No. 18-

IN THE

Supreme Court of the United States

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NONPROFIT MUTUAL INSURANCE CORPORATION,

Petitioner,

v.

UNITED STATES,

Respondent.

ON PETITION FOR WRIT OF CERTIORARI TO THE U.S. COURT OF APPEALS FOR THE FEDERAL CIRCUIT

PETITION FOR WRIT OF CERTIORARI

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BATEMAN & SLADE, INC. BOSTON, MASSACHUSETTS

QUESTION PRESENTED

This case involves the "risk corridors" program established by the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18062, which mandates that for the first three years of the ACA, the Government "shall pay" mathematically determined amounts to health insurers based on a statutory formula in order to induce them to participate in health insurance exchanges and to reduce the premiums they would otherwise charge.

In this case, the Federal Circuit held on the basis of legislative history that the Government's obligation to make risk corridors payments was extinguished by appropriations riders temporarily foreclosing certain sources of funds for the risk corridors program. The riders were included in spending bills enacted several years after the ACA was adopted — and after Petitioner had already performed its part of the bargain under the risk corridors program.

The Question Presented is: Whether a temporary cap on appropriations availability from certain specified funding sources may be construed, based on its legislative history, to abrogate retroactively the Government's payment obligations under a money-mandating statute, for parties that have already performed their part of the bargain under the statute.

PARTIES TO THE PROCEEDING

The caption to the case contains the names of all parties.

RULE 29.6 STATEMENT

Petitioner Land of Lincoln Mutual Health Insurance Company is an Illinois non-profit mutual insurance corporation currently in liquidation in Illinois state court under the supervision of the Director of the Illinois Department of Insurance, who acts as the statutory and court-affirmed liquidator. *See In the Matter of the Liquidation of the Land of Lincoln Mutual Insurance Co.*, No. 2016 CH 9210 (Cook County). No publicly traded company owns more than 10% of its stock.

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PETITION FOR A WRIT OF CERTIORARI

Land of Lincoln Mutual Health Insurance Company ("Land of Lincoln") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Federal Circuit in this case.

OPINIONS BELOW

The opinions of the Federal Circuit (Pet. App. 1a-6a, 7a-69a) are published at 892 F.3d 1184 (Fed. Cir. 2018), and 892 F.3d 1311 (Fed. Cir. 2018). The order denying rehearing and accompanying dissenting opinions (Pet. App. 141a-169a) are published at 908 F.3d 738 (Fed. Cir. 2018). The decision of the United States Court of Federal Claims (Pet. App. 70a-140a) is published at 129 Fed. Cl. 81 (2016).

JURISDICTION

The United States Court of Federal Claims had jurisdiction pursuant to the Tucker Act, 28 U.S.C. § 1491(a)(1) and the Affordable Care Act, 42 U.S.C. § 18062. The Court of Appeals had jurisdiction pursuant to 28 U.S.C. § 1295(a)(3). The Court of Appeals issued its decision on June 14, 2018 (Pet. App. 1a) and denied Petitioner's timely petition for rehearing *en banc* on November 6, 2018. *Id.* at 141a. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the Appendix. Pet. App. 170a-173a.

STATEMENT

This case concerns a novel "repeal-by-implication" doctrine created by a divided panel of the Federal Circuit, in conflict with this Court's precedent and over trenchant dissents by two judges on *en banc*. The decision below creates a blueprint for individual members of Congress and their staff to use legislative history in the appropriations process surreptitiously to renege on prior binding commitments of Congress and retroactively to eliminate the rights of those who have already performed their part of their bargain with the Federal Government.

The original statutory bargain that the Federal Circuit upended was the "risk corridors" program created by Section 1342 of the Patient Protection and Affordable Care Act ("ACA"), 42 U.S.C. § 18062, and implemented by the U.S. Department of Health and Human Services ("HHS"). Section 1342 mandates that for the first three years of the ACA, the Government "shall pay" mathematically determined amounts to health insurers based on the insurance risk they face.

In this case, a divided Federal Circuit followed its decision in the companion appeal of *Moda Health Plan, Inc. v. United States*, Petition for Certiorari pending as No. 18-__, and held on the basis of legislative history that appropriations riders temporarily foreclosing certain sources of funds for the risk corridors program extinguished the Government's obligation to make statutorily required payments. The Court of Appeals so ruled even though the riders were enacted several years after the establishment of the risk corridors program. Moreover, the Federal Circuit recognized that Section

1342 is a money-mandating statute and that Land of Lincoln would have prevailed if Congress had simply failed to appropriate any funds at all for the risk-corridor program.

This Court's review is warranted because the Federal Circuit's judgment conflicts with longstanding precedent of this Court regarding whether and when appropriations language can be deemed to abrogate retroactively the Government's obligations in an earlier money-mandating statute. This Court has held that Congress may extinguish a money-mandating statutory obligation only through express language or by clear implication and only by prospectively amending the statutory formula or prospectively revoking the entire right. But the divided panel below, despite conceding that the relevant appropriations rider neither amended the statutory formula in Section 1342 nor revoked the statutory right, nonetheless read legislative history to eliminate the Government's payment obligation retroactively through what it dubbed a "temporary cap" on payments. The Federal Circuit's departure from this Court's precedent and its creation of a new category of repeal-by-implication in an area where it has exclusive jurisdiction warrants review.

In addition, this Court's review is warranted because the question presented concerns an important issue of federal law. The Government's failure to make risk-corridors payments has already gutted a central feature of the ACA, reducing the availability of insurance and increasing its cost. When the Federal Government violated its statutory obligations, Land of Lincoln went insolvent and was placed in liquidation in 2016. As a result, some 50,000 consumers in Illinois lost their health

insurance during the policy year. The Federal Circuit's decision will trigger further insolvencies and increase the cost of insurance for tens of millions of consumers.

Moreover, the decision signals to all those doing business with the Government — including those outside the healthcare industry — that it cannot be trusted to meet its obligations and instead can avoid its commitments simply by citing retroactive appropriations legislation foreclosing certain sources of funds. Indeed, by creating a brand-new version of "repeal-by-implication" — via a mere "temporary cap" on payment sources that neither revokes nor amends a substantive entitlement and can be buried in legislative history to an appropriations rider — the decision below creates a tool for evading bicameralism and presentment, democratic accountability, and notice to those who have relied on the Government to their detriment.

An issue as momentous as this warrants plenary review by this Court. The final word should not come from a single (divided) panel of the Federal Circuit, on the basis of legislative history involving three Members of Congress, over two powerful dissents on rehearing.

A. Background

1. The "Risk Corridors" Program.

Section 1342(a) of the ACA provides that the Secretary of HHS

> shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan [("QHP")] 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.

42 U.S.C. § 18062(a).

According to HHS, the risk corridors program played a "critical role in ensuring the success of the Exchange." (Fed. Cir. Appx391). The Federal Circuit explained that, "[b]ecause insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new [ACA] exchanges, insurers faced significant risk if they elected to offer plans in these exchanges." Pet. App. 10a. The risk corridors program was "designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk." *Id.*

Section 1342 repeatedly uses the word "shall" to define HHS's risk corridors obligations and provides a statutory formula under which HHS "shall" make risk corridors payments. *See* 42 U.S.C. § 18062(a) (HHS "*shall* establish and administer a program of risk corridors" (emphasis added); § 18062(b)(1) (HHS "*shall* provide under the program" certain payments out (emphasis added); § 18062(b)(1)(A) (when "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, [HHS] *shall* pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount" (emphasis added); § 18062(b)(1)(B) (when "a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, [HHS] *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" (emphasis added).

In light of the mandatory statutory language, HHS took the view that Section 1342 was money-mandating. For example, the final rule promulgated by HHS on March 23, 2012 to implement the risk corridors program provided that QHPs "*will receive* payment from HHS" according to a statutory formula "in the following amounts, under the following circumstances":

> (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS *will pay* the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
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> (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS *will pay* to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.[1]

In March 2013, HHS explained that "[t]he risk corridor 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."[2] "This constituted the

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[1] Risk Corridor Establishment and Payment Methodology, 77 Fed. Reg. 17,251 (Mar. 23, 2012) (codified at 45 C.F.R. § 153.510) (emphasis added).

[2] Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013).

final word from HHS on the risk corridors program before the exchanges opened and the program began." Pet. App. 15a.

2. Health Insurers Provide Coverage In Reliance On The Government's Commitments.

Relying on the Government's assurances, Land of Lincoln, along with dozens of other health insurers, agreed to participate in the ACA exchanges, signed QHP contracts, priced their plans based on the expected risk of participating in the new insurance exchanges, and sold health insurance plans covering millions of Americans, including many who were previously uninsured. The risk corridors program served the Government's interest by encouraging "issuers to lower premiums by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." Pet. App. 13a (internal quotation marks, brackets, and citation omitted). As a result of these reduced premiums, the Government saved billions of dollars in premium subsidies that it would otherwise have had to pay under the ACA.

Land of Lincoln, now in liquidation because of the Government's breach of its obligations, was a non-for-profit Illinois start-up health insurer providing affordable health insurance to over 50,000 Illinois residents, many of whom lacked access to government-provided or employer-provided health insurance. Pet. App. 72a. In 2013, Land of Lincoln was approved by the Centers for Medicare and Medicaid Services ("CMS"), a unit of HHS, as a Consumer Operated and Oriented Plan (a "CO-OP"). *Id.* at 72a n.2. Land of Lincoln entered into a loan agreement with HHS requiring it to continue offering

coverage on the Illinois healthcare exchange through 2016. (Fed. Cir. Dkt. 136, at 26).

3. HHS's "Transitional Policy" Increases Insurers' Risk, After They Have Already Committed To Provide Coverage.

In November 2013, after Land of Lincoln and other insurers had already set premiums for the exchanges for 2014, HHS announced a one-year transitional policy that allowed insurers to continue to offer plans that did not comply with certain ACA standards. Pet. App. 16a. As the Court of Appeals recognized, "[t]his dampened ACA enrollment in states implementing the policy, especially by healthier individuals who elected to maintain their lower level of coverage, leaving insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums." *Id.*

HHS acknowledged that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014" but noted "the risk corridor program should help ameliorate unanticipated changes in premium revenue." *Id.* at 17a. HHS informed insurers that it would adjust the operation of the risk corridors program for the 2014 benefit year to "offset losses that might occur under the transitional policy as a result of increased claims costs not accounted for when setting 2014 premiums." *Id.* HHS projected that these new changes would "result in net payments that are budget neutral in 2014" and that it "intend[ed] to implement this program in a budget neutral manner" with adjustments over time with that goal in mind. *Id.*

4. Congress Enacts Appropriations Riders After Insurers Have Already Committed To Provide Coverage.

Because HHS had no financial obligation to make payments under the risk-corridors program until after it became effective in 2014, Congress did not include a specific appropriation for risk-corridors payments during the passage of the ACA in 2010 for that future expense.

After Land of Lincoln and other insurers had been providing coverage throughout 2014, and after 2015 plans had been priced and marketed, Congress passed a fiscal year 2015 appropriations bill for HHS on December 16, 2014 providing a lump sum for CMS's Program Management account. *Id.* at 20a. However, the lump-sum appropriation included a rider providing:

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

Id. Congress included the same language in appropriations riders for fiscal years 2016 and 2017. *Id.* Notably, Congress did not repeal or amend Section 1342 itself or alter the statutory formula under which HHS was required to make risk-corridors payments, despite repeated proposals in Congress to repeal the program *see* S.123, 114th Cong. (2015); H.R. 221, 114th Cong. (2015); 161 Cong.

Rec. S8420-21 (daily ed. Dec. 3, 2015), or expressly to cap "payments in" at "payments out." *See* S.359, 114th Cong. (2015); H.R. 724, 114th Cong. (2015).

Even after the enactment of the appropriations riders, HHS and CMS continued to recognize risk corridor payments as federal obligations. In a February 2015 final rule, CMS stated that "the Affordable Care Act requires the Secretary to make full payments to issuers."[3] It repeated that assurance in a November 19, 2015 public announcement (Fed. Cir. Appx291). On November 2, 2015, HHS expressly "reiterat[ed] that risk corridor payments are an obligation of the U.S. Government." (Fed. Cir. Appx306). In September 2016, HHS assured issuers: "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required." (Fed. Cir. Appx472). In September 2016 testimony before Congress that had been approved by the Department of Justice, the Acting Administrator of CMS repeated that assurance.[4] The Administrator was asked whether CMS took the position that "insurance plans are entitled to be made whole . . . even though there is no

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[3] HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

[4] House of Representatives, Subcommittee on Health, Committee on Energy and Commerce, *The Affordable Care Act on Shaky Ground: Outlook and Oversight*, Preliminary Transcript at 87-88 (Sept. 14, 2016), online at http://docs.house.gov/meetings/IF/IF02/20160914/105306/HHRG-114-IF02- Transcript-20160914.pdf.

appropriation." He responded: "Yes. It is an obligation of the federal government."[5]

Even the initial version of the HHS FY 2019 Budget in Brief (published online in February 2018) recognized risk-corridors payment as obligations of the Government. Pet. App. 41a. The budget proposal included more than $11.5 billion of funding, allocated to FY 2018, to fully fund the risk corridor program. The proposal stated that it "provides a mandatory appropriation to fully fund the Risk Corridors Program." (Fed. Cir. Dkt. 164).[6]

B. Procedural History Of This Case.

Land of Lincoln offered policies to consumers on the Illinois Health Insurance Marketplace in 2014, 2015, and part of 2016, until its liquidation effective October 1, 2016. Pet. App. 105-106a. For 2014, Land of Lincoln was entitled to $4,492,244 under the risk corridor program but received only $550,782, just 12.6% of the amount owed. *Id.* at 72a. For 2015 and 2016, Land of Lincoln was entitled to risk corridor payments of $68,917,591 and $52,747,976 respectively, but received nothing. (Fed. Cir. Dkt. 160).

Accordingly, in June 2016, Land of Lincoln brought this action against the Government in the Court of Federal Claims under the Tucker Act, seeking to recover money due under the risk-corridors

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[5] *Id.* at 85.

[6] After Land of Lincoln advised the Federal Circuit of HHS's budget proposal, the Government filed a letter with the Federal Circuit describing the HHS budget statements as "accounting" issues and noting that the budget proposal had been taken down from HHS's website. (Fed. Cir. Dkt. 165).

program. Pet. App. 106a. Land of Lincoln asserted five claims, including a statutory claim under Section 1342; breach-of-contract claims (both express and implied-in-fact); and a claim that HHS unlawfully took Land of Lincoln's property without just compensation in violation of the Fifth Amendment's Takings Clause. *Id.* at 73a.

In November 2016, the Court of Federal Claims granted judgment to the Government, concluding that HHS was not liable to Land of Lincoln under Section 1342 because the statute was "ambiguous" and "does not contain an express authorization for appropriations to make up any shortfall in the 'payments in' to cover all of the 'payments out' that may be due." Pet. App. 117a. The court also dismissed Land of Lincoln's remaining claims. *Id.* at 123a-140a.

C. The Decision Under Review.

A divided Federal Circuit affirmed, over a dissenting opinion by Judge Newman. The Court of Appeals acknowledged that Section 1342 "created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." Pet. App. 28a-29a. The Federal Circuit recognized that Section 1342 was "unambiguously mandatory" even though "it provided no budgetary authority to the Secretary of HHS and identified no source of funds for any payment obligations beyond payments in." *Id.* at 25a, 26a. The majority explained that "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt," and "the government's statutory obligation to pay persist[s]

independent of the appropriation of funds to satisfy that obligation." *Id.* at 26a, 27a. The majority acknowledged that insufficiency of appropriations "does not . . . cancel [the Government's] obligations, nor defeat the rights of other parties." *Id.* at 27a (internal quotation marks and citation omitted).

Nevertheless, the majority held the Government's obligation to pay was extinguished by appropriations riders enacted beginning December 16, 2014 for fiscal years 2015, 2016, and 2017. *Id.* at 29a. The Court of Appeals pointed to legislative history – in particular, a February 2014 request by two Members of Congress to the Government Accountability Office ("GAO") to determine the sources of funds that could be used to make payments in execution of the risk corridors program, *id.* at 34a,[7] as well as a statement by House Appropriations Chair Harold Rogers in connection with the riders asserting that "[i]n 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral." *Id.* at 21a.

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[7] In September 2014, GAO responded to the request by identifying two potential sources of funding. First, it found that HHS, and more specifically CMS, was permitted to draw from its general lump-sum fiscal year 2014 program-management appropriation of $3.6 billion to make payments under the risk-corridors program. Pet. App. 19a. Second, GAO concluded that "payments in" under the risk corridors program (*i.e.*, payments from QHPs to CMS) constituted "user fees," and so "any amounts collected in FY 2014 pursuant to section 1342(b)(2) would have been available . . . for making the payments pursuant to section 1342(b)(2)." *Id.* GAO added that appropriations acts "are considered nonpermanent legislation," so the language it analyzed regarding the lump-sum appropriation and user fees "would need to be included in the CMS PM appropriation for FY 2015" in order to be available to make any risk corridors payments in fiscal year 2015. *Id.* at 20a.

The Court of Appeals described the appropriations riders as "temporary measures capping risk corridor payments out at the amount of payments in." *Id.* at 38a. Yet the Court gave these temporary caps regarding the source of payments the same impact as a substantive repeal of the Government's obligation to pay.

Judge Newman, in dissent, explained that, under established precedent, the appropriations riders did not "erase the obligation" to pay. *Id.* at 53a. She warned the majority was "discarding" "[t]he classic case" of *United States v. Langston*, 118 U.S. 389 (1886), which "has stood the test of a century and a half of logic, citation, and compliance," and establishes that any intent to repeal or modify legislation must be "clearly stated." *Id.* at 56a. "The standard is high for intent to cancel or amend a statute. The standard is not met by the words of the riders." *Id.* at 59a.

In addition, Judge Newman criticized the unfairly retroactive nature of the majority's interpretation. The first rider was not enacted until December 16, 2014. By then, Land of Lincoln had nearly completed the 2014 insurance plan year, had already issued policies for the 2015 plan year (which contained guaranteed renewal rights for consumers for the 2016 plan year), and indeed had already committed by contract with HHS to provide insurance on the Illinois Exchange in 2016: "The appropriations rider cannot have retroactive effect on obligations already incurred and performance already achieved." *Id.* at 67a.

Judge Newman stressed that "[t]he government's ability to benefit from participation of private enterprise" "depends on the government's reputation

as a fair partner." *Id.* at 68a-69a. She warned that "[b]y holding that the government can avoid its obligations after they have been incurred, by declining to appropriate funds to pay the bill and by dismissing the availability of judicial recourse, this court undermines the reliability of dealings with the government." *Id.* at 69a.

D. Proceedings On Rehearing *En Banc.*

Numerous *amici* filed briefs supporting rehearing, including 17 States (Oregon, Alaska, California, Connecticut, Delaware, Hawaii, Kentucky, Maryland, Massachusetts, Minnesota, New Mexico, North Carolina, Pennsylvania, Rhode Island, Vermont, Washington, and Wyoming), plus the District of Columbia; the National Association of Insurance Commissioners; and numerous health care economists, other scholars, and health insurers.

Nevertheless, on November 6, 2018, the Federal Circuit denied rehearing and rehearing en banc, with Judges Newman and Wallach dissenting. Pet. App. 141a.

Judge Newman observed that "[t]he national impact of these health insurance cases, coupled with the role of 'appropriations riders' as a legislative tool, led to a split panel decision," and "the ensuing requests for reconsideration have been accompanied by amicus curiae briefs on behalf of the insurance industry, state governments, economists and other scholars, and the public." *Id.* at 149a. She cautioned that the Government's breach of its obligations "has caused significant harm to insurers who participated in the Affordable Care Act program" and also carries broader implications: "The government's access to

private sector products and services is undermined if non-payment is readily achieved after performance by the private sector." *Id.* at 151a-152a.

Judge Wallach, in a separate dissent joined by Judge Newman, explained that "the majority's holding regarding an implied repeal of the Government's obligation cannot be squared with Supreme Court precedent." *Id.* at 155a. He warned that "[t]o hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government's credibility as a reliable business partner" "in all sectors." *Id.* at 168a.

REASONS FOR GRANTING THE WRIT

The Court of Appeals acknowledged that the appropriations riders did not repeal or amend Section 1342. Nevertheless, the Federal Circuit, expressly relying on "legislative history," *id.* at 38a, concluded that the riders extinguished the Government's obligation to make risk-corridors payments because they evidenced "Congress's intent to temporarily cap payments out at the amount of payments in." *Id.* at 37a-38a.

This Court's review is warranted because the Federal Circuit's judgment is inconsistent with this Court's precedent and presents an important question of federal law.

First, this Court has never treated a temporary cap on appropriations from certain specified funding sources as having the same legal effect as a substantive repeal or amendment of the Government's statutory obligation to pay. To the contrary, in *United States v. Langston*, 118 U.S. 389

(1886) the Court squarely held that a mere cap on appropriations *cannot* relieve the Government of its payment obligations. Nonetheless, relying on legislative history, the Federal Circuit did exactly what this Court has prohibited. The Court of Appeals' decision directly conflicts with *Langston* and would have led to a different outcome in that case, as Judge Newman and Judge Wallach both observed. Pet. App. 56a, 62a-63a, 160a-162a.

Second, the Federal Circuit departed from the course this Court has charted for assessing the impact of appropriations legislation on pre-existing statutory mandates. This Court has repeatedly held that repeals by implication are highly disfavored and has identified only two ways in which appropriations measures may extinguish the Government's obligations to pay under prior statutes: by completely revoking the statutory entitlement to payment (as in *United States v. Dickerson*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980)), or by amending the entitlement substantively via express reformation of the statutory formula governing the entitlement (as in *United States v. Mitchell*, 109 U.S. 146 (1883), and *United States v. Vulte*, 233 U.S. 509 (1914)).

The Federal Circuit acknowledged that the appropriations riders neither revoked nor amended insurers' entitlement to payment under Section 1342. Instead, the Court of Appeals effectively created a new *third* category of congressional repeals-by-implication by interpreting the legislative history of the appropriations riders "to temporarily cap payments out." Pet. App. 37a. The Federal Circuit did so, even though in *Tennessee Valley Auth. v. Hill*, 437 U.S. 153 (1978), this Court rejected reliance on

legislative history in an appropriations bill to vary the substantive provisions of a prior statute and held that any such change must arise by express statutory language or by clear implication. Assuming, *arguendo*, that it is *ever* possible for appropriations language to repeal clear statutory obligations by mere implication, this Court should grant review because the Federal Circuit's decision is inconsistent with this Court's instructions for assessing the impact of appropriations measures on pre-existing substantive mandates and is at odds with the framework created by this Court in *TVA v. Hill, Dickerson, Will, Mitchell*, and *Vulte*.

Third, the Federal Court's decision warrants this Court's review because it interprets legislative history in an appropriations rider to *retroactively* deprive Petitioner and other insurers of vested statutory entitlements *after* they performed the services solicited by the Government. In the rare instances where this Court has found that appropriations riders either revoked or amended a substantive entitlement, it has never interpreted appropriations language enacted *after* private-party performance to have suspended or repealed a statutorily-mandated payment obligation.

The Federal Circuit's rule makes little practical or legal sense. The Court of Appeals acknowledged that Land of Lincoln would have prevailed if Congress had remained *silent* and never appropriated any funds for the risk-corridor program. Pet. App. 26a. The Court of Appeals could offer no reason why Congress' decision to (i) appropriate funds to HHS's program management account and then (ii) enact riders suspending the use of those particular funds for the risk corridors program, should lead to the opposite

outcome. As Judge Newman commented, "[t]he majority correctly states that 'the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation.' However, the majority then subverts its ruling, and holds that the government properly 'indefinitely suspended' compliance with the statute." *Id.* at 54a-55a.

This Court's review is warranted for the further reason that the question presented involves an important issue of federal law for healthcare markets and indeed for all those doing business with the Government, as Judge Newman and Judge Wallach noted. Pet. App. 68a-69a, 151a-152a, 168a.

This Court's review is amply warranted.

A. The Federal Circuit's Judgment Is Inconsistent With This Court's Precedent.

1. The Federal Circuit's Judgment Conflicts With This Court's Decision In *Langston.*

The Federal Circuit's decision conflicts with this Court's judgment in *United States v. Langston*, 118 U.S. 389 (1886), which involved a money-mandating statute promising a certain salary and a subsequent appropriations measure capped at a portion of the amount. The outcome in *Langston* would have been different under the Federal Circuit's approach.

In *Langston*, this Court held that "a statute fixing the annual salary of a public officer at a named sum, without limitation as to time," was not "deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount . . . and which contained no words that expressly, or by clear implication, modified or repealed the previous law."

118 U.S. at 394. There, an ambassador held a position under a statute providing that such a minister "shall be entitled to a salary of $7,500 a year." *Id.* at 390 (internal quotation marks and citation omitted). Although in some appropriations acts Congress appropriated the full $7,500, the legislature appropriated only $5,000 for that particular position in appropriations acts for fiscal years 1883 and 1884. *Id.* at 391. This Court held the claimant was still due $7,500 for 1883 and 1884 because the salary "was originally fixed at the sum of $7,500," and "[n]either of the acts appropriating $5,000 . . . contains any language to the effect that such sum shall be 'in full compensation' for those years" nor did either contain "an appropriation of money 'for additional pay,' from which it might be inferred that [C]ongress intended to repeal the act fixing his annual salary at $7,500." *Id.* at 393. This Court found it "not probable that [C]ongress" would "make a permanent reduction of [claimant's] salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel the courts to say that harmony between the old and the new statute was impossible." *Id.* at 394. This Court opined that "according to the settled rules of interpretation," "subsequent enactments which merely appropriated a less amount for the services of that officer for particular fiscal years" did not "abrogate[] or suspend[]" the Government's pre-existing legal obligation. *Id.* at 393-94.

The situation here is comparable to *Langston* in relevant respects. The appropriations riders did not amend or repeal the substantive provisions of Section 1342. Rather, they simply temporarily limited appropriations availability from certain specified

funding sources, while leaving other potential sources intact (such as "user fees" from "payments in"). As Judge Wallach opined, "[t]he riders do not address *whether the obligation remains payable* and, at most, only address *from whence the funds to pay the obligation may come*." Pet. App. 161a (emphasis in original). The riders did not cut off all sources of funding for the risk corridors program, prohibit risk-corridors payments (or all payments above a certain amount), or state that the non-restricted sources of funding served as full satisfaction of the Government's obligation under Section 1342. Instead, the riders merely specified particular funds from which risk corridors payments could not be made. In contrast, other provisions of the same appropriations legislation expressly repealed specified statutory provisions. *E.g.*, 2015 Consolidated and Further Continuing Appropriations Act, Pub. L. 113-235, (Dec. 16, 2014) at 128 Stat. 2492, ("Section 414 of the Social Security Act (42 U.S.C. 614) is repealed."); 128 Stat. 2525 ("Sections 65, 66, 67, and 68 of the Revised Statutes (2 U.S.C. 6569, 6570, 6571) are repealed.").

Hence, the risk-corridors riders were comparable to the appropriations measure in *Langston*, which appropriated only $5,000 for the ambassador's position for fiscal years 1883 and 1884, without cutting off all sources of funding for the position, without prohibiting payments above $5,000, and without stating that $5,000 served as full satisfaction of the Government's obligation. In substance, the appropriations measures operated in similar fashion.

Under the Federal Circuit's approach, *Langston* would have been decided differently. According to the Federal Court's reasoning, Congress's decision to

appropriate only $5,000 for the ambassador's position in 1883 and 1884 — in contrast to its decision to appropriate the full $7,500 in other years — could have been said to evidence "Congress's intent to temporarily cap" the salary for the years in question. Pet. App. 37a. Just as the Federal Circuit opined in this case that "Congress enacted temporary measures capping risk corridor payments out" at a certain amount, *id.* at 38a, this Court could have held in *Langston* that Congress enacted temporary measures capping the ambassador's salary at the amount of" $5,000. Under the Federal Circuit's approach, the ambassador in *Langston* should have lost. Instead, this Court held he should prevail.

Other circuits have faithfully hewed to *Langston. E.g.*, *In re Aiken Cnty.*, 725 F.3d 255, 260 (D.C. Cir. 2013) (Kavanaugh, J.) ("As the Supreme Court has explained, courts generally should not infer that Congress has implicitly repealed or suspended statutory mandates based simply on the amount of money Congress has appropriated.") (citing *Langston*). The Federal Circuit's departure from this Court's precedent warrants this Court's review.

2. The Federal Circuit Departed From This Court's Precedent For Assessing The Impact Of Appropriations Legislation On Substantive Mandates.

The Federal Circuit failed to follow this Court's instructions for assessing the impact of appropriations legislation on pre-existing statutory mandates. Instead, the Court of Appeals interpreted legislative history in an appropriations rider to extinguish the Government's obligations under Section 1342. The Federal Circuit's failure to adhere

to this Court's precedent is a further reason for granting review.

This "Court has had frequent occasion to note that . . . indefinite congressional expressions cannot negate plain statutory language and cannot work a repeal or amendment by implication." *St. Martin Evangelical Lutheran Church v. South Dakota*, 451 U.S. 772, 787-88 (1981); *accord Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018) (repeal-by-implication argument "faces a stout uphill climb"); *J.E.M. Ag Supply, Inc. v. Pioneer Hi-Bred Int'l, Inc.*, 534 U.S. 124, 142 (2001) (a finding of repeal by implication is a "rarity") (internal quotation and citation omitted); *Branch v. Smith*, 538 U.S. 254, 293 (2003) (O'Connor, J., concurring in part and dissenting in part) ("We have not found any implied repeal of a statute since 1975. And outside the antitrust context, we appear not to have found an implied repeal of a statute since 1917.") (citations omitted); A. Scalia & B. Garner, READING LAW 327-28 (2012) ("Repeals by implication are disfavored — 'very much disfavored . . . .'").

