increases the [Act] otherwise would generate." *Id.* at 223.

Like the language in *Dickerson*, the appropriations language in *Will* clearly indicated an alteration of the statutory obligation, because it either expressly stated that the underlying statute "shall not take effect," or prohibited the Government from using *any* appropriations source in the

; *see generally* Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA Today, Nov. 19, 2014 (noting that the President has threatened to veto twelve different bills that would have repealed all or part of the ACA).

year at issue. In contrast, the Risk Corridors appropriations riders only prevent the Government from making payments out of certain specified sources of funding.

Further, *Will* did not involve a definitive statutory obligation; rather, as the Federal Circuit has explained, any payment to which the plaintiff judges were entitled in *Will* was determined through an "uncertain, discretionary process." *Beer v. United States*, 696 F.3d 1174, 1183 (Fed. Cir. 2012) (analyzing *Will*). By contrast, Moda has a clear-cut statutory right to specific payment amounts calculated pursuant to a non-discretionary statutory formula.

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

> [N]otwithstanding any other provision of law, none of the funds appropriated by this Act shall be expended under Section 406 for services provided after ninety-five days following the date of enactment of this Act to points which, based on reports filed with the Civil Aeronautics Board, enplaned an average of eighty or more passengers per day in the fiscal year ended September 30, 1981: *Provided further*, That notwithstanding any other provision of law, payments under Section 406, exclusive of payments for services provided within the State of Alaska, shall not exceed a total of $14,000,000 for services provided during the period between March 31, 1982, and September 30, 1982, and, to the extent it is necessary to meet this limitation, the compensation otherwise payable by the Board under Section 406 shall be reduced by a percentage which is the same for all air carriers receiving such compensation . . . .

849 F.2d at 1317 (citation omitted). The court ruled in favor of the Government, holding that this language "altered any 'entitlement'" the airlines may have had under Section 406. *Id.*

As an initial matter, *Republic Airlines* was decided by the Tenth Circuit and does not bind this Court. Moreover, *Republic Airlines* is not a Tucker Act case, and the plaintiffs were petitioning for review of an order of the Civil Aeronautics Board, not seeking a monetary

judgment for the Government's failure to meet a statutory payment obligation. Thus, the well-developed case law regarding the heavy scrutiny that applies when the Government seeks to rely upon an appropriations rider to avoid Tucker Act relief was not presented.

Furthermore, the language in the *Republic Airlines* appropriations bill is again dissimilar to the language limiting Risk Corridors appropriations. The *Republic Airlines* language caps all "payments under Section 406" at $14 million, "notwithstanding any other provision of law," and expressly directs the Government that to "the extent it is necessary to meet this limitation, the compensation otherwise payable by the Board under Section 406 shall be reduced by a percentage which is the same for all air carriers receiving such compensation." In contrast, the Risk Corridors appropriations riders simply limit the sources of funding that the Government may use to fulfill its statutory obligation to make Risk Corridor payments.[17]

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

There is also a key factual distinction between Moda's claim and all three principal cases on which the Government relies. Congress limited the funding available for risk corridor payments only after insurers been induced to take material affirmative action in return for the Government's statutory commitment to make risk corridor payments. Specifically, in exchange for the Government's statutory obligation to make Risk Corridor payments to Moda if it was not

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

profitable, Moda offered Qualified Health Plans through the Health Benefit Exchanges established by the Act; priced their 2014 plans; obtained state regulatory approval of their 2014 plans and rates; and provided the underlying insurance coverage for almost a full year, *before* Congress enacted the 2015 appropriations riders in December 2014. Moda had also obtained state approval for its 2015 plans and rates, and begun selling those plans to consumers once open enrollment began on November 15, 2014, before Congress enacted the 2015 appropriations rider in December 2014. The plaintiffs in *Dickerson*, *Will*, and *Republic Airlines* did not allege a similar *quid pro quo* exchange arising out of statutory obligations established prior to the enactment of the relevant appropriations riders.

Stripping Moda of its right to Risk Corridor payments, after it had voluntarily delivered insurance for over a year pursuant to a statutory scheme in which such payments had been guaranteed, would constitute a retroactive application of law, because it "'would impair rights a party possessed when [it] acted . . . .,'" and impose new rules on a transaction already completed. *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994)). Retroactive application of statutes is "disfavored," and thus "it has become 'a rule of general application' that 'a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication.'" *Id.* (quotation omitted). No such language or necessary implication is presented by the appropriations riders.

