Nos. 18-1023, 18-1028, and 18-1038

In the Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS, PETITIONER

v.

UNITED STATES OF AMERICA

MODA HEALTH PLAN, INC., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

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

v.

UNITED STATES OF AMERICA

ON PETITIONS FOR WRITS OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

BRIEF FOR THE UNITED STATES IN OPPOSITION

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QUESTIONS PRESENTED

In the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. 18001 *et seq.*, Congress directed the Department of Health and Human Services (HHS) to establish a temporary "risk corridors" program for 2014-2016, under which HHS would collect "payments in" from relatively profitable insurers and make "payments out" to relatively unprofitable insurers pursuant to statutory formulas. 42 U.S.C. 18062 (capitalization omitted). The ACA, however, did not appropriate any funds to make payments out. In response to an inquiry from Members of Congress, the Government Accountability Office identified only two possible sources of funding from which HHS could make such payments: the amounts that HHS would collect from insurers as risk-corridors payments in, and a lump-sum appropriation for the management of certain Centers for Medicare and Medicaid Services programs. Congress then enacted appropriations acts covering all of the years at issue that confirmed the first source of funding but expressly barred HHS from using the second. The questions presented are as follows:

1. Whether the court of appeals correctly rejected petitioners' statutory claim for damages for amounts of "payments out" that Congress declined to appropriate.

2. Whether the court of appeals correctly rejected petitioners' implied-in-fact contract claims.

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OPINIONS BELOW

The opinion of the court of appeals in No. 18-1023 (18-1023 Pet. App. 1a-2a) is not published in the Federal Reporter but is reprinted at 729 Fed. Appx. 939. The opinion of the Court of Federal Claims in that case (18-1023 Pet. App. 89a-119a) is reported at 133 Fed. Cl. 1. The opinion of the court of appeals in No. 18-1028 in the appeal of petitioner Moda Health Plan, Inc. (Pet. App. 1-60)[1] is reported at 892 F.3d 1311. The opinion and order of the Court of Federal Claims in that case (Pet. App. 85-152) is reported at 130 Fed. Cl. 436. The opinion of the court of appeals in No. 18-1028 in the appeal of petitioner Blue Cross and Blue Shield of North Carolina (Pet. App. 61-62) is not published in the Federal Reporter but is reprinted at 729 Fed. Appx. 939. The opinion and order of the Court of Federal Claims in that case (Pet. App. 153-206) is reported at 131 Fed. Cl. 457. The opinion of the court of appeals in No. 18-1038 (18-1038 Pet. App. 1a-6a) is reported at 892 F.3d 1184. The opinion and order of the Court of Federal Claims in that case (18-1038 Pet. App. 70a-140a) is reported at 129 Fed. Cl. 81.

JURISDICTION

The judgments of the court of appeals in No. 18-1023 and in No. 18-1028 in the appeal of petitioner Blue Cross and Blue Shield of North Carolina were entered on July 9, 2018. The judgments of the court of appeals in No. 18-1028 in the appeal of petitioner Moda Health Plan, Inc. and in No. 18-1038 were entered on June 14, 2018. Petitions for rehearing were denied in each case on November 6, 2018 (18-1023 Pet. App. 3a-8a). The

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[1] Unless otherwise indicated, "Pet. App." refers to the appendix to the petition for a writ of certiorari in No. 18-1028.

petitions for writs of certiorari were filed on February 4, 2019. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. In the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (42 U.S.C. 18001 *et seq.*), Congress enacted a number of provisions designed to expand coverage in the individual health-insurance market. See *King* v. *Burwell*, 135 S. Ct. 2480, 2485-2487 (2015). For example, the ACA provided for billions of dollars of refundable tax credits each year to help individuals pay for insurance. *Id.* at 2489. It also prohibited insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.* at 2486. And it provided for the creation of Exchanges—online marketplaces in each State where individuals and small groups can purchase health insurance. *Id.* at 2487. All plans offered through an Exchange must be Qualified Health Plans, meaning that they provide "essential health benefits" and comply with various other regulatory requirements. 42 U.S.C. 18021(a)(1)(B); see 45 C.F.R. Pts. 155, 156.

The Exchanges created new business opportunities for insurers electing to participate in them, and insurers have a strong business incentive to do so. Among other reasons, Exchanges are the only commercial channel in which insurers can market their plans to the millions of individuals who receive federal subsidies. See 26 U.S.C. 36B (2012 & Supp. V 2017); *King*, 135 S. Ct. at 2487, 2489, 2496. Like most business opportunities, however, participating in the Exchanges also presented insurers with business risks, particularly pricing uncertainty. Participating in an Exchange meant covering an expanded risk pool of persons whose health status was unknown.

And insurers no longer could charge higher premiums or deny coverage based on a person's health. See Pet. App. 2, 157.

Seeking to mitigate the pricing risk and the incentives for adverse selection arising from this system, the ACA established three premium-stabilization programs, modeled on preexisting programs established under the Medicare program: risk adjustment, reinsurance, and risk corridors. Pet. App. 88; see *id.* at 2-3. All three programs began operating in 2014. See *id.* at 7. The risk-adjustment program is permanent, but the reinsurance and risk-corridors programs were temporary, operating only for benefit years 2014, 2015, and 2016. 42 U.S.C. 18061-18063.

All three programs were designed to mitigate risk by partially subsidizing plans with higher costs or risks, funded by amounts collected from plans with lower costs or risks. Under the risk-adjustment program, plans with healthier-than-average enrollee populations must make payments to the government, which are then used to fund payments to plans with sicker-than-average enrollee populations. 42 U.S.C. 18063. Under the reinsurance program, amounts were collected from insurers and self-insured group health plans, which were then used to fund payments to issuers of eligible plans that cover high-cost individuals in the individual market. 42 U.S.C. 18061.