Further, this Court has explained that "[t]he doctrine disfavoring repeals by implication . . . applies with even greater force when the claimed repeal rests solely on an Appropriations Act." *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978). Both House and Senate rules forbid appropriations laws from making substantive changes. *See* House Rule XXI 2(a)(2)(b); Senate Rule XVI(4).

In *Hill*, this Court expressly rejected reliance on legislative history accompanying appropriations measures as a basis for overriding a prior statutory mandate (there, the obligation for agency review under the Endangered Species Act). This Court

explained that courts should not "assume that Congress meant to repeal [a substantive law] by means of procedure expressly prohibited under the rules of Congress." 437 U.S. at 190. Otherwise, "every appropriations measure would be pregnant with prospects of altering substantive legislation," "lead[ing] to the absurd result of requiring Members to review exhaustively the background of every authorization before voting on an appropriation." *Id.* In *Hill*, this Court refused to allow statements in committee reports (*see id.* at 164, 167) to override a prior statutory obligation. *Id.* at 192-93; *see also Robertson v. Seattle Audubon Soc.*, 503 U.S. 429, 440 (1992) ("repeals by implication are especially disfavored in the appropriations context") (citing *Hill*); *Andrus v. Sierra Club*, 442 U.S. 347, 359-60 (1979) ("The rules of both Houses prohibit 'legislation' from being added to an appropriation bill.") (internal quotation marks and citation omitted). Permitting legislative history in appropriations riders to override the language of prior congressional enactments would hand legislative staffers and individual Members the power surreptitiously to thwart the will of Congress.

This Court has identified only two situations in which appropriations measures may extinguish the Government's obligations to pay under prior statutes: (i) by completely revoking the entitlement to payment (as in *Dickerson* and *Will*), or (ii) by amending the entitlement substantively via express reformation of the statutory formula governing the entitlement (as in *Mitchell* and *Vulte*).

The Federal Circuit conceded that the appropriations riders neither revoked nor amended the entitlement to payment. Instead, the Court of Appeals effectively created a new *third* category of

congressional repeals-by-implication unmoored from this Court's precedent. The Federal Circuit's departure from this Court's teaching is a further reason warranting review.

In *Dickerson*, Congress repealed a substantive provision granting a reenlistment bonus for military personnel. Appropriations bills from 1934 through 1937 provided that the bonus statute was "hereby suspended as to reenlistments made during the fiscal year" and also made clear that no money was to be paid "notwithstanding the applicable provisions of" the statute creating that bonus. 310 U.S. at 556. This Court read a subsequent 1938 version — providing that "no part of any appropriation contained in this or any other Act shall be available" for reenlistment bonuses, "notwithstanding the applicable provisions of" the bonus statute — as a continuation of this express suspension. *Id.* at 556-61. Thus, in *Dickerson,* Congress revoked the substantive entitlement to the bonus. Here, by contrast, the Federal Circuit did not suggest that Congress had repealed Section 1342 or revoked the QHP's substantive right to risk-corridor payments under the formula set forth in the statute. Nor could the Court of Appeals have reached that conclusion. The appropriations riders here did not suspend the underlying statutory obligation, prohibit the use of funding from "any other Act," or indicate that a new substantive rule would apply "notwithstanding" the substantive risk corridors obligation.

In *United States v. Will*, 449 U.S. 200 (1980), Congress passed appropriations legislation providing that a previously applicable discretionary cost-of-living adjustment for government officials "shall not take effect" in a subsequent year. 449 U.S. at 222.

For two additional years thereafter, the appropriations statutes barred the use of funds appropriated "by this Act or any other Act," as in *Dickerson*. *See Will*, 449 U.S. at 205-07. The fourth year's appropriation stated that "funds available for payment[s] . . . shall not be used." *Id.* at 208. This Court found that Congress had in each of the relevant years prospectively effected a "change [in] the application of existing law" to "rescind" the underlying, non-mandatory obligation "entirely." *Id.* at 223-24.

Thus, in *Will*, just as in *Dickerson*, the statute in question eliminated the substantive entitlement altogether and foreclosed payment of the entitlement from "this or any other" source of funds – precisely what the Federal Circuit found the risk-corridors appropriations riders did *not* do. The Court of Appeals held that there was no substantive repeal or amendment of Section 1342 (and yet inexplicably cited cases involving such substantive repeals to support its erroneous conclusion that the Government could evade its obligations under Section 1342).

In two other cases cited by the Federal Circuit, *Mitchell* and *Vulte*, Congress changed the substantive formulas in earlier enacted compensation schemes. In *Mitchell*, the appropriations law affirmatively repealed the prior substantive statute and provided a change in the compensation system for interpreters from a higher base salary to a lower base salary with a discretionary bonus pool. *See* 109 U.S. at 148 (appropriations law "repealed section 2070 of the Revised Statutes").

In *Vulte*, 1906 and 1907 appropriations legislation altered previous appropriations laws by eliminating a

10% bonus in the salary formula for military officers in Puerto Rico and Hawaii. *See* 233 U.S. at 513. In *Vulte*, a subsequent appropriations law altered a prior appropriations measure — not a substantive statute. Here, as the Federal Circuit acknowledged, Congress made no such substantive amendment to the statutory formula for calculating risk-corridors amounts owed. The riders did not change Section 1342's formula for calculating "payments out" — *i.e.*, 50% of allowable costs in excess of 103% of revenues. Land of Lincoln remains entitled to precisely the same sum, pursuant to a statutory formula in Section 1342 that Congress did not touch.

Moreover, *Vulte* undermines the Federal Circuit's decision because *Vulte* reaffirmed this Court's decision in *Langston.* *Vulte* confirmed that an appropriation bill cannot alter the effect of substantive law "unless it is expressed in the most clear and positive terms, and where the language admits of no other reasonable interpretation." 233 U.S. at 515.

In contrast to *Dickerson* and *Will*, where Congress repealed statutory entitlements, and *Mitchell* and *Vulte*, where the legislature changed the substantive formulas governing entitlements for the years in question, the appropriations riders at issue here did nothing to revoke or amend the statutory rights and obligations created by Section 1342. But two members of the panel nonetheless relied on legislative history inserted during the appropriations process to hold that a temporary cap on one potential source of funds could extinguish a right created by Congress. The Federal Circuit's departure from this Court's precedent, and its creation of a new, third category of repeal-by-implication, warrants this Court's review.

3. The Unfairly Retroactive Quality Of The Federal Circuit's Interpretation Warrants This Court's Review.

The Federal Circuit's decision warrants this Court's review for the further reason that the unfairly retroactive impact attributed by the Federal Circuit to the appropriations riders is not consistent with this Court's precedent.

This Court has never interpreted appropriation language enacted *after* private party performance to have suspended or repealed a statutorily-mandated payment obligation. For example, *Dickerson* involved a suspension of reenlistment bonuses enacted in June 1938 for reenlistments during the next fiscal year, when Dickerson reenlisted. *See* 310 U.S. at 554-55. *Will* concerned discretionary cost-of-living adjustments for existing federal employees; cost-of-living adjustments, by definition, are prospective because they are triggered only as living costs increase over time. *See* 449 U.S. at 202-03, 217-21. *Mitchell* involved a prospective change in interpreters' pay. *See* Pet. App. 61a-62a. Similarly, in *Vulte*, as Judge Newman recognized, Congress "did not retroactively strip the officers of pay for duties they had performed while subject to the higher pay." Pet. App. 61a.

Yet, according to the Court of Appeals, the Government — after inducing QHPs to offer insurance on the new exchanges and reaping the multi-billion-dollar benefit of that bargain (including substantial Government savings of otherwise payable premium subsidies) — was then able to rewrite the terms of the deal through the after-the-fact appropriations riders. Notably, the first rider was not

enacted until December 16, 2014 — after Lincoln had already performed its part of the bargain by insuring customers for 2014, issuing policies at fixed premiums for 2015, and committing to provide coverage for 2016. Land of Lincoln previously had entered into a loan agreement with the HHS obliging it to continue offering coverage on the Illinois healthcare exchange through 2016. Accordingly, Land of Lincoln had no ability to withdraw from the Illinois insurance market, even after the appropriations riders were enacted.

Depriving Land of Lincoln of promised payments after it had committed to provide insurance under the risk-corridors scheme guaranteeing such payments is an impermissible bait-and-switch. This Court has instructed that the presumption against implied repeals "carries special weight" in the context of settled reliance interests. *St. Martin Evangelical Lutheran Church*, 451 U.S. at 788 (citation omitted). This Court has warned of retroactive impacts that would "impair rights a party possessed when he acted." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994). "If the statute would operate retroactively, our traditional presumption teaches that it does not govern absent clear congressional intent favoring such a result." *Id.*

Accordingly, "legislation is rarely afforded retroactive effect. . . . [I]n service of the due process interests of 'fair notice, reasonable reliance, and settled expectations,' the law applies a presumption that new legislation governs only prospectively." *De Niz Robles v. Lynch*, 803 F.3d 1165, 1169 (10th Cir. 2015) (Gorsuch, J.) (citation omitted). "[T]he presumption that legislation operates only prospectively is nearly as old as the common law.

Indeed, the presumption is sometimes said to inhere in the very meaning of the 'legislative Powers' the framers assigned to Congress in Article I of our Constitution." *Id.* at 1169-70. As Chief Justice Marshall opined, "[i]t is a principle which has always been held sacred in the United States, that laws by which human action is to be regulated, look forwards, not backwards; and are never to be construed retrospectively unless the language of the act shall render such construction indispensable." *Reynolds v. McArthur*, 27 U.S. (2 Pet.) 417, 434 (1829); *see also Eastern Enterprises v. Apfel*, 524 U.S. 498, 547 (1998) (Kennedy, J., concurring in the judgment and dissenting in part) ("[F]or centuries our law has harbored a singular distrust of retroactive statutes."); *Gutierrez-Brizuela v. Lynch*, 834 F.3d 1142, 1145 (10th Cir. 2016) (Gorsuch, J.) ("[I]f Congress had sought to amend the law . . . , absent some clear direction otherwise (and subject to constitutional limitations on retroactive legislation), its actions would have controlled conduct arising only after the legislation went into effect.") (citing *Landgraf*); *Metroil, Inc. v. ExxonMobil Oil Corp.*, 672 F.3d 1108, 1113 (D.C. Cir. 2012) (Kavanaugh, J.) (applying D.C. law prospectively because "bedrock rule of law values . . . counsel against retroactive application of new laws").

This Court's review is warranted because the Federal Circuit disregarded this Court's precedent regarding retroactive statutory application, particularly in cases involving the impact of appropriations laws on pre-existing statutory mandates.

B. The Federal Circuit Has Decided An Important Question of Federal Law In A Manner That Warrants This Court's Review.

1. The Federal Circuit Has Provided A Blueprint For Evasion of Political Accountability.

The question presented is important because it implicates fundamental principles of political accountability and legislative responsibility. As Judge Newman commented, "[r]epealing an obligation of the United States is a serious matter, and burying a repeal in a standard appropriations bill would provide clever legislators with an end-run around the substantive debates that a repeal might precipitate." Pet. App. 56a (internal quotation marks and citation omitted).

This case illustrates the peril of relying on appropriations language to negate a statutory mandate. The Federal Circuit speculated that Congress enacted the appropriations riders in response to a GAO report requested by two Members of Congress. Pet. App. 34a. As Judge Newman noted, there was no proof to support that surmise. *Id.* at 57a. Moreover, even if the Federal Circuit's narrative were correct, a court construing an appropriation bill must focus strictly on "the 'text of the appropriation,' not [on] Congress' expectations . . . as might be reflected by legislative history." *Salazar v. Ramah Navaho Chapter*, 567 U.S. 182, 200 (2012) (citation omitted).

The Federal Circuit also cited a floor statement by Representative Rogers that "[i]n 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral." Pet. App. 21a. But Representative Rogers' statement was in error; he

referred to a non-existent HHS "regulation," which he appeared to confuse with agency guidance. *Id.* at 57a-58a. Further, as Judge Wallach noted, "Chairman Rogers did not say that the 2015 *appropriations rider* sought to make the risk corridors program budget neutral; instead, he said that such was the goal of an *HHS regulation* and that the 2015 appropriations rider sought to designate from which funds the payments out may not be made. Chairman Rogers said nothing about the 2015 appropriations rider's effect on the Government's *obligation* to make payments out." *Id.* at 164a-165a (emphases in original).

Moreover, a statement by a single legislator is not a proper basis for attributing substantive law-changing effect to an appropriations measure. Congress would be "surprised to learn that [its] careful work on the [ACA] had been undone by the simple — and brief — insertion of some [purportedly] inconsistent language in" the legislative history of an appropriations bill. *TVA*, 437 U.S. at 191.

Indeed, even after enacting the appropriations riders, Congress continued to consider proposals to repeal the risk corridors program, *see* S.123, 114th Cong. (2015); H.R. 221, 114th Cong. (2015); 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015), or expressly to cap "payments in" at "payments out." *See* S.359, 114th Cong. (2015); H.R. 724, 114th Cong. (2015). Such legislative activity would have made little sense if Congress had shared the Federal Circuit's understanding that the appropriations riders eliminated the Government's obligation to pay under Section 1342.

The Federal Circuit's interpretation of the riders also departed from the understanding of the Executive Branch. Even after the enactment of the FY 2015 appropriations rider, CMS assured QHPs in September 2015: "HHS recognizes that the ACA requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required." (Fed. Cir. Appx523). In September 2016, after Lincoln had filed suit, HHS repeated that assurance (Fed. Cir. Appx472), which DOJ approved. *See* p. 10, *supra.* In September 2016 congressional testimony, the Acting Administrator of CMS was asked whether CMS took the position that "insurance plans are entitled to be made whole . . . even though there is no appropriation," and he responded, "Yes. It is an obligation of the federal government." *Id.*

The bills containing the riders were signed into law by President Obama without any objection or signing statement, Pet. App. 38a-39a, and without any other indication that he understood that by doing so, he was eviscerating a program essential to the continued viability of the ACA. Even after oral argument in this case in the Federal Circuit in 2018, the Government apparently recognized risk-corridors payments as statutory obligations. HHS listed them as such in its proposed FY2019 budget. *Id.* at 41a n.7.

The integrity of the Government is also at stake. In the Federal Circuit's view, a money-mandating statute is nothing more than a "promise to pay, with a reserved right to deny or change the effect of the promise," which this Court has condemned as "an absurdity." *U.S. Trust Co. of New York v. New Jersey*, 431 U.S. 1, 25 (1977) (citation omitted). This

Court has instructed that "[i]t is no less good morals and good law that the Government should turn square corners in dealing with the people than that the people should turn square corners in dealing with their government." *United States v. Winstar Corp.*, 518 U.S. 839, 886 n.31 (1996) (internal quotation marks and citation omitted). The Federal Circuit's decision violates that principle.

2. The Federal Circuit's Decision Has Important Practical Ramifications.

This Court's review is warranted for the further reason that the question presented has important practical implications for the Government and those who do business with it. As Judge Newman explained, "[o]ur system of public-private partnership depends on trust in the government as a fair partner." Pet. App. 150a. "The government's access to private sector products and services is undermined if non-payment is readily achieved after performance by the private sector." *Id.* at 151a-152a. This Court has observed that, "[i]f the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily — if at all — and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012). The Federal Circuit's approach would allow ambiguous or indefinite language in an appropriations measure to negate a clear statutory mandate and would disserve the Government's interest as a participant in the marketplace, particularly during changes in Administrations or times of divided government.

With respect to health insurance specifically, the Government's refusal to make the promised risk-corridors payments "has caused significant harm to insurers who participated in the Affordable Care Act program." Pet. App. 151a. The National Association of Insurance Commissioners informed the Federal Circuit that the Government's refusal to make the promised risk-corridors payments "transformed the Exchanges from promising to punitive for the insurance industry" and that only six of the 24 health insurance CO-OPs remained in business. *Id.*

The purpose of the risk-corridors program was to share risk "*between* the Federal government and QHP insurers."[8] Under the Federal Circuit's interpretation, insurers must pay into the risk-corridors program if their allowable costs are below the statutory formula, but they bear all the risk if "payments in" are not sufficient to fund the full amount of payments mandated by Section 1342. The Federal Circuit turned risk-corridors into a risk-exacerbating program rather than a risk-reducing one. It rewrote the bargain to be "heads the Government wins, tails the insurer loses."

A fundamental purpose of the ACA was to stabilize the health insurance markets. *See King v. Burwell*, 135 S. Ct. 2480 at 2492-93 (2015) ("[T]he statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market . . . and likely create the

[8] HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,829 (Mar. 11, 2014) (emphasis added); *see also* 78 Fed. Reg. 15,410, 15,413 (March 11, 2013) ("[T]he temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 through 2016.").

very 'death spirals' that Congress designed the Act to avoid."). Yet the Federal Circuit interpreted the appropriations riders as thwarting that central purpose by eliminating a key structural safeguard — risk mitigation — for QHPs who entered into the program.

Land of Lincoln's own experience is stark proof. As a result of the Government's breach of its obligations, Land of Lincoln was ultimately driven into liquidation in 2016. More than 50,000 policyholders were left without health insurance in October of the coverage year, and many forced to endure additional healthcare expenses. A federal court found that "Land of Lincoln entered into liquidation three months prior to the end of the policy year," and its policyholders were required "to find coverage for the remainder of that year." *Dowling v. U.S. Dep't of Health and Human Services*, 325 F. Supp. 3d 884, 898 (N.D. Ill. 2018). "Some policyholders were placed in the unenviable position of finding short-term health coverage and restarting their co-payment and deductible amounts from zero." *Id.* The Government's failure to honor its obligations also forced the Illinois Life and Health Guaranty Association, health care providers, and other Illinois insurers to absorb additional costs when Land of Lincoln went insolvent.

The significance of the question presented thus warrants this Court's review.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted.

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Dated: February 4, 2019

APPENDIX

APPENDIX A

United States Court of Appeals
for the Federal Circuit

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NON-PROFIT MUTUAL INSURANCE CORPORATION,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-1224

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00744-CFL, Judge Charles F. Lettow.

Decided: June 14, 2018

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THOMAS G. HUNGAR, Office of General Counsel, United States House of Representatives, Washington, DC, for amicus curiae United States House of Representatives. Also represented by KIMBERLY HAMM, TODD B. TATELMAN.

Before PROST, *Chief Judge*, NEWMAN and MOORE, *Circuit Judges*.

Opinion for the court filed by *Chief Judge* PROST.

Dissenting opinion filed by *Circuit Judge* NEWMAN.

PROST, *Chief Judge*.

For the reasons stated in our decision in the companion case, *Moda Health Plan, Inc. v. United States*, No. 17-1994, the statutory and contract claims of appellant Land of Lincoln Mutual Health fail. Additionally, because Land of Lincoln cannot state a contract claim, its takings claim fails to the extent it relies on the existence of a contract.

What remains is Land of Lincoln's takings claim to the extent that claim arises from its statutory entitlement to full payments. We have previously held that "no statutory obligation to pay money, even where unchallenged, can create a property interest within the meaning of the Takings Clause." *Adams v. United States*, 391 F.3d 1212, 1225 (Fed. Cir. 2004) (citing *Commonwealth Edison Co. v. United States*, 271 F.3d 1327, 1340 (Fed. Cir. 2001) (en banc)). Land of Lincoln offers no basis for departing from that rule, and we see none. Accordingly, Land of Lincoln's takings claim fails.

Because we hold that the trial court correctly granted judgment for the government as a matter of law, we need not address whether the trial court properly reached that conclusion via judgment on the administrative record.

AFFIRMED

COSTS

The parties shall bear their own costs.

United States Court of Appeals
for the Federal Circuit

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NON-PROFIT MUTUAL INSURANCE CORPORATION,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-1224

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00744-CFL, Judge Charles F. Lettow.

NEWMAN, *Circuit Judge*, dissenting.

For the reasons stated in my dissent in the concurrently heard case, *Moda Health Plan, Inc. v. United States*, No. 17-1994, the ruling of the Court of Federal Claims should be reversed.

The panel majority concedes that the government has a statutory obligation to make risk corridors payments to Land of Lincoln Mutual Health Insurance Company. That obligation has not been altered by statute or regulation. The Court of Federal Claims erred in its statutory interpretation, and in its conclusion that the government need not meet the

obligations by which it induced the nation's health insurers to implement the Affordable Care Act. I respectfully dissent from my colleagues' endorsement of this flawed ruling.

APPENDIX B

United States Court of Appeals
for the Federal Circuit

MODA HEALTH PLAN, INC.,
Plaintiff-Appellee
v.
UNITED STATES,
Defendant-Appellant

2017-1994

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

Decided: June 14, 2018

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Before PROST, *Chief Judge*, NEWMAN and MOORE, *Circuit Judges*.

Opinion for the court filed by *Chief Judge* PROST.

Dissenting opinion filed by *Circuit Judge* NEWMAN.

PROST, *Chief Judge*.

A health insurer contends that the government failed to satisfy the full amount of its payment obligation under a program designed to alleviate the risk of offering coverage to an expanded pool of individuals. The Court of Federal Claims entered judgment for the insurer on both statutory and contract grounds. The government appeals. We reverse.

BACKGROUND

This case concerns a three-year "risk corridors" program described in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001 et seq.) ("ACA"), and implemented by regulations promulgated by the U.S. Department of Health and Human Services ("HHS"). The case also concerns the bills that appropriated funds to HHS and the Centers for Medicare & Medicaid Services ("CMS") within HHS for the fiscal years during which the program in question operated. We begin with the ACA.

I. The ACA

Among other reforms, the ACA established "health benefit exchanges"—virtual marketplaces in each state wherein individuals and small groups could purchase health coverage. 42 U.S.C. § 18031(b)(1). The new exchanges offered centralized opportunities for insurers to compete for new customers. The ACA required that all plans offered in the exchanges satisfy certain criteria, including providing certain "essential" benefits. *See* 42 U.S.C. §§ 18021, 18031(c).

Because insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new exchanges, insurers faced significant risk if they elected to offer plans in these exchanges. The ACA established three programs designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk corridors. 42 U.S.C. §§ 18061–63. This case concerns the risk corridors program.

Section 1342 of the ACA directed the Secretary of HHS to establish a risk corridors program for calendar years 2014–2016. The full text of Section 1342 is reproduced below:

> (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 [42 U.S.C. §§ 1395w-101 et seq.].

(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.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in

> providing benefits covered by the plan.
>
> (B) Reduction for risk adjustments and reinsurance payments
>
> Allowable costs shall [be] reduced by any risk adjustment and reinsurance payments received under section[s] 18061 and 18063 of this title.
>
> (2) Target amount
>
> The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

42 U.S.C. § 18062.

Briefly, section 1342 directed the Secretary of HHS to establish a program whereby participating plans whose costs of providing coverage exceeded the premiums received (as determined by a statutory formula) would be paid a share of their excess costs by the Secretary— "payments out." Conversely, participating plans whose premiums exceeded their costs (according to the same formula) would pay a share of their profits to the Secretary—"payments in." The risk corridors program "permit[ted] issuers to lower [premiums] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013).

On March 20, 2010, just three days before Congress passed the ACA, the Congressional Budget Office ("CBO") published an estimate of the ACA's cost. *See* Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives tbl. 2 (Mar. 20, 2010) ("CBO Cost Estimate"), https://www.cbo.gov/ sites/default/files/ 111th-congress-2009-2010/costestimate/amendrecon prop.pdf. The CBO Cost Estimate made no mention of the risk corridors program, though it scored the reinsurance and risk adjustment programs. *Id.* Overall, CBO predicted the ACA would reduce the federal deficit by $143 billion over the 2010–2019 period it evaluated. *Id.* at p.2.

Preambulatory language in the ACA referred to CBO's overall scoring, noting that the "Act will reduce the Federal deficit between 2010 and 2019." ACA § 1563(a).

II. Implementing Regulations

In March 2012, HHS promulgated regulations establishing the risk corridors program as directed by section 1342. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,251–52 (Mar. 23, 2012) (codified at 45 C.F.R. Pt. 153, Subpart F). Those regulations defined terms such as "allowable costs," "administrative costs," "premiums earned," and "target amount," all of which would ultimately factor into the calculations of payments in and payments out required by the statutory formula. *E.g.*, *Id.* at 17,236–39.

The regulations also provided that insurers offering qualified health plans in the exchanges "will

receive payment from HHS in the following amounts, under the following circumstances" and it recited the same formula set forth in the statute for payments out. 45 C.F.R. § 153.510(b). The regulations similarly provided that insurers "must remit charges to HHS" according to the statutory formula for payments in. *Id.* § 153.510(c).

In March 2013, after an informal rulemaking proceeding, HHS published parameters for payments under various ACA programs for the first year of the exchanges, 2014, including the risk corridors program. The parameters revised certain definitions and added others, notably incorporating a certain level of profits as part of the allowable administrative costs. 78 Fed. Reg. at 15,530–31 (codified at 45 C.F.R. § 153.530). The parameters also provided that an issuer of a plan in an exchange must submit all information required for calculating risk corridors payments by July 31 of the year following the benefit year. *Id.* HHS also indicated that "the risk corridors program is not required to be budget neutral," so HHS would make full payments "as required under Section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. This constituted the final word from HHS on the risk corridors program before the exchanges opened and the program began.

III. Transitional Policy

The ACA established several reforms for insurance plans—such as requiring a minimum level of coverage— scheduled to take effect on January 1, 2014. ACA § 1255. Non-compliant plans in effect prior to the passage of the ACA in 2010, however, received a statutory exemption from certain

requirements. 42 U.S.C. § 18011. This meant that insurers expected the pool of participants in the exchanges to include both previously uninsured individuals as well as individuals whose previous coverage terminated because their respective plans did not comply with the ACA and did not qualify for the grandfathering exemption.

Individuals and small businesses enrolled in non-compliant plans not qualifying for the exemption received notice that their plans would be terminated. Many expressed concern that new coverage would be "more expensive than their current coverage, and thus they may be dissuaded from immediately transitioning to such coverage." J.A. 429. In November 2013, after appellee Moda Health Plan, Inc. and other insurers had already set premiums for the exchanges for 2014, HHS announced a one-year transitional policy that allowed insurers to continue to offer plans that did not comply with certain of the ACA's reforms even for non-grandfathered plans. J.A. 429–31. HHS directed state agencies to adopt the same policies. J.A. 431.

This dampened ACA enrollment in states implementing the policy, especially by healthier individuals who elected to maintain their lower level of coverage, leaving insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums. *See* Milliman, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 Individual Market 1 (July 2016) ("Our analysis indicates that issuers in states that implemented the transitional policy generally have higher medical loss ratios in the individual

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

HHS acknowledged that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014" but noted "the risk corridor program should help ameliorate unanticipated changes in premium revenue." *Id.* HHS later extended the transitional period to last the duration of the risk corridor program. J.A. 448–62.

After further informal rulemaking (begun soon after announcing the transitional policy), HHS informed insurers that it would adjust the operation of the risk corridors program for the 2014 benefit year to "offset losses that might occur under the transitional policy as a result of increased claims costs not accounted for when setting 2014 premiums." *HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13,744, 13,786–87 (Mar. 11, 2014). This included adjustments to HHS's formula for calculating the "allowable costs" and "target amount" involved in the statutory formula. *Id.*

HHS projected that these new changes (together with changes to the reinsurance program) would "result in net payments that are budget neutral in 2014" and that it "intend[ed] to implement this program in a budget neutral manner" with adjustments over time with that goal in mind. *Id.* at 13,787.

In April 2014, CMS, the division of HHS responsible for administering the risk corridors program, released guidance regarding "Risk

Corridors and Budget Neutrality." J.A. 229–30. It explained a new budget neutrality policy as follows:

> We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after the obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

J.A. 229.

As to any shortfall in the final year of payment, CMS stated it anticipated payments in would be sufficient, but that future guidance or rulemaking would address any persistent shortfalls. J.A. 230.

IV. Appropriations

In February 2014, after HHS had proposed its adjustments to account for the transitional policy (but before HHS had finalized the adjustments), Congress asked the Government Accountability Office ("GAO") to determine what sources of funds could be used to make any payments in execution of the risk corridors program. *See* Dep't of Health & Human Servs.—Risk Corridors Program ("GAO Report"), B-325630, 2014 WL 4825237, at *1 (Comp. Gen. Sept. 30, 2014) (noting request). GAO responded that it had identified two potential sources of funding in the appropriations for "Program Management" for CMS in FY 2014. That appropriation included a lump sum in excess of three billion dollars for carrying out certain responsibilities, including "other responsibilities" of CMS as well as "such sums as may be collected from authorized user fees." *Id.* at *3 (citing Pub. L. No. 113-76 div. H, title II, 128 Stat. 5, 374 (Jan. 17, 2014)).

GAO concluded that the "other responsibilities" language in the CMS Program Management appropriation for FY 2014 could encompass payments to health plans under the risk corridors program, and so the lump-sum appropriation "would have been available for making payments pursuant to section 1342(b)(1)." *Id.* Further, GAO concluded that the payments in from the risk corridors program constituted "user fees," and so "any amounts collected in FY 2014 pursuant to section 1342(b)(2) would have been available . . . for making the payments pursuant to section 1342(b)(2)," though HHS had not planned to make any such collections or payments until FY 2015. *Id.* at *5 & n.7.

GAO clarified that appropriations acts "are considered nonpermanent legislation," so the language it analyzed regarding the lump-sum appropriation and user fees "would need to be included in the CMS PM appropriation for FY 2015" in order to be available to make any risk corridors payments in FY 2015. *Id.*

In December 2014, Congress passed its appropriations to HHS for FY 2015 (during which the first benefit year covered by the risk corridors program would conclude). That legislation reenacted the user fee language that GAO had analyzed and provided a lump sum for CMS's Program Management account; however, the lump-sum appropriation included a rider providing:

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

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491.

Representative Harold Rogers, then-Chairman of the House Committee on Appropriations, explained his view of the appropriations rider upon its inclusion in the appropriations bill for FY 2015:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014).