II. ALTERNATIVELY, THE GOVERNMENT IS LIABLE FOR BREACH OF THE IMPLIED-IN-FACT CONTRACT BETWEEN IT AND MODA (COUNT II).

The Tucker Act establishes Court of Federal Claims jurisdiction for breach of express or implied contract claims against the United States, with judgments payable from the Judgment Fund. 28 U.S.C. § 1491(a)(1); *Slattery*, 635 F.3d at 1303, 1317, 1321. The Government's contention that Section 1342 merely establishes a "benefits program" for Qualified Health Plans,

and not an implied in fact contract, Gov. Br. at 29, ignores the relationship and course of dealings between the Government and Moda. The Government has received the benefit promised by Qualified Health Plans such as Moda's — health coverage for millions of Americans, at prices that do not include a risk premium — without adhering to its side of the bargain — making risk corridor payments — even though the promise of such payments was essential to inducing health insurers into the new marketplaces in the first place.

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

A. There Was Mutuality of Intent.

In order for the Court to find that the Government has entered into an implied contract there must be "language . . . or . . . conduct on the part of the government that allows a reasonable inference that the government intended to enter into a contract." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011). *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), is the seminal case finding an implied-in-fact contract based on Government conduct, including through its published regulations. That case involved Atomic Energy Commission regulations establishing a guaranteed minimum price at which the United States would purchase uranium. The court rejected as "untenable" the Government's argument that the regulation was "a mere invitation to the industry to make offers to the Government." *Id*. at 405-06. Finding an intent to contract, the court noted that the regulation's purpose

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

Id. at 406; *see also Grav v. United States*, 14 Cl. Ct. 390, 393 (1988) (a statute requiring an agency to make payments to qualified farmers, coupled with the plaintiff meeting the qualifications for such payments, created "mutuality of intent . . . in no uncertain terms" and gave rise to an implied-in-fact contract), *aff'd* 886 F.2d 1305 (Fed. Cir. 1989); *Wells Fargo Bank, N.A. v. United States*, 26 Cl. Ct. 805 (1992) ("'There is ample case law holding that a contractual relationship arises between the government and a private party if promissory words of the former induce significant action by the latter in reliance thereon.' Thus, where a unilateral contract is at issue, the fact that only one party has made a promise does not imply that a contract does not exist. A contract comes into existence as soon as the other party commences performance." (quoting *Nat'l Rural Util. Coop. Fin. Corp. v. United States*, 14 Cl. Ct. 130, 137 (1988)) (internal citations omitted))

Applying *Radium Mines* to this case, there can be no doubt that the purpose of the Risk Corridor payment was to "induce" insurers to offer affordable coverage to a population about which they lacked information. In enacting the ACA, the Government recognized that prudent insurers pricing a product for an unknown population would need to add a "risk premium" to protect against uncertainties. It included the Risk Corridors Program to mitigate some of that uncertainty, and HHS expressly and repeatedly reminded insurers that the Risk Corridors Program should enable them to keep premiums low. Thus, like *Radium Mines*, the Government

by its conduct indicated an intent to enter into a binding contract to make a Risk Corridor payment to plans that satisfied the requirements for such a payment.

While the regulations quoted by the court in *Radium Mines* did state that the Government would enter into a "purchase contract" when presented with uranium that met its qualifications, *see* Gov. Br. at 32, the express reference to a possible contract was not the basis of the Court's decision. Rather, the "key" to *Radium Mines* "is that the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001). The Supreme Court likewise cited *Radium Mines* as an example of cases "where contracts were inferred from regulations promising payment" for purposes of Tucker Act jurisdiction. *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

In *LaVan v. United States*, 382 F.3d 1340, 1346-47 (Fed. Cir. 2004), the Federal Circuit affirmed the trial court's finding on summary judgment that the Government had entered an "implied in fact contract governing the treatment of goodwill" with the plaintiff, with that commitment reflected not in any written agreement between the parties, but in a Federal Home Loan Bank Board Resolution and an internal Board internal memorandum. The Federal Circuit rejected the Government's argument that the agency was merely performing a regulatory function, and did not require, as the Government urges here, that there be any "contract" language in the Board resolution or any pertinent regulation. *Id.*

In *New York Airways*, this Court described the mandatory statutory payment in that case as creating an implied contract once the plaintiff had satisfied the requirements for payment:

> The actions of the parties support the existence of a contract at least implied in fact. The [Civil Aeronautics] Board's rate order was, in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer.