These cases concern the third program—risk corridors—under which relatively profitable plans made payments to the government that were then used to fund payments to relatively unprofitable plans. 42 U.S.C. 18062(b); see Pet. App. 3. The ACA directed the Department of Health and Human Services (HHS) to establish and administer a program under which insurers offering individual and

small-group Qualified Health Plans between 2014 and 2016 "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums," and stated that the program "shall be based on" an existing risk-corridors program under Part D of the Medicare Act, 42 U.S.C. 1395w-101 *et seq.* 42 U.S.C. 18062(a).

Section 18062 prescribed formulas for determining whether a plan was required to pay money in or was eligible to receive money from the government—and if so how much. It defined a plan's "target amount" of costs as its premiums minus allowable "administrative costs." 42 U.S.C. 18062(c)(2). If a plan's "allowable costs" (essentially, the cost of "providing benefits") were less than its target amount by more than three percent, the plan had to pay a specified percentage of the difference to HHS, called "payments in." 42 U.S.C. 18062(b)(2) and (c)(1)(A) (capitalization omitted). Conversely, if a plan's allowable costs exceeded its target amount by more than three percent, the ACA stated that HHS "shall pay" the plan a specified percentage of the difference, called "payments out." 42 U.S.C. 18062(b)(1) (capitalization omitted). Under the statutory formulas, payments out to a plan thus would offset only a portion of the shortfall of its target amount compared to its allowable costs, not the entirety of the difference. Likewise, payments in represented only a portion of the excess of a plan's target amount over its allowable costs. HHS adopted implementing regulations that incorporated this methodology and defined various terms such as "allowable costs." 45 C.F.R. 153.500, 153.510(b) and (c).

2. For some ACA programs, the ACA itself provided funding, either by appropriating funds directly, *e.g.*, 42 U.S.C. 300gg-93(e), 18001(g)(1), 18031(a)(1), 18042(g),

18043(c), or by amending already-existing appropriations to encompass new programs, ACA § 1401(d), 124 Stat. 220. For the risk-corridors program, however, the ACA did neither. See 42 U.S.C. 18062. Instead, Congress left the determinations of whether to provide funding for risk-corridors payments out, and if so how much, to the ordinary appropriations process through which Congress generally funds government programs via annual appropriations acts.

Congress did not make those determinations until 2014. Risk-corridors collections and payments would not begin until 2015, based on a retrospective analysis of data from 2014, and thus would need to be addressed in the appropriations process for fiscal year 2015. In February 2014, anticipating that process, several Members of Congress requested the opinion of the Government Accountability Office (GAO) "regarding the availability of appropriations to make" risk-corridors payments. *Department of Health & Human Servs.—Risk Corridors Program*, B-325630, at 1 (Sept. 30, 2014), http://www.gao.gov/assets/670/666299.pdf (GAO Op.). The GAO, in turn, solicited the views of HHS, which in May 2014 identified only one source of funding for risk-corridors payments out: the amounts that HHS would collect from plans under the risk-corridors program itself as payments in. See 17-1994 C.A. App. (C.A. App.) 231-233. HHS explained that an annually recurring appropriation authorizing HHS's Centers for Medicare and Medicaid Services (CMS) to expend "such sums as may be collected from authorized user fees" encompassed expenditure of risk-corridors payments in. *Id.* at 232 (quoting Consolidated Appropriations Act, 2014 (2014 Appropriations Act), Pub. L. No. 113-76, Div. H, Tit. II, 128 Stat. 374). HHS's conclusion echoed its position

expressed in adopting implementing regulations that it had recently issued, where it had explained that HHS would implement the risk-corridors program "in a budget neutral manner." 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

In September 2014, the GAO issued its opinion, explaining that "Section [18062], by its terms, did not enact an appropriation to make the payments specified in" Section 18062. GAO Op. 3. The GAO then examined HHS's appropriations act for fiscal year 2014 and identified two provisions that, if reenacted in subsequent appropriations acts, would in its view allow funds to be used for risk-corridors payments out. See *id.* at 3-7. First, the GAO agreed with HHS that payments in under the risk-corridors program would be available under the user-fees appropriation. *Id.* at 3-6. Second, the GAO found that a separate, $3.6 billion lump-sum "[p]rogram [m]anagement" appropriation to CMS for the management of certain programs such as Medicaid and Medicare, as well as "'other responsibilities'" of CMS, also encompassed risk-corridors payments out. *Id.* at 3-4 (quoting 2014 Appropriations Act, 128 Stat. 374). The GAO concluded that, if Congress reenacted either appropriation for fiscal year 2015, HHS could expend those funds to make risk-corridors payments out. *Id.* at 4-7.

In December 2014, Congress enacted the appropriations act for HHS for fiscal year 2015, in which it addressed funding for the risk-corridors program. Consolidated and Further Continuing Appropriations Act, 2015 (2015 Appropriations Act), Pub. L. No. 113-235, Div. G, Tit. II, 128 Stat. 2477. The 2015 Appropriations Act reenacted both the user-fees appropriation and the lump-sum program-management appropriation. *Ibid.*

But Congress also enacted a proviso that expressly prohibited using funds under the program-management appropriation for the risk-corridors program:

> None of the funds made available by this Act from [CMS trust funds], or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111-148 [*i.e.*, 42 U.S.C. 18062(b)(1)] (relating to risk corridors).

2015 Appropriations Act § 227, 128 Stat. 2491.

The 2015 Appropriations Act thus made risk-corridors payments in available to fund payments out, but it eliminated the only other funding source GAO had identified. The Chairman of the House Committee on Appropriations observed in an "explanatory statement" on the bill that this approach was deliberate: he noted that, "[i]n 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," and he explained that the appropriations act "includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014) (statement of Rep. Rogers) (capitalization omitted); see 79 Fed. Reg. at 13,787.