Congress enacted identical riders in FY 2016 and FY 2017. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543.[1]

V. Subsequent Agency Action

In September 2015, CMS announced that the total amount of payments in fell short of the total amount requested in payments out. Specifically, it expected payments in of approximately $362 million but noted requests for payments out totaling $2.87 billion. J.A. 244. Accordingly, CMS planned to issue prorated payments at a rate of 12.6 percent, with any shortfall to be made up by the payments in received following the 2015 benefit year. *Id.*

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[1] Continuing resolutions in advance of the 2017 appropriations retained the same restrictions on funds. Continuing Appropriations Act, 2017, Pub. L. No. 114-223, div. C, §§ 103–04, 130 Stat. 857, 908–09; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, § 101, 130 Stat. 1005, 1005–06.

A follow-up letter noted that HHS would "explore other sources of funding for risk corridors payments, subject to the availability of appropriations" in the event of a shortfall following the final year of the program. J.A. 245.

A report from CMS shows that the total amount of payments in collected for the 2014–2016 benefit years fell short of the total amount of payments out calculated according to the agency's formula by more than $12 billion. CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

VI. Procedural History

Moda commenced this action in the Court of Federal Claims under the Tucker Act in July 2016. It seeks the balance between the prorated payments it received and the full amount of payments out according to section 1342. The Court of Federal Claims denied the government's motion to dismiss for lack of jurisdiction and for failure to state a claim and granted Moda's cross-motion for partial summary judgment as to liability.

Both sides stipulated that the government owed Moda $209,830,445.79 in accordance with the ruling on liability. J.A. 41. The trial court entered judgment for Moda accordingly. J.A. 45.

Dozens of other insurers filed actions alleging similar claims, with mixed results from the Court of Federal Claims. *See*, *e.g.*, *Molina Healthcare of Cal.,*

Inc. v. United States, 133 Fed. Cl. 14 (2017) (ruling for the insurer); *Me. Cmty. Health Options v. United States*, 133 Fed. Cl. 1 (2017) (ruling for the government).

The Court of Federal Claims had jurisdiction under the Tucker Act, 28 U.S.C. § 1491(a)(1).[2] We have jurisdiction under 28 U.S.C. § 1295(a)(3).

DISCUSSION

Moda advances claims based on two theories. First, Moda contends that section 1342 itself obligates the government to pay insurers the full amount indicated by the statutory formula for payments out, notwithstanding the amount of payments in collected. Second, Moda contends that HHS made a contractual agreement to pay the full amount required by the statute in exchange for Moda's performance (by offering a compliant plan in an exchange), and the government breached that agreement by failing to pay the full amount according to the statutory formula for payments out.

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[2] The government does not appeal the Court of Federal Claims' determination of Tucker Act jurisdiction, and it appears to concede that section 1342 is money-mandating for jurisdictional purposes (though not on the merits). Appellant's Reply Br. 11. As discussed below, we hold that section 1342 initially created an obligation to pay the full amount of payments out. We also agree with the Court of Federal Claims that the statute is money-mandating for jurisdictional purposes. *See Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (concluding a statute is money-mandating for jurisdictional purposes if it "can fairly be interpreted" to require payment of damages, or if it is "reasonably amenable" to such a reading, which does not require the plaintiff to have a successful claim on the merits).

We review the Court of Federal Claims' legal conclusion that the government was liable on both theories de novo. *See Starr Int'l Co. v. United States*, 856 F.3d 953, 963 (Fed. Cir. 2017).

I. Statutory Claim

Moda argues that section 1342 obligated the government to pay the full amount indicated by the statutory formula for payments out, not a pro rata sum of the payments in. The government responds that section 1342 itself contemplated operating the risk corridors program in a budget neutral manner (so the total amount of payments out due to insurers cannot exceed the amount of payments in). In the alternative, the government contends that appropriations riders on the fiscal years in which payments from the risk corridors program came due limited the government's obligation to the amount of payments in. Although we agree with Moda that section 1342 obligated the government to pay the full amount of risk corridors payments according to the formula it set forth, we hold that the riders on the relevant appropriations effected a suspension of that obligation for each of the relevant years.

We begin with the statute.

A. Statutory Interpretation

The government asserts that Congress designed section 1342 to be budget neutral, funded solely through payments in and that the statute carries no obligation to make payments at the full amount indicated by the statutory formula if payments in fell short.

Section 1342 is unambiguously mandatory. It provides that "[t]he Secretary *shall* establish and administer" a risk corridors program pursuant to which "[t]he Secretary *shall* provide" under the program that "the Secretary *shall* pay" an amount according to a statutory formula. 42 U.S.C. § 18062 (emphases added). Nothing in section 1342 indicates that the payment methodology is somehow limited by payments in. It simply sets forth a formula for calculating payment amounts based on a percentage of a "target amount" of allowable costs.

The government reasons that we must nevertheless interpret section 1342 to be budget neutral, because Congress relied on the CBO Cost Estimate that the ACA would decrease the federal deficit between 2010 and 2019, without evaluating the budgetary effect of the risk corridors program. Thus, according to the government, the ACA's passage rested on an understanding that the risk corridors program would be budget neutral.

Nothing in the CBO Cost Estimate indicates that it viewed the risk corridors program as budget neutral. Indeed, even if CBO had accurately predicted the $12.3 billion shortfall that now exists, CBO's overall estimate that the ACA would reduce the federal deficit would have remained true, since CBO had estimated a reduction of more than $100 billion. *See* CBO Cost Estimate at 2.

The government's amicus suggests it is "inconceivable" that CBO would have declined to analyze the budgetary impact of the risk corridors program, given its obligation to prepare "an estimate of the costs which would be incurred in carrying out

such bill." Br. of Amicus Curiae U.S. House Rep. in Supp. of Appellant at 7 (quoting 2 U.S.C. § 653). Not so. It is entirely plausible that CBO expected payments in would roughly equal payments out over the three year program, especially since CBO could not have predicted the costly impact of HHS's transitional policy, which had not been contemplated at that time. Without more, CBO's omission of the risk corridors program from its report can be viewed as nothing more than a bare failure to speak. Moreover, even if CBO interpreted the statute to require budget neutrality, that interpretation warrants no deference, especially in light of HHS's subsequent interpretation to the contrary. CBO's silence simply cannot displace the plain meaning of the text of section 1342.

The government also argues that section 1342 created no obligation to make payments out in excess of payments in because it provided no budgetary authority to the Secretary of HHS and identified no source of funds for any payment obligations beyond payments in. But it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances.

In *United States v. Langston*, 118 U.S. 389 (1886), Congress appropriated only five thousand dollars for the salary of a foreign minister, though a statute provided that the official's salary would be seven thousand five hundred dollars. The Supreme Court held that the statute fixing the official's salary could not be "abrogated or suspended by the subsequent enactments which merely appropriated a less amount" for the services rendered, absent "words that

expressly, or by clear implication, modified or repealed the previous law." *Id.* at 393. That is, the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation.

Our predecessor court noted long ago that "[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties." *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) ("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.").

It is also of no moment that, as the government notes, HHS could not have made payments out to insurers in an amount totaling more than the amount of payments in without running afoul of the Anti-Deficiency Act. That Act provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure . . . exceeding an amount available in an appropriation . . . for the expenditure." 31 U.S.C. § 1341(a)(1)(A). But the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government. *See Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 197 (2012). The Anti-Deficiency Act simply constrains government officials. *Id.*

For the same reason, it is immaterial that Congress provided that the risk corridors program established by section 1342 would be "based on the program" establishing risk corridors in Medicare Part D yet declined to provide "budget authority in advance of appropriations acts," as in the corresponding Medicare statute. *See* 42 U.S.C. § 1395w-115.[3] Budget authority is not necessary to create an obligation of the government; it is a means by which an officer is afforded that authority. *See* 2 U.S.C. § 622(2).

Here, the obligation is created by the statute itself, not by the agency. The government cites no authority for its contention that a statutory obligation cannot exist absent budget authority. Such a rule would be inconsistent with *Langston*, where the obligation existed independent of any budget authority and independent of a sufficient appropriation to meet the obligation.

We conclude that the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for

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[3] The fact that the same provision also "represents the obligation of the Secretary to provide for the payment of amounts provided under this section" cuts both ways. 42 U.S.C. § 1395w-115. Although Congress never expressly stated that section 1342 represented an obligation of the Secretary, it used unambiguous mandatory language that in fact set forth such an obligation, especially in light of Congress's intent to make the risk corridors program in the ACA "based on" Medicare's obligatory program. The government offers no basis for concluding that stating the "obligation of the Secretary" outright is the sine qua non of finding an obligation here. The plain language of the statute controls.

payments out under the risk corridors program. We next consider whether, notwithstanding that statutory requirement, Congress has suspended or repealed that obligation.

B. The Effect of the Appropriations Riders

The government next argues the riders in the appropriations bills for FY 2015 and FY 2016 repealed or suspended its obligation to make payments out in an aggregate amount exceeding payments in.[4] We agree.

Repeals by implication are generally disfavored, but "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" *United States v. Will*, 449 U.S. 200, 221–22 (1980) (quoting *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). Whether an appropriations bill impliedly suspends or repeals substantive law "depends on the intention of [C]ongress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883). The central issue on Moda's statutory claim, therefore, is whether the appropriations riders adequately expressed Congress's intent to suspend payments on the risk corridors program beyond the sum of payments in. We conclude the answer is yes.

Moda contends, however, this issue is also controlled by *Langston*. There, as discussed above,

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[4] The government's argument applies equally to FY 2017, though that appropriations bill had not yet been enacted before this case completed briefing.

the Supreme Court held that a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation because it carried no implication of Congress's intent to amend or suspend the substantive law at issue. *Langston*, 118 U.S. at 394.

Just three years before *Langston*, however, the Supreme Court held that a statute that had set the salaries of certain interpreters at a fixed sum "in full of all emoluments whatsoever" had been impliedly amended, where Congress appropriated funds less than the fixed sum set by statute, with a separate sum set aside for additional compensation at the discretion of the Secretary of the Interior. *Mitchell*, 109 U.S. at 149. The Court held:

> This course of legislation . . . distinctly reveal[ed] a change in the policy of [C]ongress on the subject, namely that instead of establishing a salary for interpreters at a fixed amount, and cutting off all other emoluments and allowances, [C]ongress intended to reduce the salaries and place a fund at the disposal of the [S]ecretary of the [I]nterior, from which, at his discretion, additional emoluments and allowances might be given to the interpreters.

Id. at 149–50. Thus, "for the time covered by those" appropriations bills, the intent of Congress was "plain on the face of the statute." *Id.* at 150.

Langston expressly distinguished *Mitchell* because the appropriations bills in *Mitchell* implied "that [C]ongress intended to repeal the act" setting a

fixed salary, with "additional pay" to be provided at the Secretary's discretion. *Langston*, 118 U.S. at 393. By contrast, Congress had "merely appropriated a less amount" for Langston's salary. *Id.* at 394.

The question before us, then, is whether the riders on the CMS Program Management appropriations supplied the clear implication of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question, as in *Mitchell*, or if Congress merely appropriated a less amount for the risk corridors program, as in *Langston*.

The Supreme Court has noted *Langston* "expresses the limit in that direction." *Belknap v. United States*, 150 U.S. 588, 595 (1893). The jurisprudence in the century and a half since *Langston* has cemented that decision's place as an extreme example of a mere failure to appropriate.[5] Our case falls clearly within the core of subsequent decisions wherein appropriations bills carried sufficient implication of repeal, amendment, or suspension of substantive law to effect that purpose, as in *Mitchell*.

In *United States v. Vulte*, 233 U.S. 509 (1914), the Supreme Court considered a series of enactments concerning bonuses for Marine Corps officers serving abroad. A 1902 act established a ten percent bonus for all such officers and appropriated funds

[5] Contrary to the suggestion of the dissent, dissent at 8, we do not discard *Langston* due to its age, rather, we simply acknowledge the extensive body of decisions since it was decided that treat it as an outer bound, consistent with the Supreme Court's view in *Belknap*.

accordingly. In 1906 and 1907, appropriations for the payment of that bonus carried a rider specifying that the funds could be used to pay officers serving "beyond the limits of the states comprising the Union of the territories of the United States contiguous thereto (*except P[ue]rto Rico and Hawaii*)." *Id.* at 512–13 (emphasis added) (citations omitted). The appropriations for 1908 contained no such rider and stated the increase of pay for officers serving abroad "shall be as now provided by law." *Id.* at 513 (citation omitted).

An officer serving in Puerto Rico in 1908 sought compensation accounting for the ten percent bonus enacted in 1902. The Supreme Court rejected the government's position that the exception in the appropriations bills of 1906 and 1907 impliedly repealed the 1902 act, noting that the appropriations riders lacked any "words of prospective extension" indicating a permanent change in the law. *Id.* at 514. Nevertheless, the Supreme Court acknowledged the appropriation riders *did* indicate Congress's intent to "temporarily suspend as to P[ue]rto Rico and Hawaii" the ten percent bonus in 1906 and 1907. *Id.*

In *Dickerson*, the Supreme Court considered the effect of various appropriations riders on a reenlistment bonus authorized by Congress in 1922. 310 U.S. at 555–56. After several years in force, an appropriations rider expressly suspended the bonus for the fiscal years ending in 1934–1937. *Id.* at 556. The text of the rider changed in the appropriations bill for the fiscal year ending in 1938. That bill omitted the express suspension, noting only that "no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1938,

shall be available for the payment" of, inter alia, the reenlistment bonus. *Id.*

The appropriations bill for the fiscal year ending in 1939 repeated that language. *Id.* at 555. Floor debates showed that Congress intended the new language to carry the same restriction expressed in the earlier appropriations bills. *Id.* at 557–61. The Supreme Court held that the appropriations bill for the fiscal year ending in 1939 evinced Congress's intent to suspend the reenlistment bonus in light of persuasive evidence to that effect. *Id.* at 561.

Finally, in *Will*, the Supreme Court considered the effect of appropriations riders on a set of statutes establishing annual pay raises for certain officials, including federal judges. 449 U.S at 204–05 (citing 5 U.S.C. § 5505). Over a span of four years, Congress passed appropriations acts with riders limiting the use of funds to pay the increases for federal judges, among others. *See id.* at 205–09. The first such rider provided that "no part of the funds appropriated in this Act or any other Act shall be used to pay the salary of an individual in a position or office referred to in" the act providing for the pay raises for federal judges. *Id.* at 206 (quoting Legislative Branch Appropriation Act, 1977, Pub. L. 94-440, 90 Stat. 1439, Title II).

The dispute in *Will* concerned whether the effect of the appropriations riders ran afoul of the Compensation Clause of the Constitution. Before reaching that issue, however, the Supreme Court first rejected the judges' contention that the appropriations bills did "no more than halt funding for the salary increases." *Id.* at 221. Acknowledging

the general rule disfavoring repeals by implication and its "especial force" when the alleged repeal occurred in an appropriations bill, the Court held that in each of the four appropriations acts in question, "Congress intended to repeal or postpone previously authorized increases." *Id.* at 221–22. This was true although the riders in years 1, 3, and 4 were "phrased in terms of limiting funds." *Id.* at 223. The Court's conclusion was bolstered by floor debates occurring in year 3 of the appropriations riders as well as language expressly suspending the pay raises in year 2, but it concluded the rider in year 1 indicated that same clear intent:

> These passages indicate[d] clearly that Congress intended to rescind these rates entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear intent of Congress in each year was to stop for that year the application of the Adjustment Act.

Id. at 224.

Congress clearly indicated its intent here. It asked GAO what funding would be available to make risk corridors payments, and it cut off the *sole* source of funding identified beyond payments in. It did so in each of the three years of the program's existence. And the explanatory statement regarding the amendment containing the first rider of House Appropriations Chairman Rogers confirms that the appropriations language was added with the understanding that HHS's intent to operate the risk corridors program as a budget neutral program meant the government "will never pay out more than it

collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). Plainly, Congress used language similar to the appropriations riders in *Vulte*, *Dickerson*, and *Will* (and quite clearer than the language in *Mitchell*) to temporarily cap the payments required by the statute at the amount of payments in for each of the applicable years—just as those decisions altered statutory payment methodologies.[6]

What else could Congress have intended? It clearly did not intend to consign risk corridors payments "to the fiscal limbo of an account due but not payable." *See Will*, 449 U.S. at 224.

Moda contends that notwithstanding the similarities between our case and the foregoing authority, Congress simply intended to limit the use of a single source of funding while leaving others available. Moda points out that the appropriations riders in *Dickerson* and *Will* foreclosed the use of funding provided by that appropriations act "or any other act," while the riders here omit that global restriction. *Compare Dickerson*, 310 U.S. at 556, and *Will*, 449 U.S. at 206, with Consolidated and Further Continuing Appropriations Act, 2015, § 227, 128 Stat. at 2491. But the Supreme Court never considered the impact of that language in *Dickerson* or *Will*, and it

[6] We do not "ratif[y] an 'indefinite suspension' of payment," dissent at 7, or a "permanent postponement," *id.* at 16. We hold only that Congress effected a suspension applicable to the fiscal years covered by each appropriations bill containing the rider, which corresponded to each fiscal year in which risk-corridor payments came due.

found effective suspensions-by-appropriations in *Mitchell* and *Vulte* even absent that language.

Moda suggests that restricting access to funds from "any other act" was necessary to foreclose HHS from using funds that remained available. It points to the CMS Program Management appropriation for FY 2014 (before the risk corridors program began and before any appropriations riders had been enacted) as well as the Judgment Fund, a standing appropriation for the purpose of paying certain judgments against the government. We address each in turn.

In response to a request of Congress, GAO concluded that the FY 2014 CMS Program Management fund "would have been available for risk-corridors payments." *See* GAO Report at *3. According to Moda, this means HHS could have used funds from the FY 2014 appropriation to make risk corridors payments for the 2015 benefit year (which concluded in FY 2015). Not so. GAO's opinion only addressed what funds from FY 2014 would have been available for risk corridors payments had any such payments been among the "other responsibilities" of CMS *for that fiscal year*. That appropriation expired in FY 2014. *See* 128 Stat. at 5 ("The following sums in this Act are appropriated . . . for the fiscal year ending September 30, 2014."). GAO specifically noted that "for funds to be available for this purpose in FY 2015, the CMS PM appropriation for FY 2015 must include language similar to the language included in the CMS PM appropriation for FY 2015." *Id.* at *5. Of course, Congress enacted the rider for FY 2015 instead.

GAO's opinion was correct. Under section 1342, HHS could not have collected or owed payments out

or payments in during FY 2014 because the statute required calculations based on allowable costs for a *plan year* and the program was to run for calendar years 2014, 2015, and 2016. Thus, HHS could not have been responsible for payments out until, at the earliest, the end of calendar year 2014, which occurred during FY 2015.

Likewise, the CMS Program Management appropriations in the continuing resolutions enacted at the end of calendar year 2014 (during FY 2015) expired in December 2014, when Congress enacted the FY 2015 appropriations act (and the first rider in question)—still before HHS could have even calculated the payments in and payments out under the risk corridors program.

Moda's reliance on the Judgment Fund is also misplaced. The Judgment Fund is a general appropriation of "[n]ecessary amounts" in order "to pay final judgments" and other amounts owed via litigation against the government, subject to several conditions. 31 U.S.C. § 1304(a). The Judgment Fund "does not create an all-purpose fund for judicial disbursement." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 431 (1990). Rather, access to the Judgment Fund presupposes liability. Moda's contention that the government's liability persists because it could pay what it owed under the statutory scheme from the Judgment Fund reverses the inquiry. The question is what Congress intended, not what funds might be used if Congress did not intend to suspend payments in exceeding payments out.

As discussed above, Congress's intent to temporarily cap payments out at the amount of

payments in was clear from the appropriations riders and their legislative history. It did not need to use Moda's proposed magic words, "or any other act," to foreclose resort to the Judgment Fund. We simply cannot infer, as Moda's position would require, that upon enacting the appropriations riders, Congress intended to preserve insurers' statutory entitlement to full risk corridors payments but to require insurers to pursue litigation to collect what they were entitled to. That theory cannot displace the plain implications of the language and legislative history of the appropriations riders.

Moda points out that Congress's intent regarding the appropriations riders must be understood with the context of other legislative efforts surrounding the ACA and the risk corridors program in particular. For example, Moda points to Congress's failed attempt to enact legislation requiring budget neutrality for the risk corridors program. *See, e.g.*, Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). But we need not and do not conclude that Congress achieved through appropriations riders what it failed to do with permanent legislation. Rather, we only hold that Congress enacted temporary measures capping risk corridor payments out at the amount of payments in, and it did so for each year the program was in effect. (We need not address, for example, what would have occurred if Congress had failed to include the rider in one of the acts appropriating funds for the fiscal years in which payments came due or if it had affirmatively appropriated funds through some other source.)

It is also irrelevant that the President signed the bills containing the appropriations riders, even as he

threatened to veto any bill rolling back the ACA, as Moda points out. *See, e.g.*, *Gregory Korte, Obama Uses Veto Pen Sparingly, But Could That Change?*, USA TODAY, Nov. 19, 2014 (noting that President Obama had threatened to veto twelve different bills that would have repealed or amended the ACA), http://www.usatoday.com/story/news/politics/2014/11/19/obama-veto-threats/19177413/. Again, we do not hold that the appropriations riders effected any permanent amendment. Moreover, Moda has offered no evidence that President Obama expressed any specific views of the implications of these appropriations riders before or after signing, much less evidence that could overcome the clear implication of the text of the riders and the surrounding legislative history.

Moda also contends that two decisions from our predecessor court, *New York Airways*, 369 F.2d at 743, and *Gibney v. United States*, 114 Ct. Cl. 38 (1949), demonstrate that the appropriations riders here do not carry such strong implications. In *New York Airways*, our predecessor court held that Congress's failure to appropriate sufficient funds to pay for services at a rate set by a government agency did not defeat the obligation to pay the full amount. 369 F.2d at 746. Floor debates indicated that "Congress was well-aware that the Government would be legally obligated to pay . . . even if the appropriations were deficient." *Id.* The court noted that Congress viewed the obligation "as a contractual obligation enforceable in the courts which could be avoided only by changing the substantive law under which the Board set the rates, rather than by curtailing appropriations," and the agency made its

similar view of the obligation clear to Congress. *Id.* at 747.

Here, the risk corridors program is an incentive program, not a quid pro quo exchange for services rendered like that in *New York Airways*. Moreover, it is much clearer here that Congress understood the appropriations riders to suspend substantive law, inasmuch as the appropriations riders directly responded to GAO's identification of only two sources of funding for the program.

In *Gibney*, a statute provided that certain employees of the Immigration and Naturalization Service would be paid overtime at a particular rate. Two subsequent statutes extended a more stringent overtime rate to other federal employees, while expressly leaving the prior rate for INS in place. A rider in an appropriations bill 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 latter two acts. 114 Ct. Cl. at 48–49. INS agents who received overtime payments at the more stringent rate fixed in the latter acts sought payment at the earlier rate.

That rider, according to the *Gibney* court, constituted "a mere limitation on the expenditure of a particular fund and had no other effect," so it could not limit the overtime rate available to an INS agent. *Id.* at 51. But the court's holding ultimately rested on a different point—that limiting overtime payments "as provided in" the new acts had no effect on the rate for INS agents, since the new acts expressly preserved their special overtime rate. The appropriations rider

did "not even purport to affect the right of immigration inspectors to overtime pay as provided in the" earlier act. *Id.* at 55. The interpretation of the appropriations riders in *Gibney* cannot be viewed in isolation of its alternative holding, and there is no safety valve built into the ACA to preserve the government's obligation notwithstanding Congress's suspension of it. Accordingly, *Gibney* is inapposite.

After oral argument in this case had occurred, Moda filed a citation of supplemental authority as permitted by Rule 28(j) of the Federal Rules of Appellate Procedure, indicating that HHS had released a proposed budget for FY 2019, including a proposal indicating an $11.5 billion outlay for risk corridors payments in FY 2018 (reflective of the effect of sequestration on the total $12.3 billion outstanding) and noting a "legislative proposal to fully fund the Risk Corridors Program." *See* Appellee's Fed. R. App. P. 28(j) Notice Suppl. Auth. ("Moda 28(j) Letter") (Feb. 16, 2018), ECF No. 83, Exh. A (*Putting America's Health First, FY 2019 President's Budget for HHS* at 51 & n.5 & n.7, 54, 93 n.7 (2018)).[7]

[7] A revised budget, released just days after Moda submitted the initial draft to the court, omitted the language Moda referred to. See *generally* Putting America's Health First, FY 2019 President's Budget for HHS (2018) (rev. Feb. 19, 2018), https://www.hhs.gov/sites/default/files/fy2019-budget-in-brief.pdf. The budget released by the White House, however, included remnants of HHS's initial draft. *An American Budget, Budget of the U.S. Government, Fiscal Year 2019* at 132, 141 (2018), OMB https://www.whitehouse.gov/wp-content/uploads/ 2018/02/ budget-fy2019.pdf.

According to Moda, this refutes the government's positions on its statutory claims. In particular, Moda states, "if the appropriation riders had substantively amended the ACA, the government would have no basis now to be proposing to appropriate funds to fulfill the entirety of its [risk corridor] obligations." Moda 28(j) Letter at 2.

Moda again misunderstands the inquiry. The question is what intent was communicated by Congress's enactments in the appropriations bills for FY 2015–2017. It is irrelevant that a subsequent Administration proposed a budget that set aside funds to make purported outstanding risk corridors payments. Of course, Congress could conceivably reinstate an obligation to make full payments, even now after the program has concluded. But the proposed budget does not place that question before us.

The intent of Congress remains clear. After GAO identified only two sources of funding for the risk corridors program—payments in and the CMS Program Management fund—Congress cut off access to the only fund drawn from taxpayers. A statement discussing that enactment acknowledged "that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838. Congress could have meant nothing else but to cap the amount of payments out at the amount of payments in for each of the three years it enacted appropriations riders to that effect.

Moda contends that this result is inconsistent with the purpose of the risk corridors program. Perhaps.

But it also seems that Congress expected the program to have minimal, if any, budget impact (even though we hold the text of section 1342 allowed for unbounded budget impact). Congress could not have predicted the shifting sands of the transitional policy implemented by HHS, which Moda blames for the higher costs it and other insurers bore through their participation in the exchanges. In response to that turn of events, Congress made the policy choice to cap payments out, and it remade that decision for each year of the program. We do not sit in judgment of that decision. We simply hold that the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program.

Thus, Moda's statutory claim cannot stand.

II. Contract Claim

Moda also asserts an independent claim for breach of an implied-in-fact contract that purportedly promised payments of the full amount indicated by the statutory formula in exchange for participation in the exchanges.

The requirements for establishing a contract with the government are the same for express and implied contracts. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997). They are (1) "mutuality of intent to contract," (2) "consideration," (3) "lack of ambiguity in offer and acceptance," and (4) "actual authority" of the government representative whose conduct is relied upon to bind the government. *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

Absent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract. *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465–66 (1985). We apply a "presumption that 'a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *Id.* (quoting *Dodge v. Board of Educ.*, 302 U.S. 74, 79 (1937)). This is because the legislature's function is to make laws establishing policy, not contracts, and policies "are inherently subject to revision and repeal." *Id.* at 466.

Moda does not contend that the government manifested intent via the text of section 1342 alone. Indeed, the statute contains no promissory language from which we could find such intent. Instead, Moda alleges a contract arising "from the combination of [the statutory] text, HHS's implementing regulations, HHS's preamble statements before the ACA became operational, and the conduct of the parties, including relating to the transitional policy." Appellee's Br. 55.

The centerpiece of Moda's contract theory (and the foundation for the trial court's decision in this case) is *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). There, the Atomic Energy Commission issued regulations titled "Ten Year Guaranteed Minimum Price," in order "[t]o stimulate domestic production of uranium." *Id.* at 404–05. The regulations established guaranteed minimum prices for uranium delivered to the commission, with specific conditions required for entitlement to the minimum price. *Id.*

The court observed that the title of the regulation indicated that the government would "guarantee" the prices recited and that the regulation's "purpose was to induce persons to find and mine uranium," when, due to restrictions on private transactions in uranium, "no one could have prudently engaged in its production unless he was assured of a Government market." *Id.* at 405–06. The court rejected the government's position that the regulations constituted a mere invitation to make an offer, holding instead that the regulation itself constituted "an offer, which ripened into a contract when it was accepted by the plaintiff's putting itself into a position to supply the ore or the refined uranium described in it." *Id.* at 405.

Moda contends that here, the statute, its implementing regulations, and HHS's conduct all evinced the government's intent to induce insurers to offer plans in the exchanges without an additional premium accounting for the risk of the dearth of data about the expanded market, in reliance on the presence of a fairly comprehensive safety net. But the overall scheme of the risk corridors program lacks the trappings of a contractual arrangement that drove the result in *Radium Mines*. There, the government made a "guarantee," it invited uranium dealers to make an "offer," and it promised to "offer a form of contract" setting forth "terms" of acceptance. *Id.* at 404–05; *see N.Y. Airways*, 369 F.2d at 752 (finding intent to form a contract where Congress specifically referred to "Liquidation of Contract Authorization"). Not so here.

The risk corridors program is an incentive program designed to encourage the provision of

affordable health care to third parties without a risk premium to account for the unreliability of data relating to participation of the exchanges—not the traditional quid pro quo contemplated in *Radium Mines*. Indeed, an insurer that included that risk premium, but nevertheless suffered losses for a benefit year as calculated by the statutory and regulatory formulas would still be entitled to seek risk corridors payments.

Additionally, the parties in *Radium Mines*, one of which was the government, never disputed that the government intended to form some contractual relationship at some time throughout the exchange. The only question there was whether the regulations themselves constituted an offer, or merely an invitation to make offers. *Radium Mines* is only precedent for what it decided. *See Orenshteyn v. Citrix Sys., Inc.*, 691 F.3d 1356, 1360 (Fed. Cir. 2012) ("Generally, when an issue is not discussed in a decision, that decision is not binding precedent.").