N.Y. Airways, 369 F.2d at 751. Similarly, the U.S. Court of Appeals for the Fifth Circuit has explained, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature;" an entity accepts the Government's offer of payment by satisfying the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F. 2d 518, 521 (5th Cir. 1948).

By contrast, there is no mutuality of intent to contract when "[t]he only effort to be expended by . . . plaintiffs [is] to fill in the blanks of a Government prepared form," when there is "discretion . . . whether to award payments," or when the parties must "negotiate and fix a specific amount" of payment. *See Baker*, 50 Fed. Cl. at 491-93. None of those factors apply here, where the amount to be paid is fixed by statute, the Government has no discretion whether to pay; and no negotiations are required.

The two cases cited by the Government are clearly distinguishable. The *ARRA Energy* plaintiff rested its unsuccessful contract claim solely upon the statute itself, *see* 97 Fed. Cl. at 27 ("Plaintiffs assert that the government's intent to enter a contract can be inferred from the conduct of Congress and the President in enacting and signing the Recovery Act"),[18] while Moda relies upon much more, including implementing regulations that set forth a promise to make the Risk Corridor payments; accompanying preamble language promising to pay the Risk Corridor payments regardless of the amounts collected from profitable insurers; the Government's establishment of a transitional policy that sharply increased the costs of health care coverage, but was coupled with an express Government reaffirmation of the availability of the Risk Corridor payments to ameliorate those costs, and repeated promises to pay, *see* pp. 4-5, 9 *supra*. The

[18] The *ARRA Energy* court upheld the plaintiff's alternative statutory claim. 97 Fed. Cl. at 18-25.

plaintiffs in *AAA Pharmacy v. United States*, 108 Fed. Cl. 321 (2012), alleged an implied contractual right to specific ***procedures*** for the appeal of a denial of Medicare billing privileges, which was understandably insufficient to constitute an exchange of core benefits and obligations.

B. There Was Consideration.

Moda's provision of health benefits to enrollees is consideration for the Government's payment of Risk Corridor payments. The Government does not argue otherwise. Indeed, the calculation of Risk Corridor payments is based on the costs incurred by Qualified Health Plans to provide those benefits. Moda incurred hundreds of millions of dollars of expenses, *see* p. 9 *supra*, and is owed Risk Corridor payments on the losses incurred on those expenses.

C. There Was Offer and Acceptance.

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

- Moda must comply with certain "issuer participation standards" including standards on benefit design; standards regarding Health Benefit Exchanges processes and procedures; and implementation and reports on quality improvement strategy, including use of Government-designed enrollee satisfaction surveys (45 C.F.R. § 156.200);
- Moda must agree to set rates for an entire benefit year, must submit rate and benefit information to the Exchange, and must submit a justification for a rate increase prior to implementation of the rate increase (45 C.F.R. § 156.210);

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

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

- may be purchased through a Health Benefit Exchange (45 C.F.R. § 155.400);
- will receive payment of "advance premium tax credits" that subsidize an individual's premium costs (45 C.F.R. § 156.440);
- will receive payments to implement cost-sharing reductions for eligible individuals (45 C.F.R. § 156.430); and
- will receive Risk Corridor payments (45 C.F.R. § 153.510).

Moda accepted the Government's offer that if it complied with the numerous and extensive requirements to be Qualified Health Plans, and served the population for whom the Government sought to provide health coverage, then it would receive the statutorily required payments, including Risk Corridor payments. As in *Radium Mines* and *New York Airways*, the conduct of the Government and Moda satisfy the offer and acceptance requirement.

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

Actual authority to contract can be express or implied; either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). "Authority to bind the Government is generally implied when such authority is considered to be an integral part of the duties assigned to a government employee." *Id.* at 324 (citing J. Cibinic and R. Nash, *Formation of Government Contracts* 43 (1982)); *see also, e.g., Fifth Third Bank of W. Ohio v. United States*, 402 F.3d 1221, 1235-36 (Fed. Cir. 2005) (implied authority to contract existed when "the ability to offer supervisory goodwill as an asset for regulatory capital purposes and to allow extended amortization of goodwill was an essential tool for encouraging acquisition of failing thrifts"); *Advanced Team Concepts, Inc. v. United States*, 68 Fed. Cl. 147, 150-51 (2005) (implied authority to contract found based on the duties of "scheduling, hiring, and paying invoices" that were central to an officer's work).