Congress reenacted the same restriction in appropriations acts covering the entire period in which the

risk-corridors program operated.[2] In accordance with those limitations, HHS used only payments in to make risk-corridors payments out. Pet. App. 13-14. In October 2015, HHS announced that payments in for 2014 (approximately $362 million) had fallen significantly short of the claims it had received for payments out (approximately $2.87 billion) and that therefore it would issue prorated payments. C.A. App. 244. HHS subsequently explained that "[t]he remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections." *Id.* at 245. HHS additionally observed that, if a shortfall remained after 2016, the final year of the program, HHS would "explore other sources of funding for risk corridors payments, subject to the availability of appropriations." *Ibid.* In November 2017, HHS published statistics indicating that payments in for the 2014-2016 period fell short of claimed payments out by approximately $12 billion. Pet. App. 14.

3. Petitioners are four insurers that operated plans subject to the risk-corridors program. Petitioners and other such insurers brought dozens of suits—including class actions—in the Court of Federal Claims against the government under the Tucker Act, 28 U.S.C. 1491, alleging that they are legally entitled to the full amount of payments out calculated under the ACA's statutory formulas. Petitioners asserted statutory claims based

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[2] Pet. App. 13 & n.1 (citing Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Tit. II, § 225, 129 Stat. 2624; Continuing Appropriations Act, 2017, Pub. L. No. 114-223, Div. C, §§ 103-104, 130 Stat. 909; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, Div. A, § 101, 130 Stat. 1005-1006; and Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, Div. H., Tit. II, § 223, 131 Stat. 543).

on 42 U.S.C. 18062, and most also asserted implied-in-fact contract claims. All petitioners sought money damages representing the difference between the amounts they received in payments out and the amounts they claim they were owed. See Pet. App. 14-15, 85-86, 107-110, 153-156, 169-170; 18-1023 Pet. App. 90a-93a; 18-1038 Pet. App. 71a-74a, 87a-91a.

In the cases of three petitioners (Maine Community Health Options (Maine Community), Blue Cross and Blue Shield of North Carolina (Blue Cross), and Land of Lincoln Mutual Health Insurance Company (Land of Lincoln)), the Court of Federal Claims ruled for the government, dismissing or granting judgment on those petitioners' statutory and implied-in-fact contract claims. Pet. App. 153-206; 18-1023 Pet. App. 89a-119a; 18-1038 Pet. App. 70a-140a. The court granted summary judgment to petitioner Moda Health Plan, Inc. (Moda), however, on its statutory and implied-contract claims. Pet. App. 85-152.[3]

4. The court of appeals ruled for the government in all four cases. Pet. App. 1-39, 61-62; 18-1023 Pet. App. 1a-2a; 18-1038 Pet. App. 1a-4a.

a. The court of appeals first issued its decision in Moda's case, in which it reversed the Court of Federal Claims' ruling in favor of Moda. Pet. App. 1-39.

i. The court of appeals concluded that Moda's statutory theory that it was entitled to unpaid payments out under 42 U.S.C. 18062 failed to state a claim. Pet. App.

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[3] Petitioners Blue Cross and Land of Lincoln also asserted express-contract claims and claims under the Fifth Amendment's Takings Clause. Pet. App. 61, 196-198, 203-204; 18-1038 Pet. App. 4a, 123a-130a, 138a-140a. The lower courts rejected those claims, see *ibid.*, and petitioners do not seek review of those rulings in this Court.

16-35. The court determined that Section 18062, when originally enacted, "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." *Id.* at 20; see *id.* at 16-21. The court further determined, however, that the appropriations provisos enacted for fiscal year 2015 and subsequent years "repealed or suspended [that] obligation." *Id.* at 21; see *id.* at 21-35. The court reasoned that, although "[r]epeals by implication are generally disfavored, * * * 'when Congress desires to suspend or repeal a statute in force, "there can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise."'" *Id.* at 21 (quoting *United States* v. *Will*, 449 U.S. 200, 222 (1980), in turn quoting *United States* v. *Dickerson*, 310 U.S. 554, 555 (1940)) (brackets omitted). The court determined that the express restrictions in Congress's annual appropriations acts had "adequately expressed Congress's intent to suspend payments on the risk corridors program beyond the sum of payments in." *Ibid.* The court found that those funding restrictions were "[p]lainly" intended to "cap the payments required by the statute at the amount of payments in for each of the applicable years." *Id.* at 26.

The court of appeals rejected Moda's argument that, in enacting those restrictions, Congress had "simply intended to limit the use of a single source of funding while leaving others available." Pet. App. 27. The court explained that "[a]fter 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." *Id.* at 34. The court also cited the explanatory statement

of the Chairman of the House Committee on Appropriations that, under the risk-corridors program, "the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." *Ibid.* (quoting 160 Cong. Rec. at H9838). The court determined that "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," and "the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." *Id.* at 34-35.

The court of appeals also concluded that Moda's implied-in-fact contract theory failed to state a claim. Pet. App. 35-38. The court observed that this Court's precedent establishes a presumption against treating a statute as a contract, and that, "[a]bsent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract." *Id.* at 35. Section 18062, the court of appeals determined, "contains no promissory language," and even Moda did not contend that its text manifested an intent by Congress to contract. *Id.* at 36. The court rejected the contention that an intent to bind the government contractually could be derived from the combination of Section 18062 and HHS's subsequent statements and regulations, concluding that "no statement by the government evinced an intention to form a contract." *Id.* at 38.

ii. Judge Newman dissented. Pet. App. 40-60. In her view, Congress's intent in enacting the appropriations restrictions was unclear absent a "statement in the legislative history suggesting that the rider was enacted in response to the GAO's report," which she concluded was lacking. *Id.* at 48. Judge Newman also opined 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 [ACA]." *Id.* at 59.

b. Based on its opinion in Moda's case, the court of appeals affirmed the rulings for the government in the other three petitioners' cases. Pet. App. 61-62 (Blue Cross); 18-1023 Pet. App. 1a-2a (Maine Community); 18-1038 Pet. App. 1a-4a (Land of Lincoln).