Here, no statement by the government evinced an intention to form a contract. The statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program. These facts cannot overcome the "well-established presumption" that Congress and HHS never intended to form a contract by enacting the legislation and regulation at issue here.

Accordingly, Moda cannot state a contract claim.

* * *

Because we conclude that the government does not owe Moda anything in excess of its pro rata share of payments in, we need not address whether payments were due annually or only at the end of the three-year period covered by the risk corridors program.

CONCLUSION

Although section 1342 obligated the government to pay participants in the exchanges the full amount indicated by the formula for risk corridor payments, we hold that Congress suspended the government's obligation in each year of the program through clear intent manifested in appropriations riders. We also hold that the circumstances of this legislation and subsequent regulation did not create a contract promising the full amount of risk corridors payments. Accordingly, we hold that Moda has failed to state a viable claim for additional payments under the risk corridors program under either a statutory or contract theory.

REVERSED

COSTS

The parties shall bear their own costs.

United States Court of Appeals
for the Federal Circuit

MODA HEALTH PLAN, INC.,
Plaintiff-Appellee

v.

UNITED STATES,
Defendant-Appellant

2017-1994

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

NEWMAN, *Circuit Judge*, dissenting.

The United States and members of the health insurance industry, in connection with the program referred to as "Obamacare," agreed to a three-year plan that would mitigate the risk of providing low-cost insurance to previously uninsured and underinsured persons of unknown health risk. This risk-abatement plan is included in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA). As described by the Court of Federal Claims,[1] the "risk corridors" provision accommodates the unpredictable risk of the

[1] *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (2017) ("Fed. Cl. Op.").

extended healthcare programs. By this provision, the government will "'share in profits or losses resulting from inaccurate rate setting from 2014 to 2016.'" Fed. Cl. Op., 130 Fed. Cl. at 444 (quoting *HHS Notice of Benefit and Payment Parameters for 2014*, 77 Fed. Reg. 73,118, 73,121 (Dec. 7, 2012)). The risk corridors program was enacted as Section 1342 of the Affordable Care Act, and is codified in Section 18062 of Title 42. Subsection (a) is as follows:

> 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 [the Medicare Act].

42 U.S.C. § 18062(a). The statute contains a detailed formula for this risk corridors sharing of profits and losses. Healthcare insurers throughout the nation, including Moda Health Plan, accepted and fulfilled the new healthcare procedures, in collaboration with administration of the ACA by the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS).

Many health insurers soon experienced losses, attributed at least in part to a governmental action called the "transitional policy." Reassurance was presented, and Moda (and others) continued to perform their obligations. Although the government

continued to collect "payments in" from insurers who more accurately predicted risk, the government has declined to pay its required risk corridors amounts, by restricting the funds available for the "payments out."

The Court of Federal Claims held the government to its statutory and contractual obligations to Moda. My colleagues do not. I respectfully dissent.

The Court of Federal Claims interpreted the statute in accordance with its terms

The ACA provides the risk corridors formula, establishing that the insurer will make "payments in" to the government for the insurer's excess profits as calculated by the formula, and "payments out" from the government for the insurer's excess losses. The formula was enacted into statute:

> 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.

42 U.S.C. § 18062(b). In March 2012, HHS issued regulations for the risk corridors program, stating that Qualified Health Plans (QHPs) "will receive payment" or "must remit charges" depending on their gains or losses. 45 C.F.R. § 153.510(b), (c). In March 2013, HHS stated:

> 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.

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15473 (Mar. 11, 2013) (JA565). Moda cites this reassurance, as Moda continued to offer and implement healthcare policies in accordance with the Affordable Care Act.

The "transitional policy" resulted in a change in the risk profile of participants in the Affordable Care Act. Moda states that "many individuals who had previously passed medical underwriting, and were considerably healthier than the uninsured population, maintained their existing insurance and did not enroll in QHPs," Moda Br. 7–8, thereby reducing the amount of premiums collected from healthier persons. HHS stated, in announcing the transitional policy, that "the risk corridor program should help ameliorate unanticipated changes in premium revenue." Letter from Gary Cohen, Dir., CMS Ctr. for Consumer Info. and Ins. Oversight

("CCIIO"), to State Ins. Comm'rs at 3 (Nov. 14, 2013) (JA431).

The transitional policy was initially announced as applying only until October 1, 2014. *Id.* at 1 (JA429). However, it was renewed throughout the period here at issue. Memorandum from Kevin Counihan, Dir., CMS CCIIO (Feb. 29, 2016) (JA457).

The risk corridors obligations were not cancelled by the appropriations riders

In April 2014, HHS-CMS issued an "informal bulletin" stating, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall." Memorandum from CMS CCIIO, Risk Corridors and Budget Neutrality (Apr. 11, 2014) (JA229). HHS also stated "that the Affordable Care Act requires the Secretary to make full payments to issuers," and that it was "recording those amounts that remain unpaid . . . [as an] obligation of the United States Government for which full payment is required." Memorandum from CMS CCIIO, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) (JA245).

The issue on this appeal is focused on the interpretation and application of the "rider" that was attached to the omnibus annual appropriations bills. This rider prohibits HHS from using its funds, including its bulk appropriation, to make risk corridors payments. My colleagues hold that this

rider avoided or indefinitely postponed the government's risk corridors obligations. The Court of Federal Claims, receiving this argument from the United States, correctly discarded it.

Meanwhile, the risk corridors statute was not repealed or the payment regulations withdrawn, despite attempts in Congress. Moda continued to perform its obligations in accordance with its agreement with the CMS's administration of the Affordable Care Act.

A statute cannot be repealed or amended by inference

To change a statute, explicit legislative statement and action are required. Nor can governmental obligations be eliminated by simply restricting the funds that might be used to meet the obligation. The appropriation riders that prohibited the use of general HHS funds to pay the government's risk corridors obligations did not erase the obligations. The Court of Federal Claims correctly so held.

The mounting problems with the Affordable Care Act did not go unnoticed. In September 2014, the General Accountability Office (GAO) responded to an inquiry from Senator Jeff Sessions and Representative Fred Upton, and stated that "the CMS PM [Centers for Medicare Services-Program Management] appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1)." Letter from Susan A. Poling, GAO Gen. Counsel, to Sen. Jeff Sessions and Rep. Fred Upton 4 (Sept. 30, 2014) (JA237) ("Poling Letter"). The GAO also stated that "payments under

the risk corridors program are properly characterized as user fees" and could be used to make payments out. *Id.* at 6 (JA239). This review also cited the available recourse to the general CMS assessment. However, in December 2014, the appropriations bill for that fiscal year contained a rider that prohibited HHS from using various funds, including the CMS PM funds, for risk corridors payments. The rider stated:

> 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 [the ACA] (relating to risk corridors).

Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014). Similar riders were included in the omnibus appropriations bills for the ensuing years. As the Court of Federal Claims recited, by September 2016, after collecting all payments in for the 2015 year, it was clear that all payments in would be needed to cover 2014 losses, and that no payments out would be made for the 2015 plan year. Moda states: "The Government owed Moda $89,426,430 for 2014 and $133,951,163 for 2015, but only paid $14,254,303 for 2014 and nothing for 2015, leaving a $209,123,290 shortfall." Moda Br. 10.

The panel majority ratifies an "indefinite suspension" of payment, stating that this was properly achieved by cutting off the funds for payment. The majority correctly states that "the

government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation." Maj. Op. at 18. However, the majority then subverts its ruling, and holds that the government properly "indefinitely suspended" compliance with the statute.[2]

In *United States v. Will*, the Court explained that "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" 449 U.S. 200, 222 (1980) (citing *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). However, this intent to suspend or repeal the statute must be expressed: "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883).

"The cardinal rule is that repeals by implication are not favored." *Posadas v. Nat'l City Bank*, 296 U.S. 497, 503 (1936). "The doctrine disfavoring repeals by implication 'applies with full vigor when . . . the subsequent legislation is an *appropriations* measure,'" as here. *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978) (citing *Comm. for Nuclear Responsibility, Inc. v. Seaborg*, 463 F.2d 783, 785

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[2] The panel majority, responding to this dissent, states that it is not ratifying an indefinite suspension of payment. Maj. Op. at 25, n.6. However, payment has not been made, and the majority finds "the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." Maj. Op. at 32. Thus Moda, and the other participating insurers, have been forced into the courts.

(D.C. Cir. 1971)). As the Court of Federal Claims observed:

> Repealing an obligation of the United States is a serious matter, and burying a repeal in a standard appropriations bill would provide clever legislators with an end-run around the substantive debates that a repeal might precipitate.

Fed. Cl. Op., 130 Fed. Cl. at 458.

The classic case of *United States v. Langston*, 118 U.S. 389 (1886), speaks clearly, that the intent to repeal or modify legislation must be clearly stated, in "words that expressly or by clear implication modified or repealed the previous law." *Id.* at 394. The Court explained that a statute should not be deemed abrogated or suspended unless a subsequent enactment contains words that "expressly, or by clear implication, modified or repealed the previous law." *Id.*

My colleagues dispose of *Langston* as an "extreme example," stating that subsequent decisions are more useful since *Langston* is a "century and a half" old. Maj. Op. at 21–22. Indeed it is, and has stood the test of a century and a half of logic, citation, and compliance. Nonetheless discarding *Langston*, the panel majority finds intent to change the government's obligations under the risk corridors statute. The majority concludes that "Congress clearly indicated its intent" to change the government's obligations, reciting two factors:

First, the majority concludes that the appropriations riders were a response to the GAO's guidance that there were two available sources of funding for the risk corridors program, and that Congress intended to remove the GAO-suggested source of funds from the HHS-CMS program management funds. My colleagues find that, by removing access to the HHS-CMS funds, Congress stated its clear intent to amend the statute and abrogate the payment obligation if the payments in were insufficient. *See* Poling Letter at 4-6 (JA237-39). Maj. Op. at 24. However, they point to no statement in the legislative history suggesting that the rider was enacted in response to the GAO's report.

Next, my colleagues look to the remarks of Chairman Harold Rogers to discern intent. He stated:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014) (explanatory statement submitted by Rep. Rogers, Chairman of the House Comm. on Appropriations, regarding the House Amendment to the Senate Amendment on H.R. 83, the Consolidated and Further Continuing Appropriations Act, 2015). Chairman Rogers is referring to the April 2014

"guidance," where HHS stated that they "anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments." Memorandum from CMS CCIIO, Risk Corridors and Budget Neutrality (Apr. 11, 2014) (JA229). In that guidance, HHS was stating its understanding that "risk corridors collections [might be] insufficient to make risk corridors payments for a year." *Id.*

In 2014, a bill to require budget neutrality in the operation of the risk corridors program was introduced. Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). The proposed legislation sought to amend Section 1342(d) of the ACA to ensure budget neutrality of payments in and payments out. The bill stated:

> In implementing this section, the Secretary shall ensure that payments out and payments in under paragraphs (1) and (2) of subsection (b) are provided for in amounts that the Secretary determines are necessary to reduce to zero the cost . . . to the Federal Government of carrying out the program under this section.

Id. at § 2(d). The proposal, introduced by Senator Marco Rubio on April 7, 2014, was an effort to change the risk corridors program. The change was proposed, but not enacted, providing an indication of legislative intent.[3]

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[3] The panel majority argues that "we need not" consider Congress' refusal to enforce budget neutrality in the risk corridors program. Maj. Op. at 28. The Court has stated otherwise: "When the repeal of a highly significant law is urged

We have been directed to no statement of abrogation or amendment of the statute, no disclaimer by the government of its statutory and contractual commitments. However, the government has not complied with these commitments—leading to this litigation.

The standard is high for intent to cancel or amend a statute. The standard is not met by the words of the riders. "[T]he intention of the legislature to repeal must be clear and manifest." *Posadas*, 296 U.S. at 503. "In the absence of some affirmative showing of an intention to repeal, the only permissible justification for a repeal by implication is when the earlier and later statutes are irreconcilable." *Morton v. Mancari*, 417 U.S. 535, 550 (1974) (citing *Georgia v. Pennsylvania R.R. Co.*, 324 U.S. 439, 456–57 (1945)). Here, where there is no irreconcilable statute, repeal by implication is devoid of any support.

The panel majority does not suggest that intent to repeal can be found in the rider itself. Nor can intent be inferred from any evidence in the record. It is clear that Congress knew what intent would have looked like, because members of Congress tried, and failed, to achieve budget neutrality in the risk corridors program.

Instead, my colleagues hold that the statutory obligation was not repealed, but only "temporarily

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upon that body and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide by that decision." *Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union*, Loc. 770, 398 U.S. 235 (1970).

suspended." The unenacted text of the proposed "Bailout Act," reproduced *supra*, would have accomplished the result of budget neutrality that the majority finds was achieved by the riders. Congress' decision to forego this proposed repeal is highly probative of legislative intent.

Precedent does not deal favorably with repeal by implication—the other ground on which my colleagues rely. The panel majority relies heavily on *United States v. Vulte*, 233 U.S. 509 (1914). However, *Vulte* supports, rather than negates, the holding of the Court of Federal Claims. The facts are relevant: Lt. Vulte's pay as a lieutenant in the Marine Corps for service in Porto Rico was initially based on the Army's pay scale, and in 1902 Congress implemented a ten percent bonus for officers of his pay grade. In the appropriations acts for foreign service, for 1906 and 1907, Congress excluded officers serving in Porto Rico from receiving the bonus. In the act for 1908, the appropriations act continued the 10% bonus but did not mention an exclusion for service in Porto Rico. Lieutenant Vulte sought the bonus for 1908. The government argued that the 1906 and 1907 acts effectively repealed the 1902 bonus. The Court disagreed, and held that although the bonus was restricted for 1906 and 1907, the 1902 act was not repealed, and he was entitled to the 1908 bonus. *Id.* at 514.

The panel majority concludes that *Vulte* established a rule of "effective suspensions-by-appropriations." Maj. Op. at 26. That is not a valid conclusion. The Court held that, by altering the bonus for 1906 and 1907, Congress cannot have intended to effectuate a permanent repeal of the 1902

statute. *Vulte*, 233 U.S. at 514-15. And *Vulte* did not retroactively strip the officers of pay for duties they had performed while subject to the higher pay. On the question of whether an annual appropriations rider can permanently abrogate a statute, the *Vulte* Court stated:

> 'Nor ought such an intention on the part of the legislature to be presumed, unless it is expressed in the most clear and positive terms, and where the language admits of no other reasonable interpretation.' This follows naturally from the nature of appropriation bills, and the presumption hence arising is fortified by the rules of the Senate and House of Representatives.

Id. at 515 (quoting *Minis v. United States*, 40 U.S. 423, 445 (1841)). The panel majority's contrary position is not supported.

The panel majority also relies on *United States v. Mitchell*, 109 U.S. 146 (1883), to support the majority's ruling of "temporary suspension." Again, the case does not support the position taken by my colleagues. In *Mitchell* an appropriations act initially set the salaries of interpreters at $400 or $500. A subsequent appropriation, five years later, set "the appropriation for the annual pay of interpreters [at] $300 each, and a large sum was set apart for their additional compensation, to be distributed by the secretary of the interior at his discretion." *Id.* at 149. The Court stated, "[t]he whole question depends on the intention of congress as expressed in the statutes," *id.* at 150, and observed that the statute clearly stated the number of interpreters to be hired,

the salary for those interpreters, and the appropriation of an additional discretionary fund to cover additional compensation. *Id.* at 149.

The relevance of *Mitchell* is obscure, for the Court found the clear intent to change interpreters' pay for the subsequent years. There is no relation to the case at bar, where the majority holds that an appropriations rider can change the statutory obligation to compensate for past performance under an ongoing statute. However, *Mitchell* does reinforce the rule that repeal or suspension of a statute must be manifested by clearly stated intent to repeal or suspend. Also, like *Vulte*, the act that in *Mitchell* was "suspended" by a subsequent appropriation was itself an appropriation, not legislation incurring a statutory obligation. The appropriation rider in *Mitchell* simply modified an existing appropriation. In Moda's situation, however, the panel majority holds that the appropriation rider can suspend the authorizing legislation. No such intent can be found in the statute, as *Mitchell* requires and as the statute in that case provided.

The panel majority's theory is not supported by *Mitchell* and *Vulte*, for the statutes in both cases contain the clearly stated intent to modify existing appropriations. Moda's situation is more like that in *Langston*, where the Court stated:

> it is not probable that congress . . . should, at a subsequent date, make a permanent reduction of his salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel

> the courts to say that harmony between the old and the new statute was impossible.

Langston, 118 U.S. at 394. Similarly, it is not probable that Congress would abrogate its obligations under the risk corridors program, undermining a foundation of the Affordable Care Act, without stating its intention to do so. The appropriations riders did not state that the government would not and need not meet its statutory commitment.

Precedent supports the decision of the Court of Federal Claims

In *New York Airways, Inc. v. United States*, the Court of Claims held that the "mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." 369 F.2d 743, 748 (Ct. Cl. 1966) (citing *Vulte*, *supra*). The Civil Aeronautics Board had provided subsidies to helicopter carriers according to a statute whose appropriation provision stated:

> 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.

Id. at 749 (citing 78 Stat. 640, 642 (1964)). However, the appropriation cap was not sufficient to cover the statutory obligation. The Court of Claims held that the insufficient appropriation did not abrogate the government's obligations to make payments. The court stated that "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 817.

Precedent also illustrates the circumstances in which intent to repeal or suspend may validly be found. In *Dickerson*, Congress had in 1922 enacted a reenlistment bonus for members of the armed forces who reenlisted within three months. For each year between 1934 and 1937 an appropriations rider stated that the reenlistment bonus "is hereby suspended." *Dickerson*, 310 U.S. at 556. For fiscal year 1938, the appropriations rider did not contain the same language, but stated that:

> no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1939, shall be available for the payment' of any enlistment allowance for 'reenlistments made during the fiscal year ending June 30, 1939 . . . .'

Id. at 555. The rider in *Dickerson* cut off funding from all sources, stating "no part of any appropriation contained in this or any other Act . . . shall be available." *Id.* The Court held that the new language continued to suspend the bonus statute, for the words, and the accompanying Congressional Record, display

the clear intent to discontinue the bonus payment. The Record stated: "We have not paid [the enlistment bonus] for 5 years, and the latter part of this amendment now before the House is a Senate amendment which discontinues for another year the payment of the reenlistment allowances." 83 Cong. Rec. 9677 (1938) (statement of Rep. Woodrum). The Record and the statutory language left no doubt of congressional intent to continue the suspension of reenlistment bonuses. The panel majority recognizes that the Court in *Dickerson* found "persuasive evidence" of "Congress's intent to suspend the reenlistment bonus." Maj. Op. at 23.

In *United States v. Will*, the Court considered statutes setting the salary of government officials including federal judges. 449 U.S. at 202. In four consecutive years, appropriations statutes had held that these officials would not be entitled to the cost-of-living adjustments otherwise paid to government employees. The annual blocking statutes were in various terms. In one year, the statute stated that the cost-of-living increase "shall not take effect" for these officials. *Id.* at 222. For two additional years, the appropriations statutes barred the use of funds appropriated "by this Act or any other Act," as in *Dickerson*. *See Will*, 449 U.S. at 205-06, 207. The fourth year's appropriation contained similar language, stating that "funds available for payments . . . shall not be used." *Id.* at 208. In each year, the language stated the clear intent that federal funds not be used for these cost-of-living adjustments.

The panel majority finds support in *Will*, and states that "the Supreme Court never considered the impact of that language in *Dickerson* or *Will*." Maj.

Op. at 25. However, in *Dickerson* the Court twice repeated the "any other Act" language, *Dickerson*, 310 U.S. at 555, 556, in concluding that the language supported the intentional suspension. And in *Will*, the Court explicitly stated that the statutory language was "intended by Congress to block the increases the Adjustment Act otherwise would generate." *Will*, 449 U.S. at 223.

The Court found legislative intent clear in these cases. In contrast, the appropriations rider for risk corridors payments does not purport to change the government's statutory obligation, even as it withholds a source of funds for the statutory payment. My colleagues' ratification of some sort of permanent postponement denies the legislative commitment of the government and the contractual understanding between the insurer and HHS-CMS.

The riders cannot have retroactive effect after inducing participation

The creation of the risk corridors program as an inducement to the insurance industry to participate in the Affordable Care Act, and their responses and performance, negate any after-the-fact implication of repudiation of the government's obligations.

The government argued before the Court of Federal Claims that its obligations to insurers did not come due until the conclusion of the three year risk corridors program, and that "HHS has until the end of 2017 to pay Moda the full amount of its owed risk corridors payments, and Moda's claims are not yet ripe because payment is not yet due." Fed. Cl. Op.,

130 Fed. Cl. at 451. We have received no advice of payments made at the end of 2017 or thereafter.

The appropriations rider cannot have retroactive effect on obligations already incurred and performance already achieved. Retroactive effect is not available to "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed. If the statute would operate retroactively, our traditional presumption teaches that it does not govern absent clear congressional intent favoring such a result." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994). Such clear intent is here absent.

Removal of Moda's right to risk corridors payments would "impair rights a party possessed when [it] acted," a "disfavored" application of statutes, for "a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication." *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *United States v. St. Louis, S.F. & Tex. Ry. Co.*, 270 U.S. 1, 3 (1926)). Such premises are absent here.

Moda has recourse in the Judgment Fund

The Government does not argue that the Judgment Fund would not apply if judgment is entered against the United States, in accordance with Section 1491:

> The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States

> founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort.

28 U.S.C. § 1491.

The Judgment Fund is established "to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law when . . . payment is not otherwise provided for . . . ." 31 U.S.C. § 1304(a); *see also* 28 U.S.C. §2517 ("Except as provided by chapter 71 of title 41, every final judgment rendered by the United States Court of Federal Claims against the United States shall be paid out of any general appropriation therefor.").

The contract claim is also supported

The Court of Federal Claims also found that the risk corridors statute is binding contractually, for the insurers and the Medicare administrator entered into mutual commitments with respect to the conditions of performance of the Affordable Care Act. The Court of Federal Claims correctly concluded that an implied-in-fact contract existed between Moda and the government. I do not share my colleagues' conclusion that "Moda cannot state a contract claim." Maj. Op. at 35.

CONCLUSION

The government's ability to benefit from participation of private enterprise depends on the

government's reputation as a fair partner. By holding that the government can avoid its obligations after they have been incurred, by declining to appropriate funds to pay the bill and by dismissing the availability of judicial recourse, this court undermines the reliability of dealings with the government.

I respectfully dissent from the panel majority's holding that the government need not meet its statutory and contractual obligations established in the risk corridors program.

APPENDIX C

In the United States Court of Federal Claims
No. 16-744C

(Filed November 10, 2016)

* * * * * * * * * * * * * * *	) Claim by qualified
	) health insurance
LAND OF LINCOLN	) plan participating
MUTUAL HEALTH	) in a federally-run
INSURANCE	) state Exchange to
COMPANY,	) damages based
	) upon statutory or
Plaintiffs,	) regulatory
	) entitlement to
	) receive "risk-
	) corridors"
v.	) payments; Section
	) 1342 of the
UNITED STATES,	) Patient Protection
	) and Affordable
Defendant.	) Care Act, 42
	) U.S.C. § 18062; 45
	) C.F.R. § 153.510;
	) claims for
	) damages based
	) upon alleged
	) breach of an
	) express contract,
	) an implied-in-fact
	) contract, or an
	) implied covenant
	) of good faith and
	) fair dealing;
* * * * * * * * * * * * * * *	) takings claim

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OPINION AND ORDER

LETTOW, Judge.

Since 2014, Land of Lincoln Mutual Health Insurance Company ("Lincoln") has provided qualified health insurance plans in Illinois under the Patient Protection and Affordable Care Act ("the Affordable Care Act" or "the Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010). In this action, Lincoln seeks damages under Section 1342 of the Act, codified at 42 U.S.C. § 18062, which establishes and governs a temporary program of "risk corridors" applicable to calendar years 2014, 2015, and 2016, where qualifying health plans ("QHPs") participating on health insurance Exchanges pay money to or receive money from the Department of Health and Human

Services ("HHS"), depending upon the ratio of premiums received to claimed costs.[1]

Lincoln is an Illinois not-for-profit company with its headquarters in Chicago that served nearly 50,000 customers on the Illinois Health Insurance Marketplace in 2014, 2015, and part of 2016. Compl. ¶ 13.[2] Lincoln suffered losses in 2014 and 2015 and thus is deemed eligible to receive payment from HHS under the risk-corridors program. HHS paid Lincoln approximately 12.6% of the amount Lincoln is due for 2014, and nothing for 2015. Compl. ¶ 8. As a general matter, the payments HHS owes to qualified health plan issuers under the program exceed the fees received by HHS under the program, and HHS has stated that it will make payments only from fees collected, to the extent such fees are available, on a proportional basis to those owed payment.

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[1] The Act assigns HHS the responsibility for implementing many aspects of the Act. HHS delegates some of those responsibilities to the Centers for Medicare & Medicaid Services ("CMS"), including the responsibility to establish and administer the risk-corridors program. *See* Delegation of Authorities, 76 Fed. Reg. 53,903, 53,904 (Aug. 30, 2011). For purposes of this opinion, both HHS and CMS will be referred to as "HHS."

[2] Lincoln is a nonprofit issuer that provided health plans through the government's Consumer Operated and Oriented Plan program, which was intended to "foster the creation of qualified nonprofit health insurance issuers." *See* 42 U.S.C. § 18042(a); Pl.'s Mot. for Judgment on the Administrative Record and Mem. in Support ("Pl.'s Mot.") at 3, ECF No. 20. Nonetheless, as an Illinois health insurance provider, Lincoln must file its rates, along with other information, with the State of Illinois and receive approval from the State before it can issue health insurance. See 215 Ill. Comp. Stat. 5/355, 5/143 (2016).

Lincoln filed its complaint on June 23, 2016, alleging that it had a statutory and regulatory entitlement to the full amount of the payments due it under the program for 2014 and 2015, totaling at least $72,859,053, and that the full entitlement was and is due on an annual basis. Compl. ¶¶ 9, 77. Additionally, Lincoln alleges that the government's actions breached an express or implied-in-fact contract, breached the implied covenant of good faith and fair dealing, and contravened the Takings Clause of the Fifth Amendment. Compl. ¶ 1. Shortly after the complaint was filed, Lincoln requested "expedite[d] disposition of this action" because, among other things, it otherwise lacked funds to survive as a continuing entity. Pl.'s Mot. for an Early Pretrial Conference Pursuant to Rule 16(a) at 1 (July 26, 2016), ECF No. 7. In that regard, Lincoln advised that "the State of Illinois Director of Insurance has obtained an Order of Rehabilitation against Lincoln dated July 14, 2016." *Id.* at 2. Absent an infusion of funds by September 30, 2016, the health insurance Lincoln was providing to citizens of Illinois would have to be cancelled. *Id.* Promptly thereafter, the court held a status conference with the parties, and, because the case involves a claim of statutory and regulatory entitlement, the court requested the government to file the administrative record of its regulations and its actions respecting Lincoln. *See* Hr'g Tr. 32:1-2 (Aug. 12, 2016). The court set an accelerated schedule for submission and briefing of potentially dispositive motions and calendared an early hearing. *See* Scheduling Order (Aug. 12, 2016), ECF No. 12. With one subsequent adjustment to the schedule, *see* Amended Scheduling Order (Oct. 18,

2016), ECF No. 36, the parties have followed this procedural path.

BACKGROUND

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119, to expand individual health insurance coverage. The Act requires health insurance providers offering health insurance in a particular state to accept all individuals and qualified employers applying for coverage in that state, subject to certain restrictions. 42 U.S.C. § 300gg-1(a). Further, the Act prohibits insurance providers from setting premiums based upon a particular person's health. *See King v. Burwell*, __ U.S., __, __, 135 S. Ct. 2480, 2486 (2015) (citing 42 U.S.C. § 300gg); *see also* 45 C.F.R. §§ 147.108-116.

Additionally, the Act establishes health insurance "Exchanges," *i.e.*, marketplaces within each state where individuals and qualified employers can purchase health insurance. *See* 42 U.S.C. § 18031. The Act provides that each individual state may administer its respective Exchange if it elects to do so, or, if the state elects not to establish an Exchange, "the Secretary shall . . . establish and operate such Exchange within the [s]tate." 42 U.S.C. § 18041(c)(1). Health insurance providers wishing to offer insurance coverage on an Exchange can only do so if they offer a "qualified health plan," which is defined within the Act and the implementing regulations. *See* 42 U.S.C. §§ 18021, 18031(b)(1)(A); 45 C.F.R. § 155.20. The Act requires insurers participating on the Exchanges to, among other requirements, be certified as qualified

health plans. *See* 42 U.S.C. § 18031(d)(4)(A), (e); 45 C.F.R. § 155.20.

A. The Risk-Corridors Program

Because the Act enabled health insurance coverage to be made available to many individuals who were previously underinsured or uninsured, Lincoln alleges that health insurance providers "had no previous experience or reliable data to meaningfully assess the risks and set the premiums for this new population of insureds." Compl. ¶ 4. Recognizing this uncertainty, Congress established three stabilization programs, *see* 42 U.S.C. §§ 18061-18063, to mitigate the uncertainty and pricing risks for insurers, which programs have become commonly known as "reinsurance," "risk corridors," and "risk adjustment," respectively. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013), AR 1807;[3] Def.'s Mot. to Dismiss and Mot. for Judgment on the Administrative Record on Count I ("Def.'s Mot.") at 6, ECF No. 22. The risk-corridors program established under Section 1342 of the Act, which is the stabilization program pertinent to Lincoln's claims, was designed to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,411, AR 1807. The risk-corridors program is a three-year temporary program that pertains to the calendar years of 2014, 2015, and

[3] "AR_ " refers to the administrative record certified by HHS and filed with this court in compliance with Rule 52.1(a) of the Rules of the Court of Federal Claims ("RCFC").