Section 1342's instruction that the Secretary "shall establish" the Risk Corridors Program and "shall pay" Risk Corridors payments, along with the Secretary's broad obligation to administer and implement the ACA, *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d)implicitly give the Secretary the authority to enter into contracts to carry out the ACA and the program. Coverage through Exchanges is carried out exclusively through private insurers' Qualified Health Plans, and the ability to contract with them is thus "integral" to the Secretary's ability to effectuate her statutory duty to implement the Risk Corridors Program and the ACA

generally. Indeed, where contracts have been inferred from statutes or regulations promising payment, the Government's authority to contract has not been questioned. *See, e.g., Radium Mines*, 153 F. Supp. 403; *N.Y. Airways*, 369 F.2d 743.

The Government argues that there is no actual authority to contract because the Anti-deficiency Act prohibits government officials from involving the "government in a[n] . . . obligation for the payment of money before an appropriation is made unless authorized by law." 31 U.S.C. § 1341(a)(1)(B). However, the GAO, whose opinions are given "special weight," *see* p. 15 *supra*, independently concluded that the Secretary had authority to make risk corridor payments under CMS's "Program Management" appropriation. GAO, HHS — Risk Corridors Program, at 3. The GAO also concluded that the Secretary had authority to make payments from the amounts HHS collected under the Risk Corridors Program. *Id.* at 4-5.

Although later Congressional actions placed restrictions on CMS's Program Management appropriation in 2015 and 2016, that action took place *after* the formation of the implied contracts in 2013 and 2014. By the time of the first appropriations riders in December 2014, Moda had already been providing services, and incurring losses, for almost a year, and had already started selling Qualified Health Plans for 2015, *see* pp. 5, 8 *supra*. Moreover, the Secretary's authority to make payments out of what HHS collects from profitable insurers continues to this day, and was the basis for the 12.6% payment that HHS has already made. Thus, the Secretary had the budget authority as well as the actual legal authority to enter into an implied contract with the Qualified Health Plans.

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

As the Government fully concedes, Gov. Br. at 30, the Supreme Court has definitively resolved that Congress cannot curtail the government's contractual liability through the

appropriations process. *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012); *Cherokee Nation of Okla. v. Leavitt*, 543 U.S. 631, 646 (2005). As the Supreme Court explained in *Salazar*,

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

132 S. Ct. at 2189 (citing *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892); *Dougherty v. United States*, 18 Ct. Cl. 496, 503 (1883); 2 GAO, *Principles of Federal Appropriations Law* 6–17 (2d ed. 1992) [hereinafter "GAO Redbook"]). This line of cases applies "even if an agency's total lump-sum appropriation is insufficient to pay all the contracts the agency has made." *Cherokee Nation*, 543 U.S. at 637. "Although the agency itself cannot disburse funds beyond those appropriated to it, the Government's 'valid obligations will remain enforceable in the courts.'" *Ramah*, 132 S. Ct. at 2189 (citing GAO Redbook at 6–17).

Moda's implied contract claim falls neatly within this line of cases. As in *Ramah*, Congress provided some funding for the Government to meet its contractual Risk Corridors obligations, *see* p. 8 *supra*, but not enough for the Government to full satisfy those obligations to all insurers. The GAO independently confirmed that the following appropriations were available to make Risk Corridors payments: the FY 2014 CMS Program Management appropriation and all funds collected by the Government from profitable insurers through the Risk Corridors program. Francesconi Decl., Exh. 24 at A150. The Government does not argue otherwise. Like the plaintiff in *Ramah*, Moda seeks payment for contractually-required amounts. The Judgment Fund is available to pay this Court's judgment for that purpose.

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

It is the Government's contrived "three-year payment" construct, not the annual payments sought by Moda, that cannot reasonably be squared with the statute.