5. Petitioners filed petitions for rehearing en banc, which the court of appeals denied in a single consolidated order. 18-1023 Pet. App. 3a-8a. Judges Newman and Wallach each filed an opinion dissenting from the denial of rehearing en banc. Pet. App. 66-84.

ARGUMENT

The court of appeals correctly concluded that petitioners could not recover money damages from the government, on either their statutory or their implied-in-fact contract theories, for the value of subsidies under a temporary program for which Congress expressly declined to appropriate funds. That conclusion does not conflict with any decision of this Court or any other court of appeals. Further review is not warranted.

1. The court of appeals correctly held that petitioners are not statutorily entitled to recover as money damages from the government the difference between the amounts of risk-corridors payments they received and the amounts they allegedly were owed under the statutory formulas. Pet. App. 16-35. As the court explained, any obligation Section 18062 originally imposed on HHS to make payments out to plans in the full amounts prescribed by the statutory formulas, irrespective of available appropriations, was eliminated by Congress's sub-

sequent enactment of appropriations provisions covering each of the years at issue that expressly prohibited HHS from using the only potential source of funding other than payments in. *Id.* at 21-35. Moreover, petitioners' statutory claims independently fail because the ACA never imposed a privately enforceable obligation on HHS to make payments out irrespective of appropriations. For both reasons, petitioners' statutory claims do not warrant further review.

a. The ACA established a temporary subsidy program to help mitigate risk and uncertainty insurers would face in participating in the Exchanges, by collecting a portion of the revenue of plans that proved to be relatively profitable and offsetting a portion of the costs of plans that proved to be relatively unprofitable. 42 U.S.C. 18062. The ACA itself, however, did not appropriate any funds with which to make payments out to unprofitable plans, instead leaving the policy decisions of whether and to what extent to fund the risk-corridors program to future Congresses in the ordinary appropriations process. When Congress subsequently confronted those policy decisions in enacting appropriations acts for the relevant years, it expressly and repeatedly prohibited HHS from using the only potential source of funds to make payments out, other than payments in collected from profitable insurers under the risk-corridors program itself. The court of appeals correctly determined that, in the particular circumstances of this statutory scheme, those subsequent actions precluded HHS from making risk-corridors payments out in excess of payments in.

i. In concluding that the appropriations riders foreclosed petitioners' statutory claims under Section 18062, the court of appeals correctly applied the settled rule

that appropriations acts, no less than other statutes, can alter or suspend preexisting statutory obligations. Pet. App. 21. This Court has long held that, "when Congress desires to suspend or repeal a statute in force, 'there can be no doubt that . . . it c[an] accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" *United States* v. *Will*, 449 U.S. 200, 222 (1980) (quoting *United States* v. *Dickerson*, 310 U.S. 554, 555 (1940)) (brackets 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), not on whether the later enactment concerns appropriations or other matters.

In decisions dating back more than a century, this Court has repeatedly applied that principle to find that appropriations acts did suspend or repeal existing obligations. In *Will*, for example, the Court concluded that appropriations acts enacted "in Years 1, 3, and 4, although phrased in terms of limiting funds, * * * nevertheless were intended by Congress to block the increases" in judges' salaries that an earlier statute "otherwise would generate." 449 U.S. at 223. Similarly, in *Dickerson*, the Court held that an appropriations act prohibiting the use of funds to pay military reenlistment allowances superseded permanent legislation providing that such allowances shall be paid. 310 U.S. at 554-555. And in *Mitchell*, the Court held that, "by the appropriation acts which cover the period for which the appellee claim[ed] compensation, Congress expressed its purpose to suspend the operation of" a prior statute fixing salaries for interpreters "and to reduce for that period the salaries of the appellee and other interpreters of the same class." 109 U.S. at 148.

Applying that same principle, the court of appeals here correctly concluded that Congress's enactment of the subsequent appropriations acts beginning in fiscal year 2015 compelled the conclusion that Congress intended to limit risk-corridors payments out to the amounts collected from insurers. Pet. App. 21-35. In contrast to certain other ACA programs for which the ACA itself provided funding, for the risk-corridors program the ACA undisputedly did not appropriate any funds for payments out. See pp. 5-6, *supra*. Instead, Congress left the determination whether and to what extent to fund the program to the ordinary appropriations process in subsequent years.

That question first became material in the lead-up to the appropriations process for fiscal year 2015, as the first cycle of risk-corridors collections and payments would not occur until calendar year 2015. In 2014, Members of Congress inquired of the GAO "what funding would be available to make risk corridors payments." Pet. App. 26. The GAO's opinion identified only two funding sources under existing appropriations that would potentially be available for payments out, if Congress were to reenact the same appropriations language in subsequent fiscal years: (1) the amounts that HHS would collect from insurers under the risk-corridors program (referred to as "user fees"), and (2) the lump-sum program-management appropriation for CMS programs such as Medicare and Medicaid, and "other responsibilities of CMS." GAO Op. 4 (brackets and citations omitted); see *id.* at 3-7.