2016. 42 U.S.C. § 18062(a). It applies only to qualified health plans offered through an Exchange. *Id.*; *see* 45 C.F.R. § 153.510.[4] The program was "based on" a similar program enacted under Part D of Title XVIII of the Social Security Act. 42 U.S.C. § 18062(a) (referring to Pub. L. No. 108-173, 117 Stat. 2066 (2003) (codified at 42 U.S.C. §§ 1395w-101 *et seq.*) ("the Medicare Program")).

The risk-corridors program calls upon HHS to provide a mechanism to even out the losses and gains of qualified health plans during the three-year phase-in period. *See* 42 U.S.C. § 18062(b); 45 C.F.R. § 153.510. When a qualified health plan issuer experiences a loss in a calendar year, such that the plan's "allowable costs" are more than 103 percent of the plan's "target amount" for that year, HHS is directed to pay the issuer a portion of that loss. 42 U.S.C. § 18062(b)(1); 45 C.F.R. § 153.510(b). Correlatively, when the issuer experiences a gain in a calendar year, such that the plan's "allowable costs" are less than 97 percent of the plan's "target amount" for that year, the issuer is directed to pay the HHS a certain amount of that gain. 42 U.S.C. § 18062(b)(2); 45 C.F.R. § 153.510(c). The "[p]ayments out" and "[p]ayments in" are specified by statute as follows:

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[4] If a health insurer chooses not to offer coverage through an Exchange, then it is not subject to the risk-corridors program. *See* 45 C.F.R Part 155 ("Exchange Establishment Standards and Other Related Standards under the Affordable Care Act"), Subpart K ("Exchange Functions: Certification of Qualified Health Plans"), § 155.1000(b) ("The Exchange must offer only health plans which have in effect a certification issued or are recognized as plans deemed certified for participation in an Exchange as a QHP, unless specifically provided for otherwise.").

(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.

42 U.S.C. § 18062(b).[5] Allowable costs include the costs incurred by the qualified health plan in

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[5] The HHS regulations implementing the payment-out methodology set forth "substantially similar terms" to those set out in the statute. Def.'s Mot. at 7 (citing 45 C.F.R. § 153.510(b)-(c)). As HHS explained:

> For example, a [qualified health plan] has a target amount of $10 million, and the [qualified health plan] has allowable costs of $10.5 million, or 105 percent of the target amount. Since 103 percent of the target amount would equal $10.3 million, the amount of allowable costs that exceed 103 percent of the target amount is $200,000. Therefore, HHS would pay 50 percent of that amount, or $100,000 to the [qualified health plan] issuer.

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,943 (July 15, 2011), AR 11295. And further:

> For example, a [qualified health plan] has a target amount of $10 million. The [qualified health plan] has allowable costs of $11.5 million, or 115 percent of the target amount. Since 108 percent of the target amount would be $10.8 million, the amount of allowable costs that exceed 108 percent of the target amount is

providing benefits under the plan, other than administrative costs. 42 U.S.C. § 18062(c)(1)(A).[6] The target amount consists of the total amount of premiums received under the plan, reduced by any administrative costs. 42 U.S.C. § 18062(c)(2).[7]

> $700,000. Therefore, HHS pays 2.5 percent of the target amount, or $250,000, plus 80 percent of $700,000, or $560,000, for a total of $810,000.

Id.

The regulations follow the Act in setting forth the obverse methodology when a qualified health plan issuer reports gains in a calendar year, but the issuer is required to make payments rather than receive payments. The issuer is required to pay HHS under the same formulas, but the allowable cost-to-target amount ratios are 97 and 92 percent, rather than 103 and 108 percent. *See* 45 C.F.R. § 153.510(b), (c).

[6] Allowable costs are also reduced by "any risk adjustment and reinsurance payments received" by the qualified health plan issuer under Sections 1341 and 1343 of the Act. 42 U.S.C. § 18062(c)(1)(B).

[7] HHS had no direct role in the premiums Lincoln charged for its health insurance coverage, either for individuals or for small groups. Hr'g Tr. 47:4-8 (Nov. 7. 2016) ("HHS has no legal say in what any QHP charges in its premiums.") (The date will be omitted from subsequent citations to the transcript of the hearing held on Nov. 7, 2016.). Rather, by providing coverage (and participating on the federally-run Exchange for Illinois), Lincoln agreed to offer qualifying plans (*e.g.*, platinum, gold, silver, bronze) and to accept applications notwithstanding pre-existing conditions. Hr'g Tr. 47:12 to 48:19; *see also* 42 U.S.C. § 18022(d) (levels of coverage). The premium rates for those plans were subject to regulation by the State of Illinois' Department of Insurance. *See supra*, at 2 n. 2; Hr'g Tr. 47:5-8.

Federal law and regulations require plans seeking premium increases to provide justification for the increases and to post the justification on the issuers' website. *See* 42 U.S.C. § 18031(e)(2); 45 C.F.R. § 155.1020. The regulations require consideration of

The Act does not include a time limit by which payments must be made to, or received from, HHS, *see* 42 U.S.C. § 18062, but the implementing regulations do include a deadline for when qualified health plan issuers must pay HHS. If a qualified health plan's allowable costs are sufficiently below the target amount such that the issuer is required to make payments to HHS, the issuer must do so "within 30 days after notification of such charges." 45 C.F.R. § 153.510(d). In March 2012, before HHS implemented this regulation, HHS noted that it had considered a 30-day deadline for paying qualified health plan issuers because "issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and [qualified health plan] issuers." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,238 (Mar. 23, 2012), AR 969. Even so, this deadline was only considered by HHS; it was not included in the proposed or final rule. *Id.* And, the implementing regulation did not refer to any time limit for HHS to make payments. *See* 45 C.F.R. § 153.510. Instead, HHS explained through a guidance bulletin issued on April 11, 2014, that if it failed to make sufficient payments for 2014, it would use the program's collected fees from 2015, and then 2016 if necessary, to satisfy amounts due. CMS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014), AR 108-09. HHS explained that it would be administering the risk-corridors payments "over the three-year life of the program, rather than annually."

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specified factors in determining rate increases. 45 C.F.R. § 155.1020(b); *see also* Hr'g Tr. 13:22 to 14:25. An Exchange can take the justification into account in deciding whether to make a plan available through the Exchange. 42 U.S.C. § 18031(e)(2).

Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014), AR 6195.

B. Funding of the Risk-Corridors Program

Paragraphs 1342(b)(1) and (2) of the Act provide that HHS "shall pay" and plans "shall pay" amounts due out and due in under the payment methodology described in Subsection 1342(b), but the Subsection is otherwise silent regarding deficits or excess funds under the risk-corridors program. *See* 42 U.S.C. § 18062(b); Def.'s Mot. at 8 ("Congress did not include in the [Act] either an appropriation or an authorization of finding for risk corridors."). The Government Accountability Office ("GAO") reached this same conclusion in 2014 in response to a congressional inquiry. *See* The Honorable Jeff Sessions, the Honorable Fred Upton, B-325630, 2014 WL 4825237, at *2 (Comp. Gen. Sept. 30, 2014), AR 116 ("Section 1342, by its terms, did not enact an appropriation to make the payments specified in [S]ection 1342(b)(1).") ("*GAO Op.*").[8] Similarly, the

[8] GAO drew upon its prior appropriation precedents for its reasoning:

> At issue here is whether appropriations are available to the Secretary of HHS to make the payments specified in section 1342(b)(1). Agencies may incur obligations and make expenditures only as permitted by an appropriation. U.S. Const., art. 1, § 9, cl. 7; 31 U.S.C. § 1341(a)(1); B-300192, Nov. 13, 2002, at 5. Appropriations may be provided through annual appropriations acts as well as through permanent legislation. *See e.g.*, 63 Comp. Gen. 331 (1984). *The making of an appropriation must be expressly stated in law.* 31 U.S.C. § 1301(d). *It is not enough for a statute to simply require an agency to make a payment.* B-

implementing regulation states that qualified health plans will receive payments from HHS without any reference to any source of funding or appropriations apart from the "payments in." *See* 45 C.F.R. § 153.510(b).

On July 15, 2011, HHS noted in a proposed rule that prior to enactment of the Affordable Care Act, the Congressional Budget Office ("CBO") analyzed the estimated costs that would be attributable to passage, but "did not score the impact of risk corridors," under the assumption that "collections would equal payments to plans in the aggregate." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. at 41,948, AR 11300; *see* Letter from Douglas W. Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, U.S. House of Representatives, Table 2 (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf ("March 2010 CBO Letter") (providing an estimate of the spending and revenue impact for the Act's two other stabilization programs, reinsurance and risk adjustment, but not for the risk-corridors program). Despite this budget-scoring circumstance and the lack of specific authorization for appropriations, on March 11, 2013, HHS stated in adopting a final rule that "[t]he risk corridors

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> 114808, Aug. 7, 1979. Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1). In such cases, we next determine whether there are other appropriations available to an agency for this purpose.

GAO Op., 2014 WL 4825237, at *2, AR 116 (emphasis added).

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 . . . ." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,473, AR 1869. Then, one year later, HHS issued a final rule stating that the risk-corridors program would be implemented "in a budget neutral manner," while also noting the possibility of "future adjustments . . . to the extent necessary." HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014), AR 4929.

In its guidance of April 11, 2014, HHS explained that under the budget-neutral criterion for administration of the program, fees collected by HHS through the program would be the only funds used to pay the qualified health plans eligible for payment. *Risk Corridors and Budget Neutrality*, AR 108; *see* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014) (noting that budget neutral means "the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect"). Thus, qualified health plans with allowable costs less than 97 percent of the target amount for the year would supply the funds used to pay qualified health plans with allowable costs greater than 103 percent of the target amount for the year. In its guidance of April 2014, HHS went on to state:

> [I]f risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment

> reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.

Risk Corridors and Budget Neutrality, AR 108. HHS has adhered to this budget-neutral implementation in subsequent rules and guidance. *See e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015), AR 8153.

In establishing this payment plan, HHS recognized the "unlikely" possibility that HHS would not receive sufficient collection fees to make all necessary payments for the 2016 calendar year, the final year of the program. HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,779, AR 8153. If such a situation did occur, however, HHS stated it would "use other sources of funding for the risk corridors payments, subject to the availability of appropriations." *Id.*

In September 2014, GAO responded to a congressional inquiry by finding that HHS, and more specifically CMS, was permitted to draw from its general lump-sum 2014 program-management appropriation of $3.6 billion to make payments under the risk-corridors program. *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-20.[9] GAO nonetheless noted

[9] The parties have reported that CMS's program-management appropriation for 2014 was spent. Hr'g Tr. 8:8-19.

that for general funds to be available in 2015, the year HHS had stated it would begin making risk-corridors payments, the 2015 CMS appropriation would have to "include language similar to the language" in the 2014 CMS appropriation. *Id.* at *5, AR 120.[10] Shortly thereafter, in December 2014, Congress enacted the Consolidated and Further Continuing Appropriations

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[10] The appropriation for 2014 specifically provided:

> For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019.

Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, Div. H, Title II, 128 Stat. 5, 374 (2014). GAO found that the appropriation "made funds available to CMS to carry out its responsibilities, which, with the enactment of [S]ection 1342, include the risk corridors program." *GAO Op.*, 2014 WL 4825237, at *3, AR 117.

Notably, the Consolidated Appropriations Act, 2014, allowed "such sums as may be collected from authorized user fees and the sale of data" to "remain available until September 30, 2019." Pub. L. No. 113-76, Div. H, Title II, 128 Stat. 374. To be subject to that limited continuing authorization, however, the user fees had to be collected in fiscal year 2014. *See* Hr'g Tr. 56:23 to 58:25.

Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014), which differed from the 2014 appropriation act by explicitly prohibiting HHS from using any of its lump-sum appropriation for payments under the risk-corridors program in the 2015 fiscal year.[11] An identical provision appeared in the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015), for the 2016 fiscal year.

In these circumstances, HHS has acknowledged its statutory obligation to make full payments to qualifying health plan issuers under Section 1342, subject to the availability of funds. *See* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. at 10,779, AR 8153 (noting that CMS would draw upon "risk corridors collections" and might be able to "use other sources of funding for the risk corridors payments, subject to the availability of

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[11] The 2015 Appropriations Act specifically stated:

> 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).

Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014).

appropriations"); Def.'s Mot. App. at A47 (CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016)) (same).[12]

C. Lincoln is a Qualified Health Plan Issuer That Has Not Yet Received All Payments Owed to It Under the Risk-Corridors Program

In September 2013, Lincoln sought to become a qualified health plan issuer and entered into an agreement with HHS, acting through CMS. Compl. ¶¶ 35-36, Ex. 2. The agreement remained valid until December 31, 2014. Compl. Ex. 2, Section III.a. Lincoln entered into similar agreements with "materially and substantially identical" terms for the calendar years of 2015 and 2016. Compl. ¶¶41, 45, Exs. 3-4.[13] Each agreement provides that the qualified health plan issuer will abide by certain standards when using "CMS Data Services Hub Web Services," such as performing certain testing and

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[12] Like plaintiff's motion, defendant's motion is accompanied by a sequentially paginated appendix, but one that consists of only two documents, *viz.*, CMS's "Standard Companion Guide Transaction Information[:] Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally [F]acilitated Exchange (FFE)[- -] Comparison Guide Version Number: 1.5[,] March 22, 2013," Def.'s Mot. App. at Al-A46, and a memorandum from CMS dated September 9, 2016 styled "Risk Corridors Payments for 2015," *id.* at A47-A48. The index to the appendix notes that this memorandum is incorrectly dated September 9, 2015.

[13] Notably, the title of the agreement changed from "Agreement Between Qualified Health Plan Issuer and [CMS]" in 2014 to "Qualified Health Plan Certification Agreement and Privacy and Security Agreement Between Qualified Health Plan Issuer and [CMS]" in the 2015 and 2016 agreements. *See* Compl. Exs. 2, 3, 4.

formatting transactions appropriately. Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. Each agreement also states that "CMS will recoup or net payments due" to the qualified health plan issuer with respect to the "payment of [f]ederally-facilitated Exchange user fees." Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b.

Thus, Lincoln was certified as a qualified health plan issuer under the risk-corridors program for the calendar years of 2014, 2015, and 2016. Lincoln alleges that it relied upon the protections offered by the risk-corridors program when it agreed to become a qualified health plan issuer, and that it set premiums for its qualified health plans at lower rates than it otherwise would have if the program had not been in place. Compl. ¶ 28; Pl.'s Mot. at 5; *cf.* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,413, AR 1809 ("The risk corridors program will protect [qualified health plan] issuers . . . against inaccurate rate setting and will permit issuers to lower rates . . . .").

Lincoln suffered losses in 2014, and as a result Lincoln was due $4,492,243.80 for 2014 under the risk-corridors program's payment methodology. AR 270. In October 2015, however, HHS announced that it received $362 million in fees under the risk-corridors program, but owed $2.87 billion in payments. CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), AR 1254. Due to the budget-neutral criterion, HHS paid qualified health plan issuers 12.6% of the payments they were owed. *Id.* As a result, HHS paid Lincoln $566,825.32, but still owes Lincoln $3,925,418.48 in risk-corridors payments for 2014. AR 270; Pl.'s Mot. at 7. HHS

explained that it will pay the remainder of the 2014 payments with fees collected from the 2015 risk-corridors program, and the 2016 program if necessary. AR 293.

Lincoln also claims that it is entitled to $71,833,251 from HHS under the risk-corridors program for losses Lincoln suffered in 2015. Pl.'s Mot. at 7-8 & App. 8 at A56 to A59.[14] HHS has not announced final collections and payments for 2015, but HHS stated in September 2015 that it anticipates "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." Def.'s Mot. App. at A47. HHS has since indicated that it plans to begin making further payments for 2014 in December 2016, but it has not yet specified the amount of fees it collected in 2015. *See* AR 1498; Def.'s Mot. at 13-14.

D. Lincoln's Action in This Court

Lincoln filed this action on June 23, 2016. It alleges that it is entitled to damages from the government on the grounds that the government violated its risk-corridors "payment obligations" under Section 1342 of the Act and the implementing federal regulations (Count I), breached an express contract or, alternatively, an implied-in-fact contract (Counts II, III), breached the implied covenant of good faith and fair dealing (Count IV), and contravened the Fifth Amendment by taking Lincoln's property for

[14] In 2015, Lincoln's experience deteriorated to the point that its adjusted risk-corridors ratio for individual coverage was 183.5% and that for small-group coverage was 177.7% Pl.'s Mot. App. 8 at A59, far removed from the target amounts.

public use without just compensation (Count V). *See generally* Compl. Lincoln demands $75,758,669.48 from the government for payments Lincoln is allegedly owed to date under the risk-corridors program, consisting of $3,925,418.48 for 2014 and $71,833,251 for 2015. Pl.'s Mot. at 2.[15] Lincoln additionally requests that the court require the government to fulfill its risk-corridors payment obligations for 2015 and 2016 within 30 days of determining payments owed. Compl. at 45.

On September 23, 2016, Lincoln filed a motion for judgment on the administrative record, and the government filed a motion to dismiss Lincoln's claims and a motion for judgment on the administrative record with respect to Count I. *See generally* Pl.'s Mot.; Def.'s Mot. The government argues that the court should dismiss Lincoln's claims for lack of jurisdiction pursuant to RCFC 12(b)(1), or, alternatively, that it is entitled to judgment on the administrative record under Count I and that the court should dismiss Counts II, III, IV, and V for failure to state a claim pursuant to RCFC 12(b)(6). *See generally* Def.'s Mot. Lincoln opposed the government's motion and filed a cross-motion for judgment on the administrative record with respect to Counts II-V, *see* Pl.'s Resp. in Opp'n to Def.'s Mot. to Dismiss and Mot. for Judgment on the Administrative Record and Cross-Mot. for Judgment on the

[15] Lincoln requested an amount of "at least $72,859,053" when it filed its complaint in June 2016, Compl. At 44-45, but Lincoln subsequently adjusted that figure in September 2016 to reflect Lincoln's final 2015 cost. *See* Pl.'s Mot. at 2; Pl.'s Reply in Support of Mot. for Judgment on the Administrative Record ("Pl.'s Reply") at 6 n.4, ECF No. 37.

Administrative Record on Counts II-V ("Pl.'s Resp. and Cross Mot"), ECF No. 29, which the government opposed, *see* Def.'s Opp'n to Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V ("Def.'s Opp'n to Pl.'s Cross Mot"), ECF No. 43. The competing motions were addressed at a hearing held on November 7, 2016.

JURISDICTION

A. The Court Has Subject Matter Jurisdiction Over Lincoln's Claims for Money Damages, but Not Over Lincoln's Request for Declaratory Relief

1. Claim for money damages under Section 1342 and the implementing regulations.

As plaintiff, Lincoln has the burden of establishing jurisdiction. *See Reynolds v. Army & Air Force Exch. Serv.*, 846 F.2d 746, 748 (Fed. Cir. 1988). Under the Tucker Act, this court has jurisdiction "to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491(a)(1). The Tucker Act waives sovereign immunity, which allows a plaintiff to sue the United States for money damages. *United States v. Mitchell*, 463 U.S. 206, 212 (1983). It does not, however provide a plaintiff with any substantive rights. *United States v. Testan*, 424 U.S. 392, 398 (1976). Rather, to establish jurisdiction, "a plaintiff must identify a separate source of substantive law that creates the right to money damages." *Fisher v.*

United States, 402 F.3d 1167, 1172 (Fed. Cir. 2005) (en banc in relevant part) (citing *Mitchell*, 463 U.S. at 216; *Testan*, 424 U.S. at 398); *Jan's Helicopter Serv., Inc. v. Federal Aviation Admin.*, 525 F.3d 1299, 1309 (Fed. Cir. 2008) (noting that the source of substantive law must be "money-mandating" to support jurisdiction under the Tucker Act). This jurisdictional inquiry is separate from the merits of the case and "does not require a determination that the plaintiff has a claim on the merits." *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 875 (Fed. Cir. 2007); *see also Engage Learning, Inc. v. Salazar*, 660 F.3d 1346, 1353 (Fed. Cir. 2011) ("We have held that jurisdiction under [the Contract Disputes Act, 41 U.S.C. § 7102(a), like the Tucker Act,] requires no more than a non-frivolous *allegation* of a contract with the government.") (emphasis in original) (citations omitted); *Jan's Helicopter Serv.*, 525 F.3d at 1309 ("There is no further jurisdictional requirement that the court determine whether the additional allegations of the complaint state a nonfrivolous claim on the merits.").

In short, the court will have jurisdiction when a plaintiff invokes a money-mandating source and makes a "non-frivolous assertion" that the plaintiff is entitled to relief under that source. *Jan's Helicopter Serv.*, 525 F.3d at 1307 n.8; *Greenlee Cnty.*, 487 F.3d at 876-77 (citations omitted). A source is money-mandating when "it can fairly be interpreted as mandating compensation" by the government. *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472 (2003) (citing *Mitchell*, 463 U.S. at 217). Under this standard, a source will be money-mandating when it is "reasonably amenable to the reading that it mandates a right of recovery in

damages." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 19 (2011) (quoting *White Mountain Apache Tribe*, 537 U.S. at 473). In contrast, a source is not money-mandating when it provides the government with "complete discretion" regarding whether it will make payments. *Doe v. United States*, 463 F.3d 1314, 1324 (Fed. Cir. 2006) (citations omitted); *see ARRA Energy Co. I*, 97 Fed. Cl. at 19 (noting that the determination of whether a source is money-mandating "generally turns on whether the government has discretion to refuse to make payments under that [source]").

While the word "may" in a statute creates a presumption of government discretion, *Doe*, 463 F.3d at 1324 (citing *McBryde v. United States*, 299 F.3d 1357, 1362 (Fed. Cir. 2002)), the Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cnty.*, 487 F.3d at 877 (quoting *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). For example, in *Agwiak*, the Federal Circuit found that a statute and its implementing regulations were money-mandating because both stated that certain employees "shall be paid" by the government. 347 F.3d at 1380; *see also Greenlee Cnty.*, 487 F.3d at 877 (finding that the relevant statute was "reasonably amenable" to a money-mandating interpretation because it provided that "the Secretary of the Interior shall make a payment . . ."); *Lummi Tribe of the Lummi Reservation v. United States*, 99 Fed. Cl. 584, 594 (2011) (finding a statute to be money-mandating because the use of the word "shall" bound the government "to pay a qualifying tribe the amount to which it is entitled under the [statutory] formula"). Even if the word "shall" is not present, a statute can

still be money-mandating when the government is required to make payments after certain statutory requirements are met. *See Fisher*, 402 F.3d at 1174-75; *see also United States v. Larionoff*, 431 U.S. 864, 869 (1977) (construing and applying a statute providing a reenlistment bonus for active duty soldiers); *Laughlin v. United States*, 124 Fed. Cl. 374, 383-85 (2015) (addressing a statute governing the Dental Office Multiyear Retention Bonus applicable to the military), *appeal filed*, No. 16-1627 (Fed. Cir.) (to be argued Dec. 8, 2016); *Hale v. United States*, 107 Fed. Cl. 339, 345-46 (2012) (applying statutes providing military service members with special and incentive bonuses), *aff'd*, 497 Fed. Appx. 43 (Fed. Cir. 2013).

Here, Section 1342 of the Act provides that when a qualified health plan's allowable costs exceed the target amount by more than 103 percent, "the Secretary *shall* pay to the plan" an amount set forth in Section 1342, depending on whether the costs exceed the target amount by more than 103 or 108 percent. 42 U.S.C. § 18062(b)(1) (emphasis added). Further, the implementing regulation states that qualified health plan issuers "will receive payment from HHS" under the criteria and formulas described in Section 1342. 45 C.F.R. § 153.510(b). Neither the statute nor the regulation use the word "may" or provide any indication that HHS has discretion to refuse risk-corridors payments if funds are available. Regardless of whether the program is budget neutral or whether full payments are required annually, which topics are addressed *infra*, it is evident that HHS is obliged to make payments to qualified health plans when certain criteria are satisfied and funds are available. HHS has acknowledged this requirement.

See, e.g., Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). Thus, Section 1342 and the implementing regulation are money-mandating sources of law.

Nonetheless, the government argues that the court does not have jurisdiction over Lincoln's claims because the payments that HHS owes are not "presently due." Def.'s Mot. at 16. To support its argument, the government cites *Todd v. United States*, where the Federal Circuit held that this court has jurisdiction under the Tucker Act only when the money damages are "actual" and "presently due." 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (quoting *Testan*, 424 U.S. at 398 (in turn quoting *United States v. King*, 395 U.S. 1, 3 (1969))). This court has found jurisdiction lacking under the "presently due" standard when, for example, a plaintiff brought suit against the government to receive a lump sum set forth in a settlement agreement between the two parties, but the agreement provided for periodic payments. See *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 179-80 (2009). Because the government was current on its periodic payments and further payments were not presently due, the plaintiff was not entitled to bring suit for the entire sum. *Id.* The government contends that a similar analysis applies to Lincoln's claims because HHS has established a three-year framework and payments under the risk-corridors programs will not be due until the end of the program in 2016, to the extent funds are available, even for losses that qualified health plans incurred in 2014 and 2015. Def.'s Mot.

at 16-17. The government argues that the "fair inference" standard, discussed *supra*, must be analyzed in conjunction with this "presently due" requirement. *See* Def.'s Opp'n to Pl.'s Mot. for Judgment on the Administrative Record ("Def.'s Opp'n to Pl.'s Mot.") at 11, ECF No. 30.

The government's argument reaches too far. The court's jurisdictional analysis differs depending on whether the plaintiff relies on a money-mandating statute. *See Bevevino v. United States*, 87 Fed. Cl. 397, 408 (2009) (noting that the Federal Circuit has "distinguished cases brought under money-mandating statutes, and those brought under statutes that are not money-mandating") (citing *Dysart v. United States*, 369 F.3d 1303, 1315 n.9 (Fed. Cir. 2004)); *Speed v. United States*, 97 Fed. Cl. 58, 66-68 (2011) (distinguishing between the jurisdictional analysis for claims arising out of a money-mandating statute and claims arising out of a contract). The cases upon which the government relies, such as *Todd* and *Annuity Transfers*, relate to allegations based upon contracts, rather than money-mandating statutes. *See Todd*, 386 F.3d at 1094; *Annuity Transfers*, 86 Fed. Cl. at 179-80. In rejecting the government's jurisdictional challenge, the court in *Bevevino* explained that the government's reliance on *Todd* was "misplaced" because the claims in *Todd* were premised on contractual obligations, whereas the claims in *Bevevino* were based upon a money-mandating statute. 87 Fed. Cl. at 407-08. Similarly, Lincoln's claim in Count I is based upon Section 1342 of the Act and its implementing regulation, which can be fairly interpreted as money-mandating sources of law. Thus, the court has jurisdiction over Lincoln's claim. In this instance, the government concedes that

at least *some* money was due and more may be due shortly, even though all of Lincoln's claimed amounts might not be payable on a current basis.[16]

2. Claims for money damages under an express contract or, alternatively, an implied-in-fact contract theory.

This court has jurisdiction "to render judgment upon any claim against the United States founded . . . upon any express or implied contract with the United States." 28 U.S.C. § 1491(a)(1). Thus, as discussed *supra*, a contract can serve as the substantive source

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[16] The government embellishes its contention that the court lacks jurisdiction over Count I by referring to HHS's three-year framework for applying "payments in" and "payments out," urging that no further payments for 2014 are now due, and averring that the "presently due" standard consequently has not been satisfied. As the government would have it, the decision by HHS to apply a three-year framework is entitled to deference under *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). *See* Def.'s Mot. at 17-18; Hr'g Tr. 70:6-9. This argument is misplaced. The government's argument addresses the merits of whether and when Lincoln is entitled to recover money under the statute, which does not correspond to the jurisdictional inquiry of whether the statute itself is money-mandating. *See Greenlee Cnty.*, 487 F.3d at 876 (explaining that the money-mandating analysis only requires the court to ask "whether the plaintiff is within the class of plaintiffs entitled to recover under the statute if the elements of a cause of action are established") (citing *Fisher*, 402 F.3d at 1172-73). The *Chevron* prongs apply to the merits of the case, as discussed *infra*. *See generally Adair v. United States*, 497 F.3d 1244 (Fed. Cir. 2007) (applying the "reasonably amendable" standard without reference to *Chevron* deference in finding jurisdiction through a money-mandating source of law, and then applying a *Chevron* analysis to the merits of the case); *Sharp v. United States*, 80 Fed. Cl. 422, 427 (2008) (same).

for a plaintiff's claim to monetary relief under the Tucker Act. *See Speed*, 97 Fed. Cl. at 64 (citing *Ransom v. United States*, 900 F.2d 242, 244 (Fed. Cir. 1990)).

Similar to the court's jurisdictional analysis of Lincoln's claim based upon Section 1342, the merits of Lincoln's contract claims must be separated from the court's assessment of its power to rule on these claims. *See Engage Learning*, 660 F.3d at 1353-54. The court has jurisdiction over express and implied contract claims as long as a plaintiff makes a "non-frivolous allegation of a contract with the government." *Id.* (citing *Lewis v. United States*, 70 F.3d 597, 602, 604 (Fed. Cir. 1995); *Gould, Inc. v. United States*, 67 F.3d 925, 929-30 (Fed. Cir. 1995)). However, the claim must still be for "actual, presently due money damages." *Speed*, 97 Fed. Cl. at 66 (citing *King*, 395 U.S. at 3).

Here, Lincoln seeks risk-corridors payments of $3,925,418.48 for 2014 and $71,833,251 for 2015. Pl.'s Mot. at 2. Lincoln argues that it is entitled to these payments under an express contract theory because prior to each year of the risk-corridors program Lincoln offered a qualified health plan, and it allegedly entered into written agreements with HHS that allegedly required HHS to make full payment for the upcoming year. *See* Compl. ¶¶ 166-78; Pl.'s Resp. and Cross-Mot. at 31-35, 39-43. Alternatively, Lincoln argues that the course of conduct between the government and Lincoln gave rise to an implied-in-fact contract that would also entitle Lincoln to full annual payments from HHS. Compl. ¶¶ 180-97; Pl.'s Resp. and Cross-Mot. at 39 ("[T]he [g]overnment's

promise to make payment can induce behavior that constitutes a mutuality of intent to contract.").