A. The "Presently Due" Issue Does Not Affect this Court's Jurisdiction.

The Government's argument that this Court lacks jurisdiction to hear Moda's claim because money damages are not "presently due," relies on *Todd v. United States*, 386 F.3d 1091 (Fed. Cir. 2004), but that case held that because the plaintiffs had not been given the promotions that would have led to higher pay, and this Court lacked jurisdiction to require such promotions, this Court also lacked jurisdiction to award damages. The instant case is easily distinguishable, as it is based upon a "money mandating" statute, *see* p. 11 *supra*, and the Federal Circuit has held that in order to establish Tucker Act jurisdiction, a plaintiff need only identify a statute, regulation, and/or constitutional provision that "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," *i.e.*, is "*reasonably amenable* to the reading that it mandates a right of recovery in damages." *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc) (emphasis in original).

Thus, if a plaintiff makes a "nonfrivolous assertion that it is within the class of plaintiffs entitled to recover under the money-mandating source, the Court of Federal Claims has jurisdiction. There is no further jurisdictional requirement that plaintiff make the additional nonfrivolous allegation that it is entitled to relief under the relevant money-mandating source." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008); *see also Albino v. United States*, 104 Fed. Cl. 801, 813 (2012) (jurisdiction exists "if a statute is reasonably amenable to a reading that is money-mandating and the plaintiff falls within the class of plaintiffs entitled to recover under the statute").

This Court has repeatedly recognized that *Fisher* articulates the proper jurisdictional test, thereby indicating that there is not an additional jurisdictional requirement that the money sought must be that "presently due." *See, e.g.*, *House v. United States*, 99 Fed. Cl. 342, 347 (2011), *aff'd*, 473 F. App'x 901 (Fed. Cir. 2012); *Tippett v. United States*, 98 Fed. Cl. 171, 179 & n.10 (2011). The case law relied upon by the Government (Gov. Br. at 13-15, 19) does not support its argument, given that the plaintiffs there, unlike Moda here, either did not seek money damages, or did not advance a statutory or contract claim that the Government has an obligation to pay.[19]

In addition, the Federal Circuit has expressly disavowed that payments must be "presently due" for this Court to have jurisdiction under the Tucker Act. Specifically, in *Kanemoto v. Reno*, the Federal Circuit held that "[t]here is no requirement in the Tucker Act that there must be a finding that money is due before the Court of Federal Claims can exercise its jurisdiction." 42 F.3d 641, 647 (Fed. Cir. 1994) (citations omitted).

B. The 2014 and 2015 Risk Corridor Payments Are Each Due, in Their Full Amounts.

The plain language of the ACA and the Risk Corridors provisions; their legislative history; their purpose and structure; the statutory construction rules established by the Supreme Court specifically in the context of the ACA; and HHS's prior stated positions, all dictate that

[19] *See United States v. Testan*, 424 U.S. 392, 407 (1976) (challenge to an employee classification); *Casitas Mun. Water Dist. v. United States*, 708 F.3d 1340 (Fed. Cir. 2013) (holding that a Takings Clause claim did not accrue); *Todd*, 386 F.3d at 1094 (challenge to the Government's failure retroactively to change the status of an airport); *Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 687-88 (Fed. Cir. 1991) (challenge to a contract termination); *Johnson v. United States*, 105 Fed. Cl. 85 (2012) (holding that plaintiff sought only cancellation of debt, and "[t]he Federal Circuit has unambiguously held that cancellation of debt does not constitute monetary damages"); *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173 (2009) (seeking a declaration approving the changes to the terms of an annuity under which the Government owed payments); *see also Wood v. United States*, 214 Ct. Cl. 744, 745 (1977) (unpublished) (42-year-old seeking a declaratory judgment when the statute specified that he was not eligible for retirement program under the statute until age 50).

Risk Corridors payments are due annually, in their full amount. The Government's contrary argument is wrong, and owed no deference for the reasons previously stated, *see* pp. 16-17 *supra*.

1. The Statute's Plain Meaning Requires Full, Annual Payments.

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

a) Section 1342 and the Broader ACA Provide for an Annual Risk Corridors Program.

The very first sentence of Section 1342 mandates that HHS establish "a program of Risk Corridors for calendar years 2014, 2015, and 2016." § 1342(a) (emphasis added). Absent contrary evidence, the use of the plural is deemed intentional, *see Dakota, Minn. & E. R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) ("Congress's use of the plural is evidence of its intent"), and the plural here indicates that there are ***multiple*** Risk Corridors — one for each calendar year ("2014, 2015, and 2016") — and separate payment obligations for each.