Less than three months after the GAO issued its opinion, Congress enacted legislation that confirmed the first source of funding that the GAO identified but eliminated the second. See 2015 Appropriations Act,

128 Stat. 2477. Specifically, Congress reenacted the user-fees appropriation, thus preserving HHS's ability to use payments in under the risk-corridors program to fund payments out. *Ibid.* But although Congress also reenacted the CMS program-management appropriation, it enacted a proviso that expressly prohibited the use of that appropriation for the risk-corridors program. See § 227, 128 Stat. 2491. The proviso stated that "[n]one of the funds made available" under the program-management appropriation "may be used for payments under [Section 18062(b)(1)] (relating to risk corridors)." *Ibid.*

A contemporaneous statement by the Chairman of the House Committee on Appropriations explained that the proviso was intended to cement HHS's own established position that the risk-corridors program would be operated in a budget-neutral manner, making payments out only to the extent funds were available from payments in. 160 Cong. Rec. at H9838 (statement of Rep. Rogers). Chairman Rogers observed that, "[i]n 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." *Ibid.* That observation presumably referred to HHS's issuance of implementing regulations in March 2014, in which HHS had stated that it would implement the risk-corridors program "in a

budget neutral manner." 79 Fed. Reg. at 13,787.[4] Chairman Rogers then explained that the appropriations act "includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec. at H9838.

Congress reenacted the same restrictions in subsequent appropriations acts covering all of the years at issue. See Pet. App. 13 & n.1; p. 9 n.2, *supra*. The court of appeals correctly determined that, in these particular circumstances, those targeted funding restrictions were "[p]lainly" intended to "cap the payments required by the statute at the amount of payments in for each of the applicable years." Pet. App. 26. As the court observed, "[w]hat else could Congress have intended?" *Id.* at 27. After consulting with the GAO, which apprised Congress of only one potential funding source for risk-corridors payments out other than payments in, Congress acted specifically and unequivocally to forbid HHS from using that funding source for payments out. The "necessary and unavoidable" conclusion, *Harford* v. *United States*, 12 U.S. (8 Cranch) 109, 109-110 (1814) (Story, J.), is that Congress intended risk-corridors payments out to be limited to funds collected from payments in.

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[4] In her dissent below, Judge Newman stated that Chairman Rogers was instead referring to separate guidance HHS had issued in April 2014. Pet. App. 49. It is unclear why Judge Newman believed that Chairman Rogers's allusion to a "regulation" issued in 2014 referred to that guidance, given that HHS had in fact promulgated a regulation in March 2014 that met Chairman Rogers's description. *Id.* at 48 (citation omitted). In any event, the April 2014 guidance to which Judge Newman referred itself had reiterated that HHS would make pro rata reductions in payments to insurers if the amounts collected were insufficient to fund full payments. See C.A. App. 229-230.

As the court of appeals explained, petitioners' contrary reading of Congress's intent is implausible. Pet. App. 27-28. Petitioner Moda asserted below that, in enacting the appropriations proviso forbidding the use of the program-management appropriation, Congress had "simply intended to limit the use of a single source of funding while leaving others available." *Id.* at 27. That reading of the appropriations provisos as concerned only with accounting minutiae blinks reality. As the court explained, the GAO had identified no funding source *other* than that program-management appropriation from which HHS could make payments out in excess of payments in, and Congress eliminated that source. *Id.* at 11-12, 26. And petitioners likewise identify no such funding source. Construing the proviso to leave intact an obligation of HHS nevertheless to make payments out above the amounts collected as payments in would "consign risk corridors payments 'to the fiscal limbo of an account due but not payable,'" a result that Congress "clearly did not intend." *Id.* at 27 (quoting *Will*, 449 U.S. at 224). It is unrealistic to assume that Congress, in eliminating the only potential source of funds for payments out in excess of payments in, intended to subject the United States to massive liability allegedly reaching billions of dollars and simply to swap risk-corridors subsidies for damages suits. The logical conclusion is instead that Congress, in enacting the subsequent appropriations legislation, made the policy decision that it had previously reserved and chose to cap payments out at payments in.

ii. Petitioners advance an array of arguments against the court of appeals' conclusion that Congress's specific appropriations legislation eliminated any obligation to make risk-corridors payments out in excess of

payments in. But they identify no valid basis for reaching a different conclusion in these circumstances.

Petitioners principally contend that the court of appeals should have examined the text of the appropriations acts in isolation and disregarded the context and history, and that the appropriations provisos do not in so many words excuse HHS from making risk-corridors payments out according to the statutory formulas. See 18-1023 Pet. 19; 18-1028 Pet. 23-24; 18-1038 Pet. 31-32. That contention lacks merit. In addressing similar issues, this Court has repeatedly looked to legislative context and history to ascertain Congress's intent in enacting funding restrictions. In *Will*, for example, the Court relied on "[f]loor remarks in both Houses" and committee reports in determining that Congress's intent was to block increases in judges' salaries that the underlying legislation would otherwise generate. 449 U.S. at 223. Likewise, in *Dickerson*, this Court relied on floor statements and other legislative history in determining that funding restrictions were intended to suspend reenlistment bonuses for the covered years. See 310 U.S. at 557-562. The Court specifically rejected the argument that it should not consider the legislative history in ascertaining the meaning of an enactment restricting previously established funding, observing that it would be "anomalous to close our minds to persuasive evidence of intention." *Id.* at 562.

The contextual basis for determining that the appropriations provisos at issue here have preclusive effect is even more powerful than in those cases. Members of Congress had solicited an opinion from the GAO—a legislative agency tasked with analyzing such issues for Congress—on the precise question of what funding would be available for risk-corridors payments out. The

first appropriations proviso was enacted less than three months after the GAO issued its opinion and tracked the GAO's analysis, reenacting both appropriations the GAO had identified but including a targeted restriction expressly prohibiting the use of one of those appropriations for the specific purpose of making risk-corridors payments, explicitly referring to the "risk corridors" program by name and by statutory citation. 2015 Appropriations Act § 227, 128 Stat. 2491. In these circumstances, Congress's intention to eliminate the only source of funding that the GAO opinion identified to make payments out in excess of payments in is beyond serious dispute. Even if any doubt existed, the explanatory statement by the House Appropriations Committee Chairman elucidating the purpose of the proviso—ensuring that HHS would adhere to its budget-neutral approach to implementing the risk-corridors program—would put it to rest. See pp. 17-18, *supra*.