The court concludes that Lincoln has sufficiently made non-frivolous contract claims against the government for monetary relief. Lincoln has established that it entered into written agreements with HHS certifying Lincoln as a qualified health plan provider under the risk-corridors program for all three years of the program. *See* Compl. Exs. 2-4. Further, the government engaged in conduct that indicated an intent to make at least some payments under the risk-corridors program to qualified health plans. *See, e.g.*, HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. at 15,411, AR 1807 ("The risk corridors program will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains.").

Thus, the court has jurisdiction over Lincoln's express and implied contract claims to the extent that the 2014 and 2015 risk-corridors payments are presently due. Under Lincoln's alleged 2014 contract with HHS, payment was due in 2015 after HHS determined the amount of payment it owed to Lincoln. HHS paid approximately 12% of that amount, *see Risk Corridors Payment Proration Rate for 2014*, AR 1254, and the remaining balance is allegedly due. Additionally, Lincoln alleges that HHS repudiated its 2015 contract obligations when HHS stated that it did not anticipate making any 2015 payments during 2016. *See* P1.'s Resp. and Cross-Mot. at 11-12; Def.'s Mot. App. at A47. Lincoln chose to treat that repudiation as a present breach. Pl.'s Resp. and Cross-Mot. at 11-12; *see Franconia Assocs. v. United*

States, 536 U.S. 129, 143-44 (2002) (noting that a plaintiff may treat the other party's repudiation as a present breach by bringing suit); *Kasarsky v. Merit Sys. Prot. Bd.*, 296 F.3d 1331, 1338 (Fed. Cir. 2002) (same) (citing *Franconia Associates*, 536 U.S. at 143-44). Under Lincoln's alleged anticipatory breach claim, HHS's stated intention not to pay constitutes a present breach and the 2015 payments owed to Lincoln are due as well.[17]

3. Claim for money damages under the Takings Clause of the Fifth Amendment.

The court has jurisdiction via the Tucker Act over claims brought under the Takings Clause of the Fifth Amendment. *See, e.g., Preseault v. Interstate Commerce*, 494 U.S. 1, 12 (1990); *Jan's Helicopter Serv.*, 525 F.3d at 1309 (citing *Moden v. United States*, 404 F.3d 1335, 1341 (Fed. Cir. 2005)). A takings claim need only be non-frivolous for this court to find jurisdiction under the Tucker Act. *Moden*, 404 F.3d at 1341. Here, Lincoln has presented a non-frivolous claim that the government took the payments that Lincoln is entitled to under Section

[17] This conclusion is not inconsistent with the holdings of *Todd* and *Annuity Transfers*, as relied upon by the government. Lincoln is requesting monetary relief attributable to HHS's alleged anticipatory breach. In contrast, the plaintiff in *Todd* was seeking non-monetary relief, *see* 386 F.3d at 1094, and the plaintiff in *Annuity Transfers* was not alleging an anticipatory breach, but was instead seeking to change the contract, *see* 86 Fed. Cl. at 179. This court has repeatedly exercised its jurisdiction over anticipatory breach claims seeking monetary relief. *See, e.g., Tamerlane, Ltd. v. United States*, 81 Fed. Cl. 752 (2008); *Franconia Assocs. v. United States*, 61 Fed. Cl. 718 (2004).

1342 and the implementing regulation. Thus, the court has jurisdiction over Lincoln's takings claim.

4. Request for declaratory relief.

Additionally, Lincoln requests that, incidental to a monetary judgment, the court declare that the government must fulfill and fully satisfy its risk-corridors payment obligations for 2015 and 2016 within 30 days of determining payments owed. Compl. at 45; Pl.'s Resp. and Cross-Mot. at 30-31. The court does not have jurisdiction over such a request.

The Tucker Act provides the court with jurisdiction to grant equitable or declaratory relief in three circumstances. *See Annuity Transfers*, 86 Fed. Cl. at 181. First, the court may "issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records" as an "incident of and collateral to" a monetary judgment. 28 U.S.C. § 1491(a)(2). Second, the court has jurisdiction to hear nonmonetary disputes arising under the Contract Disputes Act, 28 U.S.C. § 1491(a)(1) (last sentence), and third, it has juridical power to grant equitable relief in bid protests. 28 U.S.C. § 1491(b)(2). None of these three circumstances apply here. Although Lincoln is seeking declaratory relief that it contends is collateral to its request for monetary judgment, the relief sought is not necessarily derivative from or attendant to any money judgment that might issue, but rather would turn on future developments. Thus, the court does not have jurisdiction over Lincoln's request for declaratory relief.

B. Lincoln's Claims Are Ripe For Judicial Review

The justiciability doctrines of Article III apply in this court, including the ripeness requirement. *Square One Armoring Serv., Inc. v. United States*, 123 Fed. Cl. 309, 321 (2015); *see Fisher*, 402 F.3d at 1176. The government argues that Lincoln's claims are not ripe for judicial consideration because HHS has not determined the final payment amounts under the risk-corridors program and will not do so until the end of the three-year period the program is in effect. Def.'s Mot. at 20-22; Def.'s Opp'n to Pl.'s Mot. at 11-12.

The ripeness doctrine "prevent[s] the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements over administrative policies, and also . . . protect[s] the agencies from judicial interference." *Abbott Labs. v. Gardner*, 387 U.S. 136, 148 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977). An unripe claim is dismissed without prejudice. *Pernix Grp., Inc. v. United States*, 121 Fed. Cl. 592, 599 (2015) (citing *Shinnecock Indian Nation v. United States*, 782 F.3d 1345, 1350 (Fed. Cir. 2015)). In determining whether an action is ripe, the court evaluates (1) "the fitness of the issues for judicial decision" and (2) "the hardship to the parties of withholding court consideration." *Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc.*, 527 F.3d 1278, 1294-95 (Fed. Cir. 2008) (citing *Abbott Labs.*, 387 U.S. at 149).

A case will generally be fit for judicial review when "further factual development would not 'significantly advance [a court's] ability to deal with

the legal issues presented.'" *Caraco Pharm. Labs.*, 527 F.3d at 1295 (citing *National Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S. 803, 812 (2003)). Contrastingly, a claim will not be fit if it is "contingent upon future events that may or may not occur." *Systems Application & Techs., Inc. v. United States*, 691 F.3d 1374, 1383 (Fed. Cir. 2012) (citing *Thomas v. Union Carbide Agric. Prods. Co.*, 473 U.S. 568, 580-81 (1985)). The court must also consider whether its involvement "would inappropriately interfere with further administrative action." *Ohio Forestry Ass'n, Inc. v. Sierra Club*, 523 U.S. 726, 733 (1998).

Respecting hardship, the court must consider whether withholding court consideration would have an "immediate and substantial impact" on the plaintiff *Caraco Pharm. Labs.*, 527 F.3d at 1295 (quoting *Gardner v. Toilet Goods Ass'n*, 387 U.S. 167, 171 (1967)). This element of the doctrine requires a lesser showing compared to that required of a plaintiff seeking injunctive relief, which calls upon a plaintiff to show irreparable harm. *See Systems Application & Techs.*, 691 F.3d at 1385. Even so, the mere possibility of harm is not sufficient to establish hardship. *See Confederated Tribes & Bands of The Yakama Nation v. United States*, 89 Fed. Cl. 589, 616 (2009) ("[A] possible financial loss is not by itself a sufficient interest to sustain a judicial challenge to governmental action.") (quoting *Abbott Labs.*, 387 U.S. at 153); *Pernix Grp.*, 121 Fed. Cl. at 599 ("Abstract, avoidable or speculative harm is not enough to satisfy the hardship prong.").

1. Section 1342 and the implementing regulation.

In evaluating fitness for review, the parties focus on Lincoln's claim for damages under Section 1342 of the Act and the implementing regulation. Lincoln asserts that qualified health plans satisfying the conditions of Section 1342 are entitled to payment under the risk-corridors program, and the government accepts this assertion in substantial part. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). That said, the parties differ in interpreting Section 1342 and the implementing regulations. Lincoln asserts that both the statute and regulations require HHS to make full payment annually, see Pl.'s Mot. at 9-11; Pl.'s Resp. and Cross-Mot. at 12-23, while the government contends that payments are not due until the end of the program, depending upon the availability of funds, *see* Def.'s Mot. at 23-25; Def.'s Opp'n to Pl.'s Mot. at 18-22. The dispute centers on an issue of statutory interpretation and is therefore fit for judicial review. *See Coalition for Common Sense in Gov't Procurement v. Sec'y of Veterans Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006) ("[W]e find that the issues presented by the parties deal largely with legal issues of statutory construction, which we have previously held fit for pre-enforcement judicial review.") (citing *National Org. of Veterans' Advocates, Inc. v. Sec'y of Veterans Affairs*, 330 F.3d 1345, 1347 (Fed. Cir. 2003)). No further factual development is necessary in determining the meaning and application of Section 1342 and the implementing regulation.

The possibility of the government's making some or all of the risk-corridors payments in the future does not change this calculus. In *Confederated Tribes & Bands of The Yakama Nation*, the government argued that plaintiffs' breach of trust and fiduciary duties claims were not fit for judicial review because the government still had the means to obtain and provide the money requested by plaintiffs. 89 Fed. Cl. at 614-15. The government asserted that those future efforts would alter the facts of the case. *See id.* at 615. The court rejected that argument and found the claims fit for judicial review, explaining that the government's as-yet indeterminate further actions might be relevant to determining the plaintiffs' damages award, but had "no bearing on the accrual and fitness of plaintiffs' claim." *Id.* Regardless of future events, the facts underlying plaintiffs' claim of breach of trust were "fixed." *Id.* at 616. Similarly, the facts underlying Lincoln's claim are fixed as well. As Lincoln would have it, HHS allegedly breached its statutory and regulatory obligations by failing to make full payments annually. Subsequent HHS payments might bear on Lincoln's ability to receive amounts due, but they will not affect Lincoln's underlying claim.

Lincoln has also demonstrated hardship. Lincoln is allegedly due nearly $4 million for losses it suffered in 2014. AR 270; Pl.'s Mot. at 7. Further, Lincoln is allegedly due more than $70 million for losses in 2015, *see* Pl.'s Mot. at 7-8 & App. 8 at A59, but HHS has stated that it does not anticipate making any 2015 payments this year. Def.'s Mot. App. at A47. Lincoln's excess of claims paid compared to premiums received is not uncertain or speculative; as previously noted, Lincoln's adjusted risk-corridors ratios for

coverages in 2015 were more than 175% over its target for 2015 and Lincoln suffered substantial losses as a result. *See supra*, at 11 n. 14. Lincoln did not have reserves to cover the deficit, and it was placed in liquidation proceedings as of October 1, 2016. *See* Def.'s Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V at 3-4 & Attach., ECF No. 31; Pl.'s Resp. to Def.'s Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V at 4-5, ECF No. 34.[18] Coupled with Lincoln's premium-setting policies, HHS's failure to make timely payments at least contributed to this insolvency and liquidation. *See Inter-Tribal Council of Ariz., Inc. v. United States*, 125 Fed. Cl. 493, 504 (2016) (finding that plaintiffs breach of trust claim established hardship because government's "years of missed payments and lack of security" was threatening the sustainability of the trust at issue). Thus, Lincoln's claim under Section 1342 and the implementing regulations is ripe for judicial review.

2. Express and implied contract claims.

Ordinarily, a breach of contract claim ripens when the breach occurs. *See Barlow & Haun, Inc. v. United States*, 118 Fed. Cl. 597, 615-16 (2014) (citing *Nager Elec. Co. v. United States*, 368 F.2d 847, 851-52 (Ct. Cl. 1966)), *aff'd*, 805 F.3d 1049 (Fed. Cir. 2015). If a party repudiates a contract, the claim "ripens

[18] *See* Agreed Order of Liquidation with a Finding of Insolvency, *Illinois v. Land of Lincoln Mut. Health Ins. Co.*, No. 16 CH 09210 (Ill. Cir. Ct., Cook Cnty., Chancery Div. Sept. 29, 2016), appended as the attachment to Def's Mot. to Strike Pl.'s Cross-Mot. for Judgment on the Administrative Record on Counts II-V, ECF No. 31-1.

when performance becomes due or when the other party to the contract opts to treat the repudiation as a present total breach." *Id.* at 616 (citations omitted); *see also Franconia Associates*, 536 U.S. at 143 (noting that when a party repudiates a contract by renouncing a contractual duty before performance is due, the repudiation "ripens into a breach . . . if the promisee elects to treat it as such") (internal quotation marks and citations omitted).

Lincoln alleges that HHS had a contractual obligation to make full and annual payments under the risk-corridors program. Again, HHS made payments for the 2014 year, but did not pay in full. Further, as Lincoln would have it, HHS allegedly committed an anticipatory breach of the 2015 contract when it announced that it would not be making 2015 payments this year, and Lincoln has treated HHS's so-called repudiation as a present and total breach. *See* Pl.'s Resp. and Cross-Mot. at 11-12. Lincoln's contract claims for 2014 and 2015 consequently also are ripe for review.

3. Takings claim.

Generally, a regulatory takings claim is ripe when the "government entity charged with implementing the regulations has reached a final decision regarding the application of the regulations to the property at issue." *Morris v. United States*, 392 F.3d 1372, 1376 (Fed. Cir. 2004) (quoting *Williamson Cnty. Reg'l Planning Comm'n v. Hamilton Bank*, 473 U.S. 172, 186 (1985)). An agency action is final when (1) it constitutes the "consummation of the agency's decisionmaking process" such that it is not "of a merely tentative or interlocutory nature," and (2) it is

a decision where "rights or obligations have been determined" or from which "legal consequences will flow." *Barlow & Haun*, 118 Fed. Cl. at 616 (citing *Bennett v. Spear*, 520 U.S. 154, 177-78 (1997)) (internal quotation marks omitted). Additionally, a party must have first taken "reasonable and necessary steps" to allow the regulatory agency to exercise its "full discretion." *Washoe Cnty., Nev. v. United States*, 319 F.3d 1320, 1324 (Fed. Cir. 2003) (quoting *Palazzolo v. Rhode Island*, 533 U.S. 606, 620-21 (2001)).

Lincoln submitted timely accounts of its losses and entitlement to payment for 2014 and 2015, but it has received less than full payment from the government. While HHS has stated that it intends to fulfill its 2014 payment obligations as funds become available, it did not make full payments annually. This was not a tentative decision by HHS, but rather reflected the agency's budget-neutral scheme and determined Lincoln's rights as a qualified health plan issuer. HHS's actions represent a final decision on behalf of the agency, and the legal consequences of those actions have directly affected Lincoln. Lincoln's takings claim is also ripe.

STANDARDS FOR DECISION

A. Rule 12(b)(6)

Under RCFC 12(b)(6), a complaint must "contain sufficient factual matter, accepted as true, to 'state a claim to relief that is plausible on its face.'" *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007)). The facts alleged must be sufficient to "raise a right to relief above the speculative level, on the assumption

that all the allegations in the complaint are true (even if doubtful in fact)." *Kam-Almaz v. United States*, 682 F.3d 1364, 1367-68 (Fed. Cir. 2012) (quoting *Twombly*, 550 U.S. at 555). In evaluating a motion to dismiss pursuant to RCFC 12(b)(6), the court draws all "reasonable inferences" in favor of the non-moving party. *Bowers Inv. Co., LLC v. United States*, 104 Fed. Cl. 246, 253 (2011) (quoting *Sommers Oil Co. v. United States*, 241 F.3d 1375, 1378 (Fed. Cir. 2001)), *aff'd*, 695 F.3d 1380 (Fed. Cir. 2012). However, the court is not required to accept legal conclusions, even if placed within factual allegations. *See Rack Room Shoes v. United States*, 718 F.3d 1370, 1376 (Fed. Cir. 2013) (citing *Iqbal*, 556 U.S. at 678); *Kam-Almaz*, 682 F.3d at 1367-68 (citing *Twombly*, 550 U.S. at 555).

B. Judgment on the Administrative Record

In a case dependent upon the administrative record, a party is permitted to move for judgment on the administrative record pursuant to RCFC 52.1(c). The court reviews decisions of a federal agency under the standards set forth in the Administrative Procedure Act ("APA"), codified in pertinent part at 5 U.S.C. § 706(2)(A). *See Weeks Marine, Inc. v. United States*, 575 F.3d 1352, 1358 (Fed. Cir. 2009); *Meyer v. United States*, 127 Fed. Cl. 372, 381 (2016). Under the APA, a court shall set aside an agency action if the action is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A); *see Centech Grp., Inc. v. United States*, 554 F.3d 1029, 1037 (Fed. Cir. 2009); *Paralyzed Veterans of Am. v. Sec'y of Veterans Affairs*, 345 F.3d 1334, 1339 (Fed. Cir. 2003). In this instance, Lincoln argues that only the "contrary to law" aspect of the standard applies, *see* Pl.'s Reply in Support of Cross-

Mot. for Judgment on the Administrative Record on Counts II-V ("Pl.'s Reply in Support of Cross-Mot.") at 9, ECF No. 44, and the court will apply that criterion.

ANALYSIS

I. THE STATUTORY ENTITLEMENT COUNT

Land of Lincoln's fundamental claim is that HHS has misconstrued Section 1342 of the Act and that the statute when properly interpreted establishes an entitlement to "payments out" on an annual basis and in full, even in the absence of an authorization for, or appropriation of, specific funding beyond the "payments in" due under the statute.

When a party challenges an agency's interpretation of a statute administered by the agency, the court applies the two-step process established in *Chevron*, 467 U.S. at 842-43. *See White v. United States*, 543 F.3d 1330, 1333 (Fed. Cir. 2008). Under step one, the court must determine whether "Congress has directly spoken to the precise question at issue." *Chevron*, 467 U.S. at 842. "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." *Id.* at 842-43. An agency must apply an unambiguous statute according to its terms as expressed by Congress, and in that circumstance no deference is accorded an agency's interpretation. *White*, 543 F.3d at 1333 (citations omitted).

But, if Congress has not spoken to the precise issue, the court turns to step two and applies the "Chevron standard of deference." *Cathedral Candle*

Co. v. U.S. Int'l Trade Comm'n, 400 F.3d 1352, 1361 (Fed. Cir. 2005) ("[T]he *Chevron* standard of deference applies if Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'") (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)); *see White*, 543 F.3d at 1333 (noting that courts "must defer to an agency's interpretation of a statute if the statute is ambiguous or contains a gap that Congress has left for the agency to fill through regulation") (citing *Federal Express Corp. v. Holowecki*, 552 U.S. 389, 395 (2008)).

In supporting its position, Lincoln relies upon a variant of the plain-meaning doctrine applicable to *Chevron* step one, while the government contends that Section 1342 is ambiguous because of gaps in the language and urges the court to defer to the agency's interpretation under *Chevron* step two.

A. Section 1342 Provides No Specific Authorization for Use of Appropriated Funds and is Ambiguous as to Whether HHS Is Required to Make Payments Annually

Under step one of *Chevron*, "the precise question at issue" here is whether Congress intended for HHS to make full payments annually under Section 1342, regardless of the amount of fees collected under the risk-corridors program. The court begins with the language of the statute. *Sursely v. Peake*, 551 F.3d 1351, 1355 (Fed. Cir. 2009) (citing *Santa Fe Indus., Inc. v. Green*, 430 U.S. 462, 472 (1977)); *see Alexander*

v. Sandoval, 532 U.S. 275, 288 (2001) ("We therefore begin . . . our search for Congress's intent with the text and structure of [the statute]."). Statutory terms are interpreted "in accordance with [their] ordinary or natural meaning." *Sursely*, 551 F.3d at 1355 (citing *Microsoft Corp. v. AT & T Corp.*, 550 U.S. 437, 449 (2007)) (internal quotation marks omitted). When interpreting statutory terms, the court may consider the text, structure, legislative history, and canons of construction. *Delverde, SrL v. United States*, 202 F.3d 1360, 1363 (Fed. Cir. 2000).

Paragraph 1342(b)(1) provides that if a qualified health plan reports allowable costs for "any plan year" that sufficiently exceed the plan's target amount, "the Secretary shall pay to the plan" a percentage of those costs. 42 U.S.C. § 18062(b)(1). Lincoln emphasizes the "shall pay" language and the year-by-year reporting and calculus of its cost-revenue experience. Although Paragraph 1342(b)(1) contemplates that qualified health plans will be reporting costs on an annual basis via the phrase "any plan year," that arrangement reflects the year-by-year transitory aspect of the temporary risk-corridors program.[19] The "[p]ayments out" and "[p]ayments in" methodology in

[19] Lincoln also points to several other annual aspects of the program to support its argument that HHS is required to make full payments annually, *see* Pl.'s Resp. and Cross-Mot. at 14-15; Pl.'s Reply at 4, but those aspects concern HHS's requirement that qualified health plans must submit data to HHS annually, *see* 45 C.F.R. § 153.530(d), and must be certified annually, *see* 45 C.F.R. § 155.1045; Compl. Exs. 2-4. Those provisions for annual qualification for participation and for consideration of data over a calendar year do not control what is to happen with the data submitted by qualified plans and do not refer to payments to and from issuers.

Subsection 1342(b) governs the amounts that HHS must pay to and receive from qualified health plans, but it does not establish when these payments are to be made. Similarly, Subsection 1342(a) states that the Secretary "shall establish and administer" the program "for calendar years 2014, 2015, and 2016," but it does not specify the timing of the various payments over those three years.[20]

Additionally, the only statutory source of funding for the risk-corridors program is Paragraph 1342(b)(2), which refers to "[p]ayments in" from qualified health plans. 42 U.S.C. § 18062(b)(2); *see GAO Op.*, 2014 WL 4825237, at *2, AR 116 ("Section 1342, by its terms, did not enact an appropriation to make the payments specified in [S]ection 1342(b)(1)."). No other source of funds is mentioned or specified. *See supra*, at 7-9 & nn. 8-10 for a discussion of GAO's consideration of other appropriated CMS program-management funds that might have been available during fiscal year 2014. In March 2010, while Congress was considering the bills that eventually become the Affordable Care Act, the CBO provided Congress with an estimate of how the Act would affect future government spending and

[20] Lincoln argues that the plural "corridors," as opposed to "corridor," demonstrates that Congress intended to implement multiple risk corridors for each calendar year, with separate payments for each year. Pl.'s Resp. and Cross-Mot. at 14. The implementing regulations define "risk corridors" as "any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount." 45 C.F.R. § 153.500. Subsection 1342(b) sets forth multiple payment adjustment systems, depending on whether a qualified health plan's allowable costs fall above or below the target amount by specified percentages. The plural "corridors" reflects that more than one payment adjustment system exists within the program.

revenue. *See generally* March 2010 CBO Letter. The CBO explicitly provided revenue and spending estimates for the Act's two other stabilization programs, reinsurance and risk adjustment, but it omitted any budgetary estimate for the risk-corridors program. *See id.*, Table 2. That circumstance is significant. Congress explicitly relied upon the CBO's findings when enacting the Affordable Care Act. *See* Affordable Care Act § 1563.[21] Congress also provided

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[21] Section 1563 of the Act is entitled "Sense of the Senate Promoting Fiscal Responsibility." It provides:

> Sec. 1563. Sense of the Senate Promoting Fiscal Responsibility
>
> (a) FINDINGS. – The Senate makes the following findings:
>
> (1) Based on Congressional Budget Office (CBO) estimates, this Act will reduce the federal deficit between 2010 and 2019.
> (2) CBO projects this Act will continues to reduce budget deficits after 2019.
> (3) Based on CBO estimates, this Act will extend the solvency the Medicare HI Trust Fund.
> (4) This Act will increase the surplus in the Social Security Trust Fund, which should be reserved to strengthen the finances of Social Security.
> (5) The initial net savings generated by the Community Living Assistance Services and Supports (CLASS) program are necessary to ensure the long-term solvency of that program.
>
> (b) SENSE OF THE SENATE. – It is the sense of the Senate that –
>
> (1) the additional surplus in the Social Security Trust Fund generated by this Act should be reserved for Social Security and not spent in this Act for other purposes; and

appropriations or authorizations of funds for other programs within the Act, but it never has done so for the risk-corridors program. *See, e.g.*, 42 U.S.C. §§ 18031(a)(1), 18054(i); *see also National Fed'n of Indep. Bus. v. Sebelius*, ___ U.S. ___, ___, 132 S. Ct. 2566, 2583 (2012) ("Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally.") (citing *Russello v. United States*, 464 U.S. 16, 23 (1983)).[22]

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(2) the net savings generated by the CLASS program should be reserved for the CLASS program and not spend in this Act for other purposes.

Affordable Care Act § 1563, 124 Stat. 270-71.

[22] In post-enactment reports, the CBO's observations related to the risk-corridors program have been inconsistent. *See, e.g.,* Congressional Budget Office, *Estimates for the Insurance Coverage Provisions of the Affordable Care Act Updated for the Recent Supreme Court Decision*, at Tables 2, 4 (July 2012), https://www.cbo.gov/sites/default/files/112th-congress-2011-2012/reports/43472-07-24-2012-CoverageEstimates.pdf (providing spending and revenue estimates for reinsurance and risk adjustment, but not risk corridors); Congressional Budget Office, *The Budget and Economic Outlook: 2014 to 2024*, at 59 (Feb. 2014), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf (estimating the spending and revenue of the risk-corridors program and noting that "risk corridor collections . . . will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit"); Congressional Budget Office, *Insurance Coverage Provisions of the Affordable Care Act—CBO's January 2015 Baseline*, Table B-1 (Jan. 2015), https://www.cbo.gov/sites/default/files/51298-2015-01-ACA.pdf ("The risk corridors program is now recorded in the budget as a discretionary program.").

Lincoln additionally emphasizes that the risk-corridors program is explicitly "based on" Part D of the Medicare Program, *see* 42 U.S.C. § 18062(a), which requires full payments annually and is not budget neutral. Pl.'s Mot. at 12; Pl.'s Resp. and Cross-Mot. at 15-16, 18-19. However, the Medicare Program is not helpful to Lincoln's argument. The Medicare Program sets forth a risk-corridors payment program between HHS and qualified prescription drug plans. *See* 42 U.S.C. § 1395w-115. While Section 1342 is "based on" the Medicare Program and the two programs share many similarities, they are not identical. The Medicare Program specifically requires that "*[f]or each plan year*, the Secretary shall establish a risk corridor . . . ." 42 U.S.C. § 1395w-115(e)(3)(A) (emphasis added). In contrast, Congress chose to omit "for each plan year" in Section 1342 and instead required that "[t]he Secretary shall establish and administer a program of risk corridors." 42 U.S.C. § 18062(a). The only mention of "any plan year" is in reference to the qualified health plan's reported costs, rather than HHS's obligation to pay. *See* 42 U.S.C. § 18062(b)-(c). Additionally, unlike Section 1342, the Medicare Program explicitly

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These post-enactment observations by CBO are of limited utility for statutory interpretation. For purposes of determining the congressional intent underpinning Section 1342, the CBO's March 2010 estimate is the only pertinent report because that is what Congress relied upon in passing the Act. *See United States v. Fausto*, 484 U.S. 439, 455, 461 n.9 (1988) (Stevens, J., dissenting) ("If we construe a statute in a different legal environment than that in which Congress operated when it drafted and enacted the statute, we significantly increase the risk that we will reach an erroneous interpretation."), *superseded by statute as stated in Kaplan v. Conyers*, 733 F.3d 1148, 1160-61 (Fed. Cir. 2013).

provides for authorization of appropriations. *See* 42 U.S.C. § 1395w-115(a)(2) ("This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section."). "When Congress omits from a statute a provision found in similar statutes, the omission is typically thought deliberate." *Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002) (noting that Congress's failure to include an embargo in the statute, when it did so in similar statutes, suggested that Congress did not intend to impose an embargo) (citing *Immigration & Naturalization Serv. v. Phinpathya*, 464 U.S. 183, 190 (1984)). Here, the differences between the two statutes suggest that Section 1342 does not require HHS to make full payments annually.

In short, Section 1342 is ambiguous in terms of the "payments in" and "payments out" arrangement for risk-corridors payments because it does not contain an express authorization for appropriations to make up any shortfall in the "payments in" to cover all of the "payments out" that may be due.[23] And, it does not explicitly require "payments out" to be made on an annual basis, whether in full or not. *Chevron* step two thus seemingly comes into play.

Lincoln nonetheless argues that *Chevron* deference is inappropriate because (1) HHS's interpretation of Section 1342 is a *post hoc*

[23] Correlatively, the statute does not indicate the disposition of any potential *excess* of "payments in" over "payments out" for any given year, but that rather unlikely scenario is perhaps only of academic interest.

rationalization that the government has merely advanced for purposes of litigation, and (2) deference is not appropriate in the context of the Affordable Care Act. *See* Pl.'s Resp. and Cross-Mot. at 21-22.

HHS initially outlined its three-year, budget-neutral interpretation of Section 1342 in 2014, several years before this suit began. *See, e.g.*, HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. at 13,787, AR 4929; Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. HHS's interpretation thus is not merely a "convenient litigation position." *See Parker v. Office of Pers. Mgmt.*, 974 F.2d 164, 166 (Fed. Cir. 1992); *see also Auer v. Robbins*, 519 U.S. 452, 462 (1997) (rejecting petitioners' argument that the agency's interpretation was undeserving of deference merely because it was presented through a legal brief, and holding that there was "no reason to suspect that the interpretation [did] not reflect the agency's fair and considered judgment on the matter in question"). Rather, HHS's interpretation reflects the agency's deliberations and efforts through the rulemaking process. The fact that the agency may have taken inconsistent positions prior to 2014 does not alter the analysis. *See Chevron*, 467 U.S. at 863-64 ("The fact that the agency has from time to time changed its interpretation of the term 'source' does not, as respondents argue, lead us to conclude that no deference should be accorded the agency's interpretation of the statute . . . . [T]he fact that the agency has adopted different definitions in different contexts adds force to the argument that the definition itself is flexible . . . .").