That there is a new risk corridor every year is no surprise, given that everything about the program is annual. The ACA mandates payment based on premiums and costs ***for each plan year*** from 2014-16; all calculations are made on a plan year basis. *See* §§ 1342(c)(1)(A) ("The amount of allowable costs of a plan for any year …."), 1342(c)(2) ("The target amount of a plan

for any year …."); *see also* § 1342(b) (calculating risk corridor "[p]ayments out" and "[p]ayments in" based on ratio of allowable costs to target amounts "for any plan year").

Indeed, Qualified Health Plan insurers must submit their data to HHS annually for the preceding year, so that HHS may calculate annual risk corridor amounts based on that data. 45 C.F.R. § 153.530(d). All Qualified Health Plans are certified for an Exchange one year at a time. *See, e.g.*, 45 C.F.R. § 155.1045. Moreover, other aspects of the ACA require payments between insurers and the Government — namely, those dealing with risk adjustment and reinsurance — are paid annually.[20] HHS has not also made full, annual Risk Corridors payments only because Congress withheld the funds to do so.

Indeed, HHS explicitly announced (prior to the appropriations riders) that it would be making Risk Corridor payments on an annual basis. As noted as pp. 3-4 *supra*, certain profitable insurers are required to make risk corridor payments to HHS, and HHS long ago dictated that such insurers make those payments annually, within 30 days after the Government provides its final calculations with respect to a given year, 45 C.F.R. § 153.510(d).[21] HHS ***acknowledged that the deadline for payments by HHS to unprofitable insurers like Moda that are owed risk corridor payments, should be exactly the same***: "***QHP [Qualified Health Plan] issuers who are***

[20] The Risk Adjustment Program transfers funds from issuers with low actuarial risk to plans with high actuarial risk in order to offset insurer losses from a higher proportion of high-cost enrollees. ACA § 1343, 42 U.S.C. § 18063; 45 C.F.R. pt. 153, Subparts D, G. Issuers are required to report data annually, and CMS determines risk adjustment charges makes payments using this data for each benefit year. *See* ACA § 1343(a); 45 C.F.R. § 153.310(e). The Reinsurance Program spreads the cost of very large insurance claims across all coverage providers in order to reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' claims associated with high-cost enrollees. ACA § 1341, 42 U.S.C. § 18061; 45 C.F.R. pt. 153, Subpart C. Reinsurance charges are collected and payments made annually. *See* ACA § 1341(b)(1), (3); 45 C.F.R. §§ 153.230(b), 153.240(b).

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

owed these [Risk Corridors] amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." 77 Fed. Reg. at 17,238.

In fact, HHS did make its payments to Moda with respect to 2014 pursuant to that time schedule, albeit only 12.6% of the total owed amount, *see* p. 9 *supra*. And, HHS has announced that it will make payments relating to 2015 consistent with that same timetable (although again, in insufficient amounts, *see* p. 9 *supra*). Nor is there any reason why Section 1342 would delay payment of the 2014 and 2015 Risk Corridors payments until some date in 2017: under the statutory formula, once the Risk Corridors payment obligation is calculated for one year, nothing in subsequent years changes the amount due, *see* § 1342.

The Government offers no explanation how or when the mandatory Risk Corridors payment will be made, other than it is supposedly not due until sometime after 2017, at which time Congress would perhaps have changed its mind and appropriated the money so HHS can itself meet its payment obligations. But this turns the world on its head. As established in Section I *supra*, the Tucker Act provides aggrieved parties the right to obtain a judgment (from a permanent appropriation, *see* 31 U.S.C. § 1304) for a statutorily obligation payment the Government has failed to make. Neither the Tucker Act nor the Judgment Fund provide for multi-year delays in the disbursement of sums owed. The Government cannot justify an inexcusable delay in Moda's receipt of payments to which it is entitled by statute and contract, based on a hope and prayer that other money might someday be available.

b) The ACA Risk Corridors Program Is "Based on" the Part D Medicare Program, Which Requires Full, Annual Payments.

Supporting the requirement of full, annual ACA risk corridor payments is the comparable payment scheme established by Medicare Part D, which Congress required HHS to use as the basis of the ACA Risk Corridors Program. *See* § 1342(a) ("Such [ACA Risk Corridors] program

shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.].”). Medicare Part D, which provides health insurance coverage for prescription drugs, establishes its own Risk Corridors Program. 42 U.S.C. § 1395w-115(e).