Petitioner Land of Lincoln additionally contends (18-1038 Pet. 4) that the appropriations provisos could not have modified HHS's purported obligation to make risk-corridors payments because those provisos were "temporary," included within time-limited appropriations statutes. That is incorrect. As in *Dickerson* and *Will*, each of the appropriations enactments here suspended Section 18062's payment directive for the period in which the appropriations act was in effect. In combination, the appropriations acts had the effect of capping payments at the total amount collected from insurers.

Petitioners attempt to distinguish *Dickerson* and *Will*, observing that the appropriations legislation in those cases "prohibited the government from using *any* funds to pay the specified obligations," whereas the appropriations enactments here did not contain similar

language. 18-1028 Pet. 29; see 18-1023 Pet. 33-34; 18-1038 Pet. 25-26. That observation overlooks the fact that Congress's objective in enacting the appropriations provisos was not to eliminate *all* funding for risk corridors and thereby prohibit *any* payments out, as language like that in *Dickerson* and *Will* would accomplish. Its objective was to cap payments out at the amounts collected from insurers as payments in, thus ensuring that the program would remain budget neutral. Congress accomplished that objective by preserving the user-fees appropriation that enabled HHS to make payments out from the funds collected as payments in, while barring any resort to the only potential source of funding the GAO had identified *other* than payments in.

Petitioners further suggest that the general presumption against retroactivity requires construing the appropriations provisos not to affect any preexisting obligation of HHS to make risk-corridors payments out. See 18-1023 Pet. 22-23; 18-1028 Pet. 23; 18-1038 Pet. 29-30. That presumption, however, is inapposite here. "Statutes are disfavored as retroactive when their application 'would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed.'" *Fernandez-Vargas* v. *Gonzales*, 548 U.S. 30, 37 (2006) (citation omitted). In this respect, "[t]he modern law thus follows Justice Story's definition of a retroactive statute, as 'taking away or impairing vested rights acquired under existing laws, or creating a new obligation, imposing a new duty, or attaching a new disability, in respect to transactions or considerations already past.'" *Ibid.* (quoting *Society for the Propagation of the Gospel* v. *Wheeler*, 22 F. Cas. 756, 767 (C.C.D.N.H. 1814) (Story, J.)) (brackets omitted).

The appropriations provisos here do not implicate those principles. Neither in appropriating certain funds for risk-corridors payments nor in forbidding HHS from using other funds for that purpose did Congress impair any already-existing rights, increase any existing liability for past conduct, or impose new duties. The ACA itself, which established the risk-corridors program, appropriated no funds for that program. Congress addressed funding for the first time in the appropriations act for fiscal year 2015, which simultaneously appropriated payments in and foreclosed resort to the program-management appropriation for payments out. Insurers, moreover, could not have had any entitlement to risk-corridors payments out before 2015 because payments for 2014—the first year of operation—could not even be calculated until the conclusion of the 2014 calendar year and the submission of data by plans. That is not retroactive legislation. In any event, even if the presumption against retroactivity were implicated, it is overcome where Congress's intent to do so is clear. See, *e.g.*, *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976). Congress's intent to foreclose payments out in excess of payments in for the duration of the risk-corridors program is unambiguous. The program operated for only three years, and Congress included the proviso in appropriations enactments governing that entire period.

Petitioners finally contend that this Court's decision in *United States* v. *Langston*, 118 U.S. 389 (1886), requires rejecting the court of appeals' conclusion here. See 18-1023 Pet. 29; 18-1028 Pet. 28; 18-1038 Pet. 19. Their reliance on *Langston* is misplaced. The underlying statute at issue in *Langston* provided that "[t]he representative at Hayti shall be entitled to a salary of

$7500 a year." 118 U.S. at 390 (quoting Rev. Stat. § 1683 (1878)). For a number of years, Congress appropriated each year the full sum of $7500, but then for three subsequent years Congress appropriated only $5000. See *id.* at 390-392. Based on a close analysis of the text and context of the annual appropriations acts, this Court declined to infer from the acts that "merely appropriated a less amount" than the official's full salary that Congress had intended to reduce his salary for those years. *Id.* at 394.[5]

Petitioners err in contending that *Langston* is "indistinguishable" and compels the same conclusion in this case. 18-1028 Pet. 28; see 18-1023 Pet. 29, 32-33; 18-1038 Pet. 19-22. Unlike the statute at issue in *Langston*, Section 18062 did not give petitioners any "entitle[ment]" to risk-corridors payments. 118 U.S. at 390 (citation omitted). Nor did Congress merely fail to appropriate taxpayer funds for risk-corridors payments. Congress appropriated the amounts collected from plans as payments in, while *explicitly* barring HHS from using the only other source—and the only taxpayer funds—that the GAO had identified (or that petitioners have identified) as a potential source for payments out. Congress's precisely calibrated action here cannot plausibly be characterized as an oversight or inadvertent omission. And this Court has long made clear that, where the context of an appropriations act reflects "a broader purpose" and consists of "more than the mere omission to appropriate a sufficient sum," courts must give effect to that intent. *United States* v. *Vulte*, 233 U.S. 509, 515 (1914).

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[5] The Court did not order the government to make payment of the remainder. The Judgment Fund had not yet been established, and accordingly an Act of Congress was required to pay the judgment. See Act of Aug. 4, 1886, ch. 903, 24 Stat. 275, 281-282.