In resisting deference, Lincoln also relies on *King v. Burwell*, __ U.S. at __ , 135 S. Ct. at 2488-89, where the Supreme Court did not give deference to the Internal Revenue Service's ("IRS") interpretation of the Affordable Care Act. The Court reasoned that deference was not appropriate because that "extraordinary case[]" involved tax credits that were "central" to the Act's statutory scheme, implicated "billions of dollars" that would affect health insurances prices, and related to an implicit delegation of authority from Congress to the IRS, which did not have expertise in health insurance policy. *Id.* Here, in contrast, Congress delegated the responsibilities of administering the risk-corridors program to HHS, which addresses health insurance policy in a variety of different contexts. Lincoln has failed to demonstrate that this setting is sufficiently "extraordinary" to obviate reference to *Chevron* deference.

B. HHS's Three-Year, Budget-Neutral Interpretation of Section 1342 is Reasonable Under the Chevron *Step-Two Standard of Deference*

Under step two of *Chevron*, the court must defer to HHS's interpretation of Section 1342 as long as that interpretation is reasonable. HHS's interpretation was reflected in its final rule on May 27, 2014, when it stated that it intended "to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually." Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. "[A] court must defer to an agency's reasonable interpretation of a statute and

must not substitute its own judgment for that of the agency even if the court might have preferred another interpretation and even if the agency's interpretation is not the only reasonable one." *Wheatland Tube Co. v. United States*, 495 F.3d 1355, 1360-61 (Fed. Cir. 2007); *see also Federal Express Corp.*, 552 U.S. at 395 (holding that when an agency interprets an ambiguous statute through a regulation, the court must defer to the agency's reasonable interpretation).

Section 1342 directs HHS to establish the risk-corridors program and sets forth the amounts that HHS must receive and pay under the payment methodology subsection, but it does not obligate HHS to make annual payments or authorize the use of any appropriated funds. HHS's interpretation is consistent with the CBO's 2010 report, Congress's decision explicitly to authorize funds for other sections of the Act but not Section 1342, and Congress's choice to omit from Section 1342 the critical appropriation language used in the Medicare Program, as discussed *supra*. HHS's three-year, budget-neutral interpretation reasonably reflects these circumstances.

Lincoln argues that HHS's interpretation is unreasonable because HHS's failure to make full payments annually defeats the purpose of the risk-corridors program, which is to provide stability and protection for qualified health insurance plans. *See* Pl.'s Resp. and Cross-Mot. at 19-20. In this vein, HHS has repeatedly acknowledged its obligation to pay qualified health plans that are eligible for payment under the risk-corridors program. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195

("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."). That said, HHS's payments in due course, not necessarily annually, to the extent funds are available from "payments in" without resort to appropriated funds, can still serve the program, albeit not to the extent Lincoln urges. Importantly, Lincoln's argument based on broad purposes is not persuasive. "[P]olicy considerations cannot override our interpretation of the text and structure of [a statute], except to the extent that they may help to show that adherence to the text and structure would lead to a result so bizarre that Congress could not have intended it." *Chamberlain Grp., Inc. v. Skylink Techs., Inc.*, 381 F.3d 1178, 1192 (Fed. Cir. 2004) (quoting *Central Bank, N.A. v. First Interstate Bank, N.A.*, 511 U.S. 164, 188 (1994)); *see also Sharp*, 80 Fed. Cl. at 433 ("While the outcome of granting more money to married people than to similarly situated single people may seem odd, it is entirely reasonable to assume a scenario in which various factions within Congress, each of which had different policy goals, were motivated to—and did—compromise in order to pass the Veterans Benefits Act of 2003.").[24] HHS's

[24] As the Supreme Court observed in *Board of Governors of Fed. Reserve Sys. v. Dimension Fin. Corp.*, 474 U.S. 361, 373-74 (1986), "[a]pplication of 'broad purposes' of legislation at the expense of specific provisions ignores the complexity of the problems Congress is called upon to address and the dynamics of legislative action." The Court commented that "Congress may be unanimous in its intent to stamp out some vague social or economic evil; however, because its members may differ sharply on the means for effectuating that intent, the final language of the legislation may reflect hard-fought compromises." *Id.* at 374; *see also America Online, Inc. v. United States*, 64 Fed. Cl. 571, 579 (2005) (quoting and relying on *Dimension Financial* in construing an excise tax statute).

interpretation does not lead to such a "bizarre" result. Congress directed HHS to establish the risk-corridors program and make payments as necessary and appropriate, but it gave HHS discretion in administering the program.

The primary implementing regulation for the risk-corridors program, 45 C.F.R. § 153.510, sets forth substantially similar terms to Section 1342. As to "payments out," the regulation provides:

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

45 C.F.R. § 153.510(b). Correlatively to Section 1342, the regulation omits any reference to when payment from HHS is due or how HHS is to fund the program.

There is no deadline for HHS to make payments to the qualified health plan issuers. *See generally* 45 C.F.R. § 153.510. The only relevant difference is that the regulation explicitly provides a deadline for qualified health plan issuers to remit overages to HHS. *See* 45 C.F.R. § 153.510(d). Thus, for the reasons discussed *supra*, the court finds HHS's interpretation of the ambiguous statute to be reasonable. HHS's decision not to make full payments annually cannot be considered contrary to law. The government's motion for judgment on the administrative record with respect to Count I is granted.

II. THE CONTRACT COUNTS

A. Count II: Lincoln Has Failed to Allege a Valid Express Contract Because the Agreements Between Lincoln and HHS Do Not Establish Any Contractual Commitment Pertaining to the Risk-Corridors Program

Lincoln alleges that it entered into three one-year contracts with HHS when it agreed to be a qualified health plan issuer for 2014, 2015, and 2016 and that HHS breached those contracts by failing to make full payments annually. *See* Compl. ¶¶ 166-78, Exs. 2-4. The government responds that the agreements between Lincoln and HHS are not contracts and are unrelated to the risk-corridors program. *See* Def.'s Mot. at 31-37; Def.'s Opp'n to Pl.'s Cross-Mot. at 12-18. For the reasons set out below, the court concludes that Lincoln has failed to establish that an express contract exists between Lincoln and HHS respecting the risk-corridors program.

To establish a valid contract with the government, a plaintiff must demonstrate "(1) mutuality of intent to contract, (2) consideration, (3) lack of ambiguity in offer and acceptance, and (4) authority on the part of the government agent entering the contract." *Suess v. United States*, 535 F.3d 1348, 1359 (Fed. Cir. 2008) (citations omitted). In evaluating an alleged contract, the court begins with the language of the agreement. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (citing *Foley Co. v. United States*, 11 F.3d 1032, 1034 (Fed. Cir. 1993)). When the terms of the agreement are "clear and unambiguous, they must be given their plain and ordinary meaning." *Bell/Heery v. United States*, 739 F.3d 1324, 1331 (Fed. Cir. 2014) (quoting *McAbee Constr., Inc. v. United States*, 97 F.3d 1431, 1435 (Fed. Cir. 1996)) (internal quotation marks omitted). Additionally, the agreement is "construed as a whole and 'in a manner that gives meaning to all of its provisions and makes sense.'" *Id.* (quoting *McAbee Constr.*, 97 F.3d at 1435); *see also Jowett, Inc. v. United States*, 234 F.3d 1365, 1368 (Fed. Cir. 2000).

Here, Lincoln entered into one-year agreements with HHS for 2014, 2015, and 2016. *See* Compl. Exs. 2-4.[25] The agreements certified Lincoln as a qualified health plan issuer, as required by the Affordable Care Act and the implementing regulations. *See* 42 U.S.C. § 18031(d)(4)(A), (e); 45 C.F.R. § 155.20. The substance of each agreement is contained in the "Acceptance of Standard Rules of Conduct," where the

[25] The three agreements are not identical, but they are substantially similar and contain the same language in pertinent part.

qualified health plan issuer agrees to use HHS's internet services in accord with the conduct outlined in the agreement. *See* Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The conduct specifically relates to the qualified health plan's communications through the government's internet service. The qualified health plan agrees to properly test and format transactions, submit test transactions, and abide by certain transaction standards, among other internet service-related requirements. *See* Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The agreements do not explicitly refer to the risk-corridors program. *See generally* Compl. Exs. 2-4. Rather, they reflect Lincoln's agreement to comply with HHS's standards and the government's acceptance of Lincoln into the Affordable Care Act's Exchange program. Because Illinois elected not to establish an Exchange under the provisions of 42 U.S.C. § 18031(d), HHS stepped in to provide a federally-run Exchange in Illinois pursuant to 42 U.S.C. § 18041(c). The plain language of the agreements does not indicate any contractual commitment on behalf of HHS to make risk-corridors payments.[26]

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[26] The government also notes that Lincoln's express contract claim, if accepted, would result in an "artificial policy distinction" between the qualified health plans using federally-facilitated Exchanges and the qualified health plans using state-established Exchanges. *See* Def.'s Mot. at 36-37. The risk-corridors program applies to all qualified health plans. *See generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. However, only qualified health plans under the federally-facilitated Exchanges, not the state-established Exchanges, enter into the types of agreements with HHS that are at issue here. *See* Def.'s Mot. at 36-37. Thus Lincoln's express contract theory, if adopted, would create an inconsistent and unintended result where some

Lincoln presents several arguments as to why the agreements represent a contractual obligation to pay qualified health plans under the risk-corridors program, including that: (1) the agreements provide that HHS will "undertake all reasonable efforts to implement systems and processes" to support the qualified health plan issuers, (2) the agreements state that they are "governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated by HHS," and (3) the agreements state that HHS "will recoup or net payments due" to qualified health plan issuers "against amounts owed" to HHS with respect to the "payment of [f]ederally-facilitated Exchange user fees." *See* Compl. Exs. 2-4; Pl.'s Resp. and Cross-Mot. at 33-34. These arguments do not constitute persuasive support to Lincoln's position for the reasons set forth below.

First, HHS's obligation "to implement systems and processes," *see* Compl. Ex. 2, Section II.d; Ex. 3, Section III.a; Ex. 4, Section III.a, must be read in the context of the agreements as a whole. The agreements explicitly relate to the qualified health plan's use of HHS's "Data Services Hub Web Services." *See* Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The qualified health plan agrees to abide by certain requirements so that it can be certified to offer insurance through this internet service. Given this context, "systems and processes" must relate to the electronic system that HHS and the qualified health plan will be using, and the processes that support this electronic system.

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qualified health plans have an allegedly express contractual basis for risk-corridors payments, but others do not.

This interpretation is reinforced by the language of the "Companion Guide," which is explicitly cited within the agreement. *See, e.g.*, Compl. Ex. 2, Section II.b; Ex. 3, Section II.b; Ex. 4, Section II.b. The guide identifies the various processes that are implicated by HHS's internet service, such as the testing process and validation process. *See* Def.'s Opp'n to Pl.'s Cross-Mot. at 13-14, App. at A1-A5. The "systems and processes" language does not give rise to any risk-corridors obligations.

Second, the general reference to "the laws and common law of the United States, including . . . such regulations as may be promulgated from time to time by the Department of Health and Human Services or any of its constituent agencies," Compl. Ex 2, Section V.g; Ex. 3, Section V.g; Ex. 4, Section V.g, does not incorporate the risk-corridors program into the agreement. For a contract to incorporate a document, "the incorporating contract must use language that is *express* and *clear*, so as to leave no ambiguity about the identity of the document being referenced, nor any reasonable doubt about the fact that the referenced document is being incorporated into the contract." *Northrop Grumman Info. Tech., Inc. v. United States*, 535 F.3d 1339, 1344 (Fed. Cir. 2008) (emphasis in original). A reference to the laws of the United States, or to statutes or regulations generally, will typically not suffice to incorporate a specific statutory provision or regulation. *See, e.g., St. Christopher Assocs., L.P. v. United States*, 511 F.3d 1376, 1384 (Fed. Cir. 2008) (holding that a general reference to the agency's regulations did not incorporate a specific regulation promulgated by the agency or a specific section of the agency's handbook); *Smithson v. United States*, 847 F.2d 791, 794-95 (Fed. Cir. 1988) (holding

that a contract did not incorporate an agency's regulations, despite the statement in the contract that it was "subject to the present regulations of the [agency] and to its future regulations not inconsistent with the express provisions hereof"); *Dobyns v. United States*, 118 Fed. Cl. 289, 315-16 (2014) (holding that an agreement's reference to "all laws regarding or otherwise affecting the Employee's employment" did not incorporate specific agency provisions). As the Federal Circuit explained in *Smithson*, holding otherwise would allow a private party to "choose among a multitude of regulations as to which he could claim a contract breach" and impose entirely new obligations on the government through implication. 847 F.2d at 794 (internal quotation marks and citations omitted). Here, the general reference to federal law and HHS regulations does not expressly or clearly incorporate the specific risk-corridors provisions upon which Lincoln relies.

Third, HHS's obligations regarding "[f]ederally-facilitated Exchange user fees," *see* Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b, do not relate to the risk-corridors program. Neither Section 1342 of the Act nor Section 153.510 of the regulations refer to such fees. *See* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Rather, the term "user fees" is included in Section 1311 of the Act, which permits the Exchanges "to charge assessments or user fees to participating health insurance issuers." 42 U.S.C. § 18031(d)(5)(A).[27] The implementing regulations, under a provision entitled "Requirement for

[27] The cited Subparagraph relates to state-established Exchanges, but as noted *supra*, at 3, 6 n.7, HHS provided an Exchange in Illinois when the State did not.

[f]ederally-facilitated Exchange user fee," explain that participating health insurance issuers offering plans through a federally-facilitated Exchange "must remit a user fee to HHS." 45 C.F.R. § 156.50(c)(1), (2).[28] HHS is obligated to adjust or reduce the user fee if the issuer satisfies certain conditions, such as making payments for a contraceptive service. *See id.* § 156.50(d). Thus, the agreements between HHS and Lincoln simply acknowledge that Lincoln will pay the user fee set forth in Section 156.50 of the implementing regulations. The reference to HHS's recouping or netting payments reflects the agency's obligations described in Section 156.50(d), which states when an adjustment to the user fee is applicable. The risk-corridors program is not mentioned as a basis for an adjustment. *See generally* 45 C.F.R. § 156.50(d).

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[28] In 2014, HHS and GAO described risk-corridors payments as "user fees." *See* Letter from William B. Schultz, Gen. Counsel, HHS, to Julia C. Matta, Assistant Gen. Counsel, GAO (May 20, 2014) ("Schultz-Matta Letter"), AR 1482-84; *GAO Op.*, 2014 WL 4825237, at *3-5, AR 117-19. These characterizations were made, however, in the context of analyzing the 2014 appropriation act's reference to "sums as may be collected from authorized user fees." *See* Schultz-Matta Letter, AR 1482-84; *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-19. Here, in contrast, the agreements between Lincoln and HHS do not simply contain the term "user fees," but instead refer to "*[f]ederally-facilitated Exchange user fees.*" *See* Compl. Ex. 2, Section II.c; Ex. 3, Section III.b; Ex. 4, Section III.b (emphasis added). In this setting, Section 156.50 of the implementing regulations is instructive rather than HHS's and GAO's past characterizations, because Section 156.50 explicitly addresses a "[f]ederally-facilitated Exchange user fee." *See* 45 C.F.R. § 156.50(c), (d).

Thus, Lincoln has failed to allege that the agreements between Lincoln and HHS created a valid express contract pertaining to risk-corridors payments. The government's motion to dismiss Lincoln's claim of breach of an express contract is granted.

B. Count III: Lincoln Has Failed to Allege a Valid Implied-in-Fact Contract Because Mutuality of Intent and Offer and Acceptance are Lacking, and Even if an Implied-in-Fact Contract Did Exist, the Scope of the Contract Would be Limited by the Implementing Regulations

Lincoln alleges that it formed an implied-in-fact contract with the government and that the government implicitly agreed to make full risk-corridors payments annually, which it has failed to do. *See* Compl. ¶¶ 180-97; Pl.'s Resp. and Cross-Mot. at 35-39. The government responds that Section 1342 and the implementing regulations and the course of conduct of the parties do not establish the existence of any contract between the government and qualified health plans. *See* Def.'s Mot. at 37-42.

An implied-in-fact contract is based upon a meeting of the minds, which is inferred from the conduct of the parties and the surrounding circumstances. *Night Vision Corp. v. United States*, 469 F.3d 1369, 1375 (Fed. Cir. 2006) (citing *Hanlin v. United States*, 316 F.3d 1325, 1328 (Fed. Cir. 2003)). The requirements for a binding contract are the same for express and implied contracts. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997); *see Prudential Ins. Co. of Am. v. United States*, 801

F.2d 1295, 1297 (Fed. Cir. 1986) (noting that to find an implied-in-fact contract, "all of the elements of an express contract must be shown by the facts or circumstances surrounding the transaction . . . so that it is reasonable, or even necessary, for the court to assume that the parties intended to be bound").[29] Plaintiff has the burden of proving that a valid contract exists. *Harbert/Lummus Agrifuels Projects v. United States*, 142 F.3d 1429, 1434 (Fed. Cir. 1998); *see Hanlin*, 316 F.3d at 1328 (noting that plaintiff has the burden of establishing an implied-in-fact contract); *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 328-29 (2012) (granting the government's motion to dismiss when plaintiff failed to allege the necessary elements for a valid contract with the government).

"[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued . . . ." *National R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry.*,

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[29] To support its implied contract claim, Lincoln argues that it relied on the government's alleged offer to make risk-corridors payments when Lincoln chose to participate on the Illinois Exchange. *See* Pl.'s Resp. and Cross-Mot. at 36. However, detrimental reliance is not an element of an implied-in-fact contract claim. *Steinberg v. United States*, 90 Fed. Cl. 435, 444 (2009), *appeal dismissed*, 451 Fed. Appx. 915 (Fed. Cir. 2010). It is an element of an implied-in-law claim, over which this court does not have jurisdiction. *See, e.g., International Data Prods. Corp. v. United States*, 492 F.3d 1317, 1325 (Fed. Cir. 2007); *Baistar Mech. Inc. v. United States*, __ Fed. Cl. __, __, 2016 WL 5404169, at *7 (2016); *XP Vehicles, Inc. v. United States*, 121 Fed. Cl. 770, 782-83 (2015).

470 U.S. 451, 465-66 (1985) (citing *Dodge v. Bd. of Educ.*, 302 U.S. 74, 79 (1937)) (internal quotation marks omitted); *see AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 ("Only when statutes or regulations have clearly expressed the Government's intent to enter into a contractual arrangement with program participants have courts found an implied-in-fact contract.") (citations omitted). For example, in *Hanlin*, the Federal Circuit rejected plaintiff's claim that the relevant statute and regulation gave rise to an implied-in-fact contract. 316 F.3d at 1329-30. There, the statute provided that the agency "may direct" payment of attorneys' fees under certain circumstances, but the regulation stated that such fee arrangements "will be honored" by the agency only when specific conditions were met. *Id.* at 1328-29. The Federal Circuit explained that "[t]he statute and the regulation set forth the [agency's] authority and obligation to act, rather than a promissory undertaking . . . . The statute is a directive from the Congress to the [agency], not a promise from the [agency] to the [plaintiff]." *Id.* at 1329; *see also AAA Pharmacy*, 108 Fed. Cl. at 328-29 (dismissing plaintiff's breach of contract theory based on the government's alleged failure to abide by Medicare regulations because the regulations represented the government's independent obligations and did not indicate an intent to contract).

Here, similarly, Section 1342 and the implementing regulations do not provide any express or explicit intent on behalf of the government to enter into a contract with qualified health plan issuers. Although the provisions may mandate payment from HHS, albeit not annually, when a qualified health plan satisfies statutory and regulatory conditions,

that alone does not demonstrate intent to contract. *See ARRA Energy Co. I*, 97 Fed. Cl. at 28 (dismissing plaintiffs' implied-in-fact contract claim because the statute failed to indicate an unambiguous offer or intent to contract, even though the government may have had a statutory obligation to make an award to the plaintiffs); *see also Hanlin*, 316 F.3d at 1331 (noting that an agency "may indeed be obligated to follow a statute and regulation regardless of whether it also has a contractual duty to perform"). HHS's obligation to make risk-corridors payments when certain conditions are met represents the agency's independent authority and obligation as directed by Congress, not any promissory undertaking or offer to qualified health plans issuers such as Lincoln. Thus there is no apparent mutuality of intent to contract.

To support its implied contract claim, Lincoln primarily relies on *Radium Mines, Inc. v. United States*, where the court construed a regulation as an offer that invited acceptance by performance. 153 F. Supp. 403, 405-06 (Ct. Cl. 1957). Lincoln contends that HHS's obligation to make payments under the risk-corridors program constituted an offer, which Lincoln accepted by participating in the Exchange as a qualified health plan and complying with the various statutory and regulatory requirements. *See* Pl.'s Resp. and Cross-Mot. at 39-41. However, in *Radium Mines*, the regulation explicitly provided that the government would contract with uranium producers that offered to sell uranium to the government, as long as certain conditions were met. *See* 153 F. Supp. at 405-06. For example, one provision in the regulation stated that "the Commission will forward to the person making the offer a form of contract containing applicable terms

and conditions ready for his acceptance." *Id.* at 405. And similarly, in *Grav v. United States*, 14 Cl. Ct. 390, 391-93 (1988), *aff'd*, 886 F.2d 1305 (Fed. Cir. 1989), the court held that a statute gave rise to an implied-in-fact contract between the government and private parties because it stated that "the Secretary shall offer to enter into a contract . . . ." Here, unlike the regulation in *Radium Mines* and the statute in *Grav*, Section 1342 and the implementing regulations make no explicit reference to an offer or contract. *See AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 (finding that a regulation providing for payment from the government did not create an implied-in-fact contract because, unlike in *Radium Mines*, the regulation did "not include any language manifesting either an offer or an intent to enter into contract"); *ARRA Energy Co.* I, 97 Fed. Cl. at 27-28 (finding that a statute did not create an implied-in-fact contract because, unlike in *Radium Mines*, it did not clearly express an intent to contract).

Additionally, Lincoln relies on *New York Airways, Inc. v. United States*, 369 F.2d 743, 745 (Ct. Cl. 1966), where the relevant statute provided that the "Postmaster General shall make payments out of appropriations for the transportation of mail by aircraft . . . as is fixed and determined by the [Civil Aeronautics] Board . . . ." The Board promulgated an order that fixed the monthly compensation for mail transporters, including plaintiffs. *Id.* at 744. In finding an implied-in-fact contract, the court stated that the Board's order constituted "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." *Id.* at 751. The facts of *New*

York Airways, however, are distinguishable from Lincoln's implied-in-fact contract claim. In *New York Airways*, the plaintiffs' were entitled to fixed monthly compensation from the Board in exchange for transporting mail; no further action was necessary because the Board's order invited acceptance by performance. *Id.* That invitation and acceptance were deemed to form a binding obligation even though the appropriations that had been made for the mail service had been exhausted. *Id.* at 746-49. In contrast, qualified health plans are not entitled to compensation solely by offering health insurance on the Exchange. The only health plans eligible for payment are those that suffer sufficiently high losses and submit those losses to the government. *See* 45 C.F.R. §§ 153.510(b), (g), 156.430(c). Even then, HHS has some discretion in determining when payments will be made because the risk-corridors program does not require full payments annually, as discussed *supra*. Thus, Section 1342 and the implementing regulations do not constitute an offer or invite acceptance by performance alone. *See Baker v. United States*, 50 Fed. Cl. 483, 495 (2001) (holding that a regulation did not constitute an offer inviting acceptance by performance because further action from the agency was necessary before the private party was entitled to the benefits provided in the regulation).

Alternatively, even assuming Lincoln could show that Section 1342 and the implementing HHS regulations constituted a contractual offer relating to risk-corridors payments that Lincoln accepted, thus

giving rise to an implied-in-fact-contract,[30] Lincoln cannot establish that HHS breached a contractual obligation. *See Anderson v. United States*, 73 Fed. Cl.

[30] Assuming that Lincoln could show mutuality of intent and offer and acceptance, consideration and authority to contract would not bar Lincoln's 2014 and 2015 contract claims, but the latter element would bar a claim for 2016. As consideration for HHS's payments, Lincoln provided health insurance on the government Exchange and complied with various regulatory requirements. *See* Pl.'s Resp. and Cross-Mot. at 39-40. Additionally, HHS may have had authority to contract when it entered into the 2014 and 2015 agreements with Lincoln. One caveat to that observation is that the Anti-Deficiency Act prevents an agency from authorizing an expenditure that exceeds available appropriations or contracting for a monetary payment in advance of available appropriations, unless authorized by law. 31 U.S.C. § 1341(a)(1)(A), (B); *see Hercules Inc. v. United States*, 516 U.S. 417, 427 (1996). An alleged contract with the government that does not comply with the Anti-Deficiency Act will be void *ab initio, see Springfield Parcel C, LLC v. United States*, 124 Fed. Cl. 163, 190 (2015), due to lack of contracting authority, *see, e.g., Rick's Mushroom Serv., Inc. v. United States*, 521 F.3d 1338, 1346 (Fed. Cir. 2008). However, if the agency has authority when the contract is formed, the Anti-Deficiency Act is not triggered and a subsequent government action that restricts available funds will not negate the formation of that contract. *See Wetsel-Oviatt Lumber Co. v. United States*, 38 Fed. Cl. 563, 570 (1997). Here, the 2014 and 2015 agreements certifying Lincoln as a qualified health plan were signed before December 2014, *see* Compl. Exs. 2-3, when Congress enacted the 2015 appropriations bill that restricted risk-corridors payments to fees collected under the program. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. at 2491. Prior to the appropriations bill, the GAO determined that HHS had the authority to use general CMS appropriations to make risk-corridors payments. *GAO Op.*, 2014 WL 4825237, at *2-5, AR 116-20. Thus, HHS may have had sufficient appropriations to make a contract regarding risk-corridors payments prior to December 2014 without triggering the Anti-Deficiency Act, but not thereafter.

199, 201 (2006) ("For plaintiff to recover on her breach of contract claim, she must establish the existence of a valid contract with defendant and a breach of a duty created by that contract.") (citing *San Carlos Irrigation & Drainage Dist. v. United States*, 877 F.2d 957, 959 (Fed. Cir. 1989); *Cornejo-Ortega v. United States*, 61 Fed. Cl. 371, 373 (2004)). If a valid implied contract obligated HHS to make risk-corridors payments, HHS's contractual obligations would be defined by Section 1342 and the implementing regulations pertaining to the risk-corridors program. As discussed *supra*, neither Section 1342 of the Act nor Section 153.510 of the regulations dictate when HHS must make payments. Additionally, subsequent to Lincoln's 2014 qualified health plan certification but prior to Lincoln's 2015 certification, HHS expressly stated that it would be implementing a three-year, budget-neutral scheme for risk-corridors payments. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260, AR 6195. Lincoln cannot establish that HHS breached any implied contract because the three-year, budget-neutral risk-corridors program has not ended.

Thus, the government's motion to dismiss Lincoln's breach of implied-in-fact contract claim is granted.

C. Count IV: Lincoln Failed to Allege a Breach of the Implied Covenant of Good Faith and Fair Dealing Because No Valid Contract Exists

Lincoln alleges that the government breached the implied covenant of good faith and fair dealing by failing to make full risk-corridors payments annually.

See Compl. ¶¶ 199-209. Every contract contains an implied "duty of good faith and fair dealing in its performance and enforcement." *Metcalf Constr. Co. v. United States*, 742 F.3d 984, 990 (Fed. Cir. 2014) (quoting *Restatement (Second) of Contracts* § 205 (1981)). However, this implied duty only attaches to a valid contract and will not otherwise apply. *See, e.g.*, *HSH Nordbank AG v. United States*, 121 Fed. Cl. 332, 341 (2015) ("[S]ince Plaintiff failed to establish either an express or implied contract . . . , its dependent claim for a breach of implied covenant of good faith and fair dealing also must be dismissed."), *aff'd*, 644 Fed. Appx. 1004 (Fed. Cir. 2016); *Westlands Water Dist. v. United States*, 109 Fed. Cl. 177, 205 (2013) ("[T]here is no contractual . . . duty to which the implied duty of good faith and fair dealing can attach."). Because Lincoln failed to allege a valid express or implied contract with the government, the dependent implied covenant claim does not appertain. The government's motion to dismiss Lincoln's breach of implied covenant of good faith and fair dealing is granted.

III. THE TAKINGS COUNT

Lincoln alleges that HHS's failure to make full risk-corridors payments annually violated the Fifth Amendment because it resulted in a taking of Lincoln's property for public use without just compensation. *See* Compl. ¶¶211-17. The Takings Clause of the Fifth Amendment provides that private property shall not be taken without just compensation. U.S. Const. amend. V, cl. 4. In evaluating a takings claim, the court must first determine whether the plaintiff has a cognizable interest in the property at issue. *Karuk Tribe of Cal.*

v. Ammon, 209 F.3d 1366, 1374 (Fed. Cir. 2000) (citations omitted). Absent a valid property interest, a plaintiff's takings claim will fail as a matter of law. *Earman v. United States*, 114 Fed. Cl. 81, 112 (2013), *aff'd*, 589 Fed. Appx. 991 (Fed. Cir. 2015). If the plaintiff does have a property interest, only then will the court determine whether the government's actions constituted a taking of that interest. *Adams v. United States*, 391 F.3d 1212, 1218 (Fed. Cir. 2004).