As discussed above, rather than directly specifying that the Secretary “shall pay” the risk corridor amounts, Medicare Part D instead only specifies that the Secretary “shall establish a risk corridor,” *see* p. 16, *supra*. But Part D is ***very*** specific about the payment timetable, providing that each “risk corridor” is specific to the plan year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (“*For each plan year* the Secretary shall establish *a risk corridor* for each prescription drug plan and each MA–PD plan. The *risk corridor for a plan for a year* shall be equal to a range as follows . . . .”) (emphasis added); 42 C.F.R. § 423.336(a)(2)(i) (“*For each year*, CMS establishes *a risk corridor* for each Part D plan. The *risk corridor for a plan for a coverage year* is equal to a range as follows . . . .”) (emphasis added); *see also* 42 C.F.R. § 423.336(c)(2) (“CMS at its discretion makes either lump-sum [risk corridor] payments or adjusts monthly [risk corridor] payments *in the following payment year* ….”) (emphasis added).

Where “Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the [administrative or judicial] interpretation given to the incorporated law, at least insofar as it affects the new statute.” *Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978).[22] Thus, just as does Medicare Part D, the ACA

[22] *See also Am. Fed. of Gov. Emps., AFL-CIO v. United States*, 46 Fed. Cl. 586, 599-600 (2000) (applying interpretation given to statute with “the same purposes” as statute at issue in the present case), *aff’d*, 258 F.3d 1294 (Fed. Cir. 2001); *Leroy v. Sec’y of Dep’t of Health & Human Servs.*, No. 02–392V, 2002 WL 31730680, at *14 (Fed. Cl. Oct. 11, 2002) (applying definition of specific statutory term from previous Act that was referenced in newer Act, the latter of which did not define the term); *James v. Santella*, 328 F.3d 1374, 1377-78 (Fed. Cir. 2003) (applying interpretation given to language from previous statute that was incorporated into newer statute); (continued…)

requires HHS to establish a program to make and receive payments in the year following each risk corridor year.

c) The Government Identifies No Language Supporting its "Three-Year Payment Framework."

The Government identifies no statutory language supporting its position that payments for each Risk Corridor may be collectively spread across, and delayed until the end of, the three-year length of the ACA Risk Corridors Program, and/or set off against payments and charges from other risk corridor years.

Furthermore, absent an evident statutory purpose to the contrary, courts read statutes and regulations to preserve common law principles. *See United States v. Texas*, 507 U.S. 529, 534 (1993). Under the common law that, in the absence of a specific timetable, payments must be made within a reasonable time. *Goodman v. Praxair, Inc.*, 494 F.3d 458, 465 (4th Cir. 2007) (observing, in context of statute of limitations discussion, that the elapse of a "commercially reasonable time for payment" is one event that could establish a breach of contract); *see also Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013) (when there is not a specified timetable for performance, performance must occur within a reasonable time).

The Government has identified nothing suggesting it is reasonable to withhold for three years the hundreds of millions of dollars owed Moda, when such Risk Corridors payments were understood *ab initio* to be critical to the stability and integrity of the ACA Health Benefit Exchanges. Given Risk Corridors' annual structure and underlying purpose, no reasonable interpretation permits anything other than Risk Corridors payments in each year following the

---

Cohen v. United States, 105 Fed. Cl. 733, 752-53 (2012) (analyzing and applying interpretations of Copyright Act provisions regarding minimum statutory damages that were incorporated into amendments to the Patent Act), *aff'd*, 528 F. App'x 996 (Fed. Cir. 2013).

plan year. *See King v. Burwell*, 135 S. Ct. 2480, 2492-93 (2015) ("the statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market . . . , and likely create the very 'death spirals' that Congress designed the Act to avoid").

2. The Legislative History Also Demonstrates that HHS Must Make Full, Annual Risk Corridor Payments.

While there is little ACA legislative history,[23] the Risk Corridors Program of the ACA is, as noted at pp. 45-46 *supra*, required by statute to be "based on" Part D. Therefore, Part D's statutory language, implementing regulations and legislative history are relevant to the present dispute. *See, e.g.*, *Cohen*, 105 Fed. Cl. at 753 (analyzing older law's legislative history when interpreting new law that incorporated portions of the older law); *American Federation of Government Employees, AFL-CIO*, 46 Fed. Cl. at 598-600 (same).