Unable to shoehorn these cases into *Langston*'s narrow holding, petitioners seek to extend it far beyond its facts. But *Langston*'s reasoning was focused on the specific enactments and circumstances presented in that case. See 118 U.S. at 390-392. And more than a century ago—just seven years after *Langston*—this Court cautioned against overreading the decision in that fashion. In *Belknap* v. *United States*, 150 U.S. 588 (1893), the Court cautioned that *Langston*'s ruling in the claimant's favor marked "the limit in that direction." *Id.* at 595. Instead of reflexively extending *Langston*, the Court in *Belknap* examined the statutes and context before it and concluded that a claimant's salary was limited to amounts subsequently appropriated. See *id.* at 595-597. The court of appeals here likewise properly declined to extend *Langston* and instead faithfully applied the principles established by decades of this Court's decisions.[6]

b. Further review of the court of appeals' decision is therefore unwarranted because petitioners' challenges to the court's conclusion fail on their own terms. Thus, even assuming arguendo, as petitioners contend, that when originally enacted Section 18062 imposed a privately enforceable obligation on HHS to make full risk-corridors payments in accordance with the statutory for-

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[6] Petitioners also rely on *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153 (1978). 18-1023 Pet. 27; 18-1028 Pet. 21; 18-1038 Pet. 23-24. That case held (as relevant) only that acts appropriating funds for a particular dam were not intended to override the requirements of the Endangered Species Act of 1973, 16 U.S.C. 1531 *et seq.* See 437 U.S. at 189-191. Here, by contrast, Congress imposed explicit funding conditions that eliminated the only potential source of funding for a particular program other than revenue generated by the program itself.

mulas, the court correctly held that Congress's subsequent action in the relevant appropriations legislation eliminated any such obligation. But petitioners' arguments also fail, and the decision below does not warrant review, for the independent reason that Section 18062 never imposed any such absolute, privately enforceable obligation to begin with. Although that issue has no practical significance in light of the court's ultimate conclusion, the absence of any such obligation would provide a free-standing basis to affirm the judgment below even if petitioners' arguments regarding the appropriations provisos had merit. See *Dahda* v. *United States*, 138 S. Ct. 1491, 1498-1500 (2018) (affirming on alternative ground). That additional ground counsels strongly against granting review here.

Petitioners seek money damages from the federal government representing the amounts of risk-corridors subsidies that they allege HHS was required but failed to pay. But nothing in the text of the statutory provision on which they rely, Section 18062, confers on plans subject to the risk-corridors program any such entitlement. Petitioners instead asked the courts below to infer a privately enforceable right to monetary relief from the fact that Section 18062 instructed an Executive Branch official, the Secretary of HHS, to make payments in accordance with certain formulas. Such an inference cannot be sustained here under well-settled law.

As the Federal Circuit has long recognized, statutory instructions to an agency to make payments cannot be read in isolation, but must be read in light of the overarching command of the Anti-Deficiency Act, 31 U.S.C. 1341 *et seq.* See *Highland Falls-Fort Montgomery Cent. Sch. Dist.* v. *United States*, 48 F.3d 1166, 1171 (Fed. Cir.), cert. denied, 516 U.S. 820 (1995). The Anti-Deficiency Act

generally forbids federal agencies from making payments unless and until Congress provides the necessary appropriation. See 31 U.S.C. 1341. That prohibition is no mere nicety; knowingly and willfully violating the Anti-Deficiency Act is a federal crime, punishable by fines and imprisonment. See 31 U.S.C. 1350. When a statutory instruction to a federal official to pay money is properly read together with the Anti-Deficiency Act, Congress's complete direction to the official is therefore to pay the money specified *if and only if* sufficient appropriations exist.

In *Highland Falls*, for example, the amounts earmarked in annual appropriations acts were insufficient for the Secretary of Education to pay school districts the full amount calculated under a statutory formula in the underlying substantive statute. The Secretary thus reduced the payments pro rata. 48 F.3d at 1169. The Federal Circuit rejected the school district's claim for damages, reasoning that, by making pro rata reductions in the amounts to which school districts were entitled, the Secretary "harmonized the requirements of [the substantive statute] and the appropriations statutes with the requirements of 31 U.S.C. §§ 1341(a)(1)(A)," *i.e.*, the Anti-Deficiency Act. *Id.* at 1171. Because the Secretary dutifully followed Congress's complete directions, including the Anti-Deficiency Act, there was no statutory violation. See *ibid.*

The same is true of the ACA's risk-corridors program. Although read in isolation Section 18062 provided for HHS to pay funds in accordance with the statutory formulas, that provision did not exist in a vacuum. HHS was obligated by the Anti-Deficiency Act to construe Section 18062 to require only the payment of

funds validly appropriated for that purpose. Once Congress appropriated payments in to make payments out but expressly eliminated the only other potential source of funding, HHS had no alternative but to cap payments out at payments in. It would not have been faithful to, but instead in contravention of, Congress's direction for HHS to expend more than the amounts appropriated.

The posture of these cases, in which petitioners seek hundreds of millions of dollars in money damages against the federal government, puts the illogic of petitioners' contrary position in stark relief. Petitioners brought suit under the Tucker Act, which "do[es] not [it]sel[f] create substantive rights." *United States* v. *Bormes*, 568 U.S. 6, 10 (2012) (brackets, citation, and internal quotation marks omitted). They must therefore identify another source of law that "confer[s] a substantive right to recover money damages from the United States." *United States* v. *Testan*, 424 U.S. 392, 398 (1976). "[T]he test for determining whether a statute that imposes an obligation but does not provide the elements of a cause of action qualifies for suit under the Tucker Act"—and "more specifically, whether the failure to perform an obligation undoubtedly imposed on the Federal Government creates a right to monetary relief"—is "whether the statute can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained." *Bormes*, 568 U.S. at 15-16 (citation and internal quotation marks omitted).