Here, Lincoln does not have a valid property interest in receiving full risk-corridors payments annually. Lincoln's statutory entitlement claim does not give rise to a takings claim because Lincoln is not entitled to full payments annually, and because a statutory right to payment is not a recognized property interest. *See Adams*, 391 F.3d at 1225 (holding that appellants' right to unpaid compensation under the Fair Labor Standards Act did not create a property interest); *Hicks v. United States*, 118 Fed. Cl. 76, 85 (2014) ("Even if plaintiff's demand represented a genuine obligation of the government, the failure to pay such a monetary obligation would not amount to a taking.") (citations omitted); *Meyers v. United States*, 96 Fed. Cl. 34, 62 (2010) (dismissing plaintiffs' takings claim based on the Conservation Security Program because the program's monetary benefits did not provide plaintiff with a property interest), *appeal dismissed*, 420 Fed. Appx. 967 (Fed. Cir. 2011). Additionally, although contracts are property, Lincoln's contract claims do not establish a property interest because Lincoln failed to allege the elements of a valid express or implied-in-fact contract related to risk-corridors payments. *See, e.g., Piszel v. United States*, 121 Fed. Cl. 793, 803 (2015) ("[T]his [c]ourt has long recognized

that *valid* contracts are property.") (emphasis added), *aff'd*, 833 F.3d 1366 (Fed. Cir. 2016). Thus, the government's motion to dismiss Lincoln's takings claim is granted.

CONCLUSION

For the reasons stated above, the government's motion for judgment on the administrative record is GRANTED with respect to Count I, and the government's motion to dismiss plaintiff's complaint pursuant to RCFC 12(b)(6) is GRANTED with respect to Counts II, III, IV, and V. Plaintiff's motion and cross-motion for judgment on the administrative record are DENIED. The clerk will enter judgment in accord with this disposition.

No costs.

It is so ORDERED.

*s/*Charles F. Lettow
Charles F. Lettow
Judge

APPENDIX D

United States Court of Appeals for the Federal Circuit

MODA HEALTH PLAN, INC.,
Plaintiff-Appellee

v.

UNITED STATES,
Defendant-Appellant

2017-1994

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NON-PROFIT MUTUAL INSURANCE CORPORATION,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-1224

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00744-CFL, Judge Charles F. Lettow.

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

v.

UNITED STATES,
Defendant-Appellee

2017-2154

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00651-LKG, Judge Lydia Kay Griggsby.

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-2395

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

ON PETITIONS FOR REHEARING EN BANC

STEVEN ROSENBAUM, Covington & Burling LLP, Washington, DC, filed a petition for rehearing en banc for plaintiff-appellee in 2017-1994. Also represented by BRADLEY KEITH ERVIN; CAROLINE BROWN, PHILIP PEISCH, Brown & Peisch PLLC, Washington, DC.

DANIEL P. ALBERS, Barnes & Thornburg LLP, Chicago, IL, filed a petition for rehearing en banc for plaintiff-appellant in 2017-1224. Also represented by SCOTT E. PICKENS, Washington, DC; JONATHAN MASSEY, Massey & Gail LLP, Washington, DC.

LAWRENCE SHER, Reed Smith LLP, Washington, DC, filed a combined petition for panel rehearing and rehearing en banc for plaintiff-appellant in 2017-2154. Also represented by KYLE RICHARD BAHR, JAMES CHRISTOPHER MARTIN, CONOR MICHAEL SHAFFER, COLIN E. WRABLEY, Pittsburgh, PA.

STEPHEN JOHN MCBRADY, Crowell & Moring, LLP, Washington, DC, filed a petition for rehearing en banc for plaintiff-appellant in 2017-2395. Also represented by CLIFTON S. ELGARTEN, SKYE MATHIESON, DANIEL WILLIAM WOLFF.

ALISA BETH KLEIN, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC, filed a response to the petitions for defendant-appellee in 2017-1224, 2017-2154, 2017-2395 and defendant-appellant in 2017-1994. Also represented by JOSEPH H. HUNT, MARK B. STERN, CARLEEN MARY ZUBRZYCKI.

WILLIAM LEWIS ROBERTS, Faegre Baker Daniels LLP, Minneapolis, MN, for amici curiae Association for Community Affiliated Plans, Alliance of Community Health Plans in 2017-1994. Also represented by JONATHAN WILLIAM DETTMANN, NICHOLAS JAMES NELSON.

STEVEN ALLEN NEELEY, JR., Husch Blackwell LLP, Washington, DC, for amicus curiae National Association of Insurance Commissioners in 2017-1994. Also represented by KIRSTEN A. BYRD, Kansas City, MO.

URSULA TAYLOR, Strategic Health Law, Chapel Hill, NC, for amicus curiae Blue Cross Blue Shield Association in 2017-1994. Also represented by SANDRA J. DURKIN, Butler Rubin Saltarelli & Boyd LLP, Chicago, IL.

BENJAMIN N. GUTMAN, Oregon Department of Justice, Salem, OR, for amici curiae State of Oregon, State of Alaska, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Kentucky, State of Maryland, State of Massachusetts, State of Minnesota, State of New Mexico, State of North Carolina, State of Pennsylvania, State of Rhode Island, State of Vermont, State of Washington, State of Wyoming, District of Columbia in 2017-1994. Also represented by ELLEN F. ROSENBLUM. State of Oregon also represented by PEENSEH SHAH.

LESLIE BERGER KIERNAN, Akin, Gump, Strauss, Hauer & Feld, LLP, Washington, DC, for amicus curiae America's Health Insurance Plans in 2017-1994, 2017-1224. Also represented by ROBERT K.

HUFFMAN, PRATIK A. SHAH; RUTHANNE MARY DEUTSCH, HYLAND HUNT, Deutsch Hunt PLLC, Washington, DC; RALPH C. NASH, George Washington University Law School, Washington, DC.

STEPHEN A. SWEDLOW, Quinn Emanuel Urquhart & Sullivan, LLP, Chicago, IL, for amici curiae Health Republic Insurance Company, Common Ground Healthcare Cooperative, Kate Bundorf, Scott Harrington, Mark Pauly, Michael Chernew, Thomas McGuire, Leemore Dafny, Kosali Simon in 2017-1224. Amicus curiae Health Republic Insurance Company also represented by J. D. HORTON, ADAM WOLFSON, Los Angeles, CA.

Before PROST, *Chief Judge*, NEWMAN, LOURIE, DYK, MOORE, REYNA, WALLACH, TARANTO CHEN, HUGHES, and STOLL, *Circuit Judges*.*

NEWMAN, *Circuit Judge*, with whom WALLACH *Circuit Judge*, joins, dissents from the denial of the petitions for rehearing en banc.

WALLACH, *Circuit Judge*, with whom NEWMAN, *Circuit Judge*, joins, dissents from the denial of the petitions for rehearing en banc.

PER CURIAM.

ORDER

Appellee Moda Health Plan, Inc. and appellants Land of Lincoln Mutual Health Insurance Company

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* Circuit Judge O'Malley did not participate.

and Maine Community Health Options each filed petitions for rehearing en banc. Appellant Blue Cross and Blue Shield of North Carolina filed a petition for panel rehearing and rehearing en banc. A response to the petitions was invited by the court and filed by the United States. Several motions for leave to file amici curiae briefs were filed and granted by the court. The petitions for rehearing, response, and amici curiae briefs were first referred to the panel that heard the appeals, and thereafter to the circuit judges who are in regular active service. A poll was requested, taken, and failed.

Upon consideration thereof.

IT IS ORDERED THAT:

The petitions for panel rehearing are denied.

The petitions for rehearing en banc are denied.

The mandates of the court will issue on November 13, 2018.

FOR THE COURT

November 6, 2018
Date

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of Court

United States Court of Appeals
for the Federal Circuit

MODA HEALTH PLAN, INC.,
Plaintiff-Appellee

v.

UNITED STATES,
Defendant-Appellant

2017-1994

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NON-PROFIT MUTUAL INSURANCE CORPORATION,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-1224

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00744-CFL, Judge Charles F. Lettow.

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

v.

UNITED STATES,
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2017-2154

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MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellant

v.

UNITED STATES,
Defendant-Appellee

2017-2395

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

NEWMAN, *Circuit Judge*, with whom WALLACH, *Circuit Judge*, joins, dissenting from denial of the petition for rehearing en banc.

The judiciary's role is to assure fidelity to law and to the Constitution. The Federal Circuit has a special responsibility as a national court, for no other circuit court is in our jurisdictional loop. Thus when questions of national impact reach us, it devolves upon us to bring the full potential of the court to bear.

The national impact of these health insurance cases, coupled with the role of "appropriations riders" as a legislative tool, led to a split panel decision; and the ensuing requests for reconsideration have been accompanied by amicus curiae briefs on behalf of the insurance industry, state governments, economists and other scholars, and the public, advising us on the law, the Constitution, the legislative process, and the national interest. From the court's denial of rehearing en banc, I respectfully dissent.

The facts are simple; the principle large. The critical question concerns the methods by which the government deals with non-governmental entities that carry out legislated programs. Here, in order to persuade the nation's health insurance industry to provide insurance to previously uninsured or uninsurable persons, and thus to take insurance risks of unknown dimension, the Affordable Care Act[1] provided that insurance losses over a designated percentage would be reimbursed, and comparable

[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

profits would be turned over to the government—the "risk corridors" program.

With this statutory commitment that the government "shall pay," 42 U.S.C. § 18062(b), the nation's insurance industry provided the designated health insurance. However, when large losses were experienced by some carriers, the government refused to appropriate the funds to pay the statutory shortfall, and required that existing funds not be used for this purpose. Thus the insurers, who had performed their part of the bargain, were denied the promised compensation. My colleagues now ratify that denial.

This is a question of the integrity of government. "It is very well to say that those who deal with the Government should turn square corners. But there is no reason why the square corners should constitute a one-way street." *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 387–88 (1947) (Jackson, J., dissenting); *see also* 48 C.F.R. § 1.102(b)(3) ("The Federal Acquisition System will . . . [c]onduct business with integrity, fairness, and open-ness."). Our system of public-private partnership depends on trust in the government as a fair partner. And when conflicting interests arise, assurance of fair dealing is a judicial responsibility.

I have previously elaborated on the violations of law and legislative process that apparently are ratified by the panel majority, *see Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1331–40 (Fed. Cir. 2018) (Newman, J., dissenting). On these petitions for rehearing en banc, many amici curiae have provided advice. For example, America's Health

Insurance Plans, a national association of the insurance industry, states:

> The panel majority's opinion, however, now makes it a risky business to rely upon the government's assurances. That deals a crippling blow to health insurance providers' business relationships with the government, which depend upon the providers' ability to trust that the government will act as a fair partner.

Br. of America's Health Ins. Plans, Inc. as Amicus Curiae in Supp. of Reh'g En Banc at 3, Aug. 20, 2018, ECF No. 111.

The amici report that this government action has caused significant harm to insurers who participated in the Affordable Care Act program. The National Association of Insurance Commissioners informs the court that "only six of the 24 CO-OPs operating at peak participation were still in business," and that the government's refusal to make the promised payments "transformed the Exchanges from promising to punitive for the insurance industry." Br. of Amicus Curiae The Nat'l Ass'n of Ins. Comm'rs in Supp. of Pl.-Appellee at 12, 14, Aug. 28, 2017, ECF No. 51. The Court of Federal Claims put it plainly, that the government's position that it can renege on its legislated and contractual commitments "is hardly worthy of our great government." *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 466 (2017).

In the national interest, there is even more at stake than these promises to the health insurance industry. The governments access to private sector

products and services is undermined if non-payment is readily achieved after performance by the private sector. The Court has stated that "[i}f the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily—if at all— and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191–92 (2012).

Our national strength is our government ruled by law. The implementation of that rule has been reinforced in history: "It is as much the duty of Government to render prompt justice against itself in favor of citizens as it is to administer the same between private individuals." Abraham Lincoln, First Annual Message to Congress (Dec. 3, 1861), *reprinted* in James D. Richardson, A Compilation of the Messages and Papers of the Presidents 1789-1897, vol. VI 44, 51 (1897).

"It is emphatically the province and duty of the judicial department to say what the law is." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803). At a minimum, this court should review this matter en banc. From the denials of rehearing, I respectfully dissent.

United States Court of Appeals
for the Federal Circuit

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Plaintiff-Appellee

v.

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Defendant-Appellant

2017-1994

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v.

UNITED STATES,
Defendant-Appellee

2017-2395

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WALLACH, *Circuit Judge*, with whom NEWMAN, *Circuit Judge*, joins, dissenting from the denial of the petition for rehearing en banc.

This case involves the obligation of Appellant United States ("the Government") to make so-called "risk corridors payments" to providers of certain health insurance plans, with the payments designed to help insurers mitigate risk when joining the new healthcare exchanges created by the Patient Protection and Affordable Care Act ("ACA"). *See* Pub. L. No. 111-148, 124 Stat. 119 (2010). The panel majority holds that, although it agrees with Appellee Moda Health Plan, Inc. ("Moda") that "the plain language of section 1342 [of the ACA, i.e., 42 U.S.C. § 18062 (2012)] created an obligation of the [G]overnment to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program," *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1322 (Fed. Cir. 2018), Congress repealed or suspended the Government's obligation to make the risk corridors payments by subsequently enacting *riders to appropriations bills*, *see id.* at 1322, 1331. However, the majority's holding regarding an implied repeal of the Government's obligation cannot be squared with Supreme Court precedent, which states that "[t]he doctrine disfavoring repeals by implication applies with full vigor when the subsequent legislation is an *appropriations* measure." *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978) (internal quotation marks, ellipsis, and citations omitted). Because I believe the appropriations riders did not impliedly repeal the Government's obligations to make risk corridors payments, I respectfully

dissent from the denial of the petition for rehearing en banc.

DISCUSSION

I. The Government Is Legally Obligated to Make Risk Corridors Payments

Section 1342(a) of the ACA provides that the Secretary of the U.S. Department of Health and Human Services ("HHS")

> shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan [("QHP")] 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.

42 U.S.C. § 18062(a). The ACA provides a statutory formula whereby HHS receives "[p]ayments in" from QHP issuers that have excess profits and makes certain "[p]ayments out" to QHP issuers with excess losses. *Id.* § 18062(b)(1), (2). "Because insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new [ACA] exchanges, insurers faced significant risk if they elected to offer plans in these exchanges," and the risk corridors program was "designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk." *Moda*, 892 F.3d at 1314; *see id.* at 1315 ("The risk corridors program permitted issuers to lower premiums by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016

markets." (internal quotation marks, brackets, and citation omitted)). HHS explained "[t]he risk corridors program is not statutorily required to be budget neutral . . . . HHS will remit payments as required under [§] 1342." *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013).

Moda, for example, began participating in the health care exchanges as an issuer of QHPs in 2014. J.A. 61–62. As of March 2017, Moda was owed the following payments out under the risk corridors program: "$75,879,282.72 for benefit year 2014 and $133,951,163.07 for benefit year 2015, for a total of $209,830,445.79." J.A. 41 (Joint Status Report); *see* J.A. 44 (entering judgment, by Court of Federal Claims, for the total amount).

I agree with the majority that § 1342 obligates the Government to make risk corridors payments. I begin with the plain language of § 1342. *See BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (providing that statutory interpretation "begins with the statutory text"); *see also Sandifer v. U.S. Steel Corp.*, 571 U.S. 220, 227 (2014) ("It is a fundamental cannon of statutory construction that . . . words will be interpreted as taking their ordinary, contemporary, common meaning." (internal quotation marks and citation omitted)). Section 1342 uses the word shall to define HHS's risk corridors obligations. *See* 42 U.S.C. § 18062(a) (reciting that HHS "*shall* establish and administer a program of risk corridors" (emphasis added)), (b)(1) (dictating that HHS "*shall* provide under the program" certain payments out (emphasis added)), (b)(1)(A) (stating that when "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, [HHS] *shall pay* to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount" (emphasis added)), (b)(1)(B) (stating that when "a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, [HHS] *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" (emphasis added)).

The word shall typically sets forth a command. *See* 1A N. Singer & J. Singer, Sutherland on Statutes and Statutory Construction § 32A:11 (7th ed. 2009) ("The use of the word [shall] as a command is now firmly fixed, both in common speech, in the second and third persons, and in legal phraseology."). "Dictionaries from the era of . . . enactment," *Sandifer*, 571 U.S. at 228, establish that shall generally imposes a mandatory duty, *see Shall, Black's Law Dictionary* (9th ed. 2009) (defining shall as "[h]as a duty to; more broadly, is required to" and explaining "[t]his is the mandatory sense that drafters typically intend and that courts typically uphold"); *Shall, Webster's New World College Dictionary* (4th ed. 2009) (explaining that shall is often "used . . . to express determination, compulsion, obligation, or necessity"). Although the "circumstances, or the context of an act" may indicate that the word shall is to be interpreted as "merely permissive, rather than imperative," Sutherland § 32A:11, nothing in § 1342 or the ACA indicates that the use of the word shall in relation to the Government's obligation to make risk corridors payments was intended to be interpreted in

the permissive sense, rather than the imperative, *see* 42 U.S.C. § 18062. *See generally* Pub. L. No. 111-148, 124 Stat. 119. Indeed, the Supreme Court has routinely treated the word shall as an imperative. *See SAS Inst. Inc. v. Iancu*, 138 S. Ct. 1348, 1352 (2018) ("The word 'shall' generally imposes a nondiscretionary duty . . . ."); *Kingdomware Techs., Inc. v. United States*, 136 S. Ct. 1969, 1977 (2016) ("Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement."); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) ("[T]he mandatory 'shall[]' . . . normally creates an obligation impervious to judicial discretion." (citation omitted)). Therefore, the plain language of § 1342 requires HHS to make certain payments out in accordance with the statutory formula provided therein. *See* 42 U.S.C. § 18062(b)(1).

Section 1342 establishes this duty without respect to budgetary considerations, such as achieving budget neutrality or availability of appropriations. *See id.* § 18062; *see also Greenlee Cty. v. United States*, 487 F.3d 871, 878 (Fed. Cir. 2007) (providing a situation where a statute subjected Government liability for payments to the county to amounts appropriated by Congress). Therefore, as the panel majority found, the statutory text unambiguously obligates the Government to make the full risk corridors payments. *See Moda*, 892 F.3d at 1322 ("We conclude that the plain language of [§] 1342 *created an obligation* of the [G]overnment to pay participants in the health benefit exchanges the *full amount* indicated by the statutory formula for payments out under the risk corridors program." (emphases added)).

II. The Appropriations Riders Did Not Impliedly Repeal the Government's Obligation

"As a general rule, repeals by implication are not favored. This rule applies with *especial force* when the provision advanced as the repealing measure was enacted *in an appropriations bill*." *United States v. Will*, 449 U.S. 200, 221–22 (1980) (emphases added) (internal quotation marks and citations omitted). "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883). The Supreme Court looks for "words that expressly, or by clear implication, modified or repealed the previous law." *United States v. Langston*, 118 U.S. 389, 394 (1886).

When Congress passed an appropriations bill to HHS in December 2014 for fiscal year 2015, it included an appropriations rider stating:

> *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 [§] 1342(b)(1) . . . (relating to risk corridors).

Consolidated and Further Continuing Appropriations Act, 2015 ("FY 2015 Appropriations"), Pub. L. No. 113-235, div. G, § 227, 128 Stat. 2130, 2491 (emphases added). Appropriations riders for fiscal years 2016 and 2017 included identical language. Consolidated Appropriations Act, 2017 ("FY 2017 Appropriations"),

Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624.[1]

These appropriations riders do not clearly establish that Congress intended to repeal the Government's obligation to make risk corridors payments. The riders do not address *whether the obligation remains payable* and, at most, only address *from whence the funds to pay the obligation may come. See, e.g.,* FY 2015 Appropriations § 227. The present case is similar to *Langston*, in which the Supreme Court held that "a statute fixing the annual salary of a public officer at a named sum, without limitation as to time," was not "deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount . . . and which contained no words that expressly, or by clear implication, modified or repealed the previous law." 118 U.S. at 394. There, the claimant held a position, for which a statute indicated a person serving in that position "shall be entitled to a salary of $7,500 a year." *Id.* at 390 (internal quotation marks and citation omitted). While in some subsequent appropriations acts Congress appropriated the full $7,500, Congress

[1] The majority's holding was limited to the appropriations riders for fiscal years 2015 and 2016 because the appropriations rider for fiscal year 2017 "had not yet been enacted before this case completed briefing." *Moda*, 892 F.3d at 1322 n.4. The majority explained that "[t]he [G]overnment's argument [for an implied repeal] applies equally" to the 2017 appropriations rider. *Id.* That appropriations rider became law in May 2017. *See generally* FY 2017 Appropriations. The majority's opinion, therefore, has the effect of repealing risk corridor payments for each of the years obligated by § 1342, i.e., 2014–2016. *See* 42 U.S.C. § 18062(a).

appropriated only $5,000 for that particular position in appropriations acts for fiscal years 1883 and 1884. *See id.* at 391. The Supreme Court held the claimant was still due $7,500 for 1883 and 1884 because the salary "was originally fixed at the sum of $7,500," and "[n]either of the acts appropriating $5,000 . . . contains any language to the effect that such sum shall be 'in full compensation' for those years" nor did either contain "an appropriation of money 'for additional pay,' from which it might be inferred that [C]ongress intended to repeal the act fixing his annual salary at $7,500." *Id.* at 393. The Supreme Court found it "not probable that [C]ongress" would "make a permanent reduction of [claimant's] salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel the courts to say that harmony between the old and the new statute was impossible." *Id.* at 394.

Similarly, the appropriations riders at issue, enacted after Congress imposed the risk corridors payment obligation in the ACA, appropriated a lower amount. The riders *do not state* that this lower amount serves as full satisfaction of the Government's obligation under § 1342. *See, e.g.*, FY 2015 Appropriations § 227. Nor do the appropriations riders cut off *all* sources of funding for the risk corridors program. *See, e.g., id.* (specifying particular funds from which risk corridors payments may not be made). In *Gibney v. United States*, our predecessor court held that appropriations language similar to the riders here was "a mere limitation on the expenditure of a particular fund," and "d[id] not have the effect of either repealing or even suspending an existing statutory obligation any more than the failure to pay

a note in the year in which it was due would cancel the obligation stipulated in the note." 114 Ct. Cl. 38, 50–51 (1949); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 752 (Ct. Cl. 1966) (explaining "the failure of Congress . . . to appropriate or make available sufficient funds does not repudiate the obligation").

Akin to the situation here, the appropriations bill in *Gibney* stated "*none of the funds* appropriated for the Immigration and Naturalization Service *shall be used to pay* compensation for overtime services." 114 Ct. Cl. at 48 (emphases added); *see* FY 2015 Appropriations § 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 payments* under [§] 1342(b)(1) . . . ." (emphases added)); *see also Beer v. United States*, 696 F.3d 1174, 1185 (Fed. Cir. 2012) (en banc) (holding that a 2001 amendment to an appropriations bill did not impliedly repeal a 1989 law that guaranteed judicial cost of living adjustments). Because I believe § 1342 is "reasonabl[y] constru[ed]" as setting forth the Government's obligation to make risk corridors payments out and the appropriations riders as simply designating from which funds the payments out may not be made, I believe we must "give effect to the provisions of each," rather than finding the statutory obligation impliedly repealed. *Langston*, 118 U.S. at 393.

Although the majority points to a single statement made during legislative debates for the 2015 appropriations rider to support its position that each appropriations rider intended to make the risk corridors program budget neutral, *see Moda*, 892 F.3d at 1325, this statement hardly provides the requisite clear legislative intent for an implied repeal. Then-Chairman of the House Committee on Appropriations Harold Rogers stated:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent the [Centers for Medicare and Medicaid Services] Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). However, the Supreme Court has indicated "[t]he whole question depends on the intention of [C]ongress as *expressed in the statutes*." *Mitchell*, 109 U.S. at 150. It is not appropriate to rely on Chairman Rogers's statement to inject ambiguity into the appropriations riders' plain meaning. *See Gibney*, 114 Ct. Cl. at 53 ("We must take what the [appropriations bill] says and not what one member of [Congress] might have been under the impression it contained."). Even if it is appropriate to look beyond the text of the statutes, the above statement does not support the majority's position. Chairman Rogers did not say that the 2015 *appropriations rider* sought to

make the risk corridors program budget neutral; instead, he said that such was the goal of *an HHS regulation* and that the 2015 appropriations rider sought to designate from which funds the payments out may not be made. *See* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). Chairman Rogers said nothing about the 2015 appropriations rider's effect on the Government's *obligation* to make payments out. *See id.*

If anything, I believe it is more probative of legislative intent that Congress, eight months before it passed the first appropriations rider, introduced legislation to repeal the Government's obligation to make full risk corridors payments by requiring budget neutrality, but failed to pass that legislation. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, § 2, 113th Cong. (2014) (proposing to add to § 1342 a subsection that states that HHS "shall ensure that payments out and payments in . . . are provided for in amounts that [HHS] determines are necessary to reduce to zero the cost"); *see also Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962) ("When the repeal of a highly significant law is urged upon [Congress] and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide by that decision."), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union, Local 770*, 398 U.S. 235 (1970). Less than two months after enacting the first of the appropriations riders, Congress considered but did not pass legislation solely meant to make the risk corridors program budget neutral. *See* Taxpayer Bailout Protection Act, H.R. 724, § 2, 114th Cong. (2015) (providing that payments out should not exceed payments in);

Taxpayer Bailout Protection Act, S. 359, § 2, 114th Cong. (2015) (same). While we are generally "reluctant to draw inferences from the failure of Congress to act," *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 220 (1983), I understand these facts to support a finding that Congress did not intend the appropriations riders either to repeal the Government's obligation to make risk corridors payments or to decrease the Government's exposure to liability by temporarily capping the amount of payments by making the program budget neutral, *see id.* (stating "it would . . . appear improper for us to give a reading to [an a]ct that Congress considered and rejected").

While the majority attempts to cast its opinion as holding "that Congress enacted *temporary* measures capping risk corridor payments out at the amount of payments in," *Moda*, 892 F.3d at 1327 (emphasis added), this characterization does not withstand scrutiny. Under the majority's holding, the appropriations riders have substantively altered the Government's § 1342 obligations for *every year* of the risk corridors program by no longer requiring the Government to make payments out subject to the statutory formula. *See id.* at 1322; *see also* 42 U.S.C. § 18062(b)(1) (providing the statutory formula for payments out). For instance, in the case of Moda, the Government has not made the full payments out in 2014, as calculated by the formula, and has not made a *single* payment out in 2015. *See Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 448 (2017). Accordingly, I believe the majority erred in its consideration of the appropriations riders.

III. This Case Raises an Exceptionally Important Issue Regarding the Government's Reliability as an Honest Broker

The majority's holding casts doubt on the Government's continued reliability as a business partner in all sectors. The Government induced health insurance providers to enter the risky health exchanges through, inter alia, the risk corridors program. *See* Bundorf et al. Amicus Br. ("Economists & Professors Amicus Br.")[2] 3–7, *Land of Lincoln Health Ins. Co. v. United States*, No. 2017-1224, ECF No. 188. As the majority acknowledges, "[b]ecause insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new [ACA] exchanges, insurers faced significant risk if they elected to offer plans in these exchanges." *Moda*, 892 F.3d at 1314. The risk corridors program was "designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk" by "permit[ting] issuers to lower premiums by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 1314, 1315 (internal quotation marks, brackets, and citation omitted). Therefore, "[b]y reducing the risk of participating in a newly created market, the Government encouraged firms to enter a new market[, i.e., the health care exchanges,] characterized by considerable uncertainty in the risk profile of potential enrollees (and, thus, profitability)." Economists & Professors Amicus Br. 6.

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[2] This amicus brief was submitted by "distinguished economists and professors of health policy, economics, and management." Economists & Professors Amicus Br. 1.

QHP issuers, like Moda, entered the health care exchanges and set premiums with the belief that they would receive risk corridors payments, *see* J.A. 61–62, and Congress, subsequently, passed the relevant appropriations riders, *see, e.g.*, FY 2015 Appropriations § 227. To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government's credibility as a reliable business partner. For example, the ACA also "clearly and unambiguously imposes an obligation on . . . HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans," *Montana Health Co-Op v. United States*, No. 18-143C, 2018 WL 4203938, at *5 (Fed. Cl. Sept. 4, 2018), but the Government refused to make those payments for reasons similar to those here, *see id.* at *1.

The Government's refusal to honor its obligation has important consequences. "Based on the Government's own official calculations, QHP [i]ssuers are owed about $12.3 billion dollars for the 2014–2016 plan years." Health Republic Ins. Co. & Common Ground Healthcare Cooperative's Amicus Br. ("Health Republic Amicus Br.") 9, *Land of Lincoln Health Ins. Co. v. United States*, No. 2017-1224, ECF No. 189; *see Moda*, 892 F.3d at 1319 (acknowledging that the Government's shortfall of payments out equaled "more than $12 billion"). These shortfalls have negatively affected not only health insurance providers but also health insurance recipients. For instance, by the end of 2016, eighteen of twenty-four health cooperatives that were participating in the exchanges were no longer in business because a lack

of capital, in part, due to the lack of risk corridors payments. Nat'l Ass'n of Ins. Comm'rs Amicus Br. 12–13, *Moda Health Plan, Inc. v. United States*, No. 2017-1994, ECF No. 51. Several health insurance companies "withdrew from the ACA exchanges entirely," and others still offering plans "had to compensate for this uncertainty in payment by offering health plans at *higher prices* than before." Health Republic Amicus Br. 11 (emphasis added). These consequences, which impact the cost of health care insurance for virtually all Americans, make this case fit for en banc consideration.

CONCLUSION

Rather than faithfully applying Supreme Court and our precedent disfavoring repeals by implication, *see, e.g., Tenn. Valley Auth.*, 437 U.S. at 190, the majority holds that Congress clearly manifested its intent to repeal the Government's statutory obligation to make risk corridors payments pursuant to the ACA's formula, *see* 42 U.S.C. § 18062, through appropriations riders. I believe this conclusion is unsound. Thus, I respectfully dissent from the court's denial of the petition for rehearing en banc as to all of the above-captioned cases.

APPENDIX E

Section 1342 of the ACA, 42 U.S.C. § 18062

(a) In general

The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w-101 et seq.].

(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.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.