The legislative history of Part D continuously emphasized the annual nature of risk corridor payments. Congressional testimony noted that "[t]he Federal Government has large-scale experience with the use of Risk Corridors;" that such a program "can limit both the downside risk and upside gain for an insurance organization"; and that Risk Corridors are annual in nature. *Expanding Coverage of Prescription Drugs in Medicare: Hearing before the Comm. on Ways and Means, H. of Representatives*, 108th Cong., 2003 WL 23996388, at *115-17 (Apr. 9, 2003) (Statement of Cori E. Uccello and John M. Bertko, American Academy of Actuaries). Following debate, Congress reported that it agreed to enact a Risk Corridors Program that proceeded in phases, with the first risk corridor in 2006-07 and then a subsequent phase from 2008-11, in which the corridors would be broadened and plans would be at full risk for a greater portion of their gains and losses. 149 Cong. Rec. H.11877, 12000 (Nov. 20, 2003) (H.R. Rep.

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

No. 108-391 (2003) (Conf. Rep.)). All amounts for these Risk Corridors calculations were annual. *Id.*

HHS demonstrated its understanding of Congress's intent with respect to the Part D Risk Corridors Program by requiring annual payments from all parties. 42 C.F.R. § 423.336(c). It is this history that informed Congress when, in enacting the ACA, it dictated that the ACA Risk Corridors Program be based on Medicare part D.

C. Moda's Risk Corridors Claims Are Ripe for the 2014 and 2015 Plan Years.

The Government's related argument that "Moda's claims are not ripe because HHS has not yet finally determined the total amount of payments that Moda (or any other issuer) will receive under the Risk Corridors Program," Gov. Br. at 20, misapprehends the ripeness doctrine, which requires only "fitness" — that "further factual development would not significantly advance [a court's] ability to deal with the legal issues presented" — and "hardship" — that withholding court consideration of an action would cause hardship to the plaintiff because the complained-of conduct has an "immediate and substantial impact" on the plaintiff. *Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc.*, 527 F.3d 1278, 1294-95 (Fed. Cir. 2008) (internal citations omitted).

With respect to "fitness," the Government does not contest that Moda incurred compensable risk corridor losses for both the 2014 and 2015 plan years for which it has not received payment in full, and will not receive from HHS in light of the appropriations riders. The exact damages owed will be for this Court to determine *do novo*, *see, e.g.*, *Tektel, Inc. v. United States*, 121 Fed. Cl. 680, 687 (2015). Thus, no "further fact development" might eliminate Moda's current claims, nor affect the Court's ability to deal with the issues presented.

Moreover, the Government owes Moda significant Risk Corridor payments, which alone is more than sufficient to establish "hardship." *See Coal. for Common Sense in Gov.*

Procurement v. Sec'y of Veteran Affairs, 464 F.3d 1306, 1316 (Fed. Cir. 2006). While it is theoretically possible that Congress would appropriate funds specifically for making full Risk Corridors payments, this does not make Moda's claims unripe. If the mere possibility of future congressional appropriations made a Tucker Act claim unripe, then *New York Airlines*, *Langston*, *District of Columbia*, *Gibney*, and S*alazar* were all wrongly decided.

CONCLUSION

The Government's motion to dismiss should be denied, and Moda's motion for partial summary judgment as to liability should be granted.

Respectfully submitted,

/s/ Steven J. Rosenbaum
Steven J. Rosenbaum
Counsel of Record
(srosenbaum@cov.com)
Caroline M. Brown
Philip J. Peisch
Covington & Burling LLP
One CityCenter
850 Tenth Street, N.W.
Washington, D.C., 20001
(202) 662-5568
(202) 778-5568

Counsel for Plaintiff

October 25, 2016

CERTIFICATE OF SERVICE

I hereby certify that on this 25th day of October 2016, a copy of the foregoing, the Plaintiff's Memorandum in Opposition to Defendant's Motion to Dismiss, and in Support of Plaintiff's Cross Motion for Partial Summary Judgment as to Liability, was filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

Pursuant Rule 5.5(c) and Section IV.9 of Appendix E of the Rules of the Court of Federal Claims, I have also mailed courtesy copies of this filing to chambers.

Respectfully submitted,

/s/ Steven J. Rosenbaum
Steven J. Rosenbaum
Counsel of Record
(srosenbaum@cov.com)
Covington & Burling LLP
One CityCenter
850 Tenth Street, N.W.
Washington, D.C., 20001
(202) 662-5568
(202) 778-5568