To prevail here, petitioners therefore would have to establish that Congress perceived its own decision not to appropriate any funds for payments out in excess of payments in—and HHS's faithful implementation of that congressional funding decision, as required by the Anti-Deficiency Act—as wrongdoing in need of a remedy.

And they would have to establish that Congress intended to mandate compensation to insurers for that putative injury, which consisted of anticipated but unpaid subsidies that Congress itself made the decision not to fund. Petitioners have never made that showing. Indeed, it would be highly illogical to construe Congress's imposition of funding restrictions in such a self-defeating fashion, as merely (and obliquely) substituting a cumbersome damages remedy for unfunded subsidies. It would also apparently be unprecedented. The government is not aware of any decision of this Court in which it upheld a damages award as a remedy for payments contemplated by statute that Congress declined to fund.

The court of appeals stated that this Court's decision in *Salazar* v. *Ramah Navajo Chapter*, 567 U.S. 182 (2012), requires overlooking the Anti-Deficiency Act in determining whether HHS had an obligation to pay (and whether petitioners have a privately enforceable entitlement to receive) money damages. Pet. App. 19. The panel stated that it was "of no moment" that HHS could not have made risk-corridors payments beyond amounts appropriated "without running afoul of the Anti-Deficiency Act," reasoning that *Ramah* "rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government." *Ibid.* That statement was not necessary to the court of appeals' disposition and was therefore dictum and "not precedential." *National Am. Ins. Co.* v. *United States*, 498 F.3d 1301, 1306 (Fed. Cir. 2007) (citations omitted).

It was also incorrect. As the Federal Circuit itself has emphasized in other cases, it was critical to *Ramah*'s reasoning that the case concerned *contractual* obligations. See, *e.g.*, *Prairie Cnty.* v. *United States*, 782 F.3d 685, 689 (Fed. Cir.), cert. denied, 136 S. Ct. 319 (2015). In

Prairie County, the Federal Circuit correctly rejected the argument that *Ramah*'s reasoning should be extended to *statutory* claims. See *id.* at 689-690. Whatever limitations apply if Congress seeks to abrogate or alter contractual obligations it has previously incurred, they have no bearing on obligations that Congress imposes on federal agencies by statute. Congress is free, subject to constitutional principles not at issue here, to qualify agencies' statutory authority and duties, and courts accordingly must interpret statutory directives to an agency to pay money in light of all of Congress's instructions to the agency, including related appropriations acts and the Anti-Deficiency Act.

The court of appeals' judgment that petitioners' statutory claims lack merit was therefore correct even independent of the court's conclusion that the appropriations legislation eliminated any obligation HHS had to make payments out in excess of payments in. Although that conclusion was correct, this Court "may affirm a lower court judgment on any ground permitted by the law and the record," *Dahda*, 138 S. Ct. at 1498 (brackets, citation, and internal quotation marks omitted), and the fact that the ACA never imposed such an obligation would provide a fully sufficient basis to do so. The substantial likelihood that the statutory question petitioners present would have no practical effect on the outcome of these cases provides a further reason to deny review.

2. The court of appeals also correctly rejected the contention of petitioners Moda and Blue Cross (18-1028 Pet. 30-32) that Section 18062 created an implied-in-fact contract that the government breached by distributing

a smaller amount of subsidies than Section 18062's formulas had contemplated. Pet. App. 35-38. That conclusion also does not warrant further review.[7]

The implied-in-fact contract claim petitioners Moda and Blue Cross advance fails for the simple yet fundamental reason that Section 18062's risk-corridors program—in which profitable plans cross-subsidized a portion of unprofitable plans' costs—did not create a contract with the government. "For many decades, this Court has maintained that absent some clear indication that the legislature intends to bind itself contractually, the presumption is that 'a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *National R.R. Passenger Corp.* v. *Atchison, Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-466 (1985) (*Amtrak*) (quoting *Dodge* v. *Board of Educ.*, 302 U.S. 74, 79 (1937)); see also *Rector, Church Wardens, & Vestrymen, of Christ Church* v. *County of Philadelphia*, 65 U.S. (24 How.) 300, 302 (1861).

As the Court has explained, "[t]his well-established presumption is grounded in the elementary proposition that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state." *Amtrak*, 470 U.S. at 466. "Policies, unlike contracts, are inherently subject to revision and repeal," and so "to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative

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[7] Petitioner Maine Community did not allege an implied-in-fact contract claim, see 18-1023 Pet. App. 91a, and petitioner Land of Lincoln has abandoned its implied-in-fact contract claim, see generally 18-1038 Pet. 16-36; cf. 18-1038 Pet. App. 3a-4a.

body." *Ibid.* Accordingly, "the party asserting the creation of a contract must overcome this well-founded presumption," and a court must "proceed cautiously both in identifying a contract within the language of a regulatory statute and in defining the contours of any contractual obligation." *Ibid.*

The court of appeals correctly determined that nothing in Section 18062 overcomes that long-established presumption. Pet. App. 36-38. Although petitioners Moda and Blue Cross characterize Section 18062 as a "statutory promise," 18-1028 Pet. i, the court explained that "the statute contains no promissory language" from which an intent to contract could be found. Pet. App. 36. Petitioner Moda acknowledged as much below. *Ibid.*

To the extent petitioners Moda and Blue Cross seek to derive a contractual promise from the statutory text combined with HHS's post-enactment statements and regulations, that effort fails for at least two reasons. First, as the court of appeals explained, "no statement by the government evinced an intention to form a contract." Pet. App. 38. The regulations simply tracked the language of Section 18062, see 45 C.F.R. 153.510(b) and (c), and HHS repeatedly recognized that its ability to make risk-corridors payments was subject to the availability of appropriations. See 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) (stating that, if collections are insufficient to fund payments, "HHS will use other sources of funding for the risk corridors payments, *subject to the availability of appropriations*" (emphasis added)); 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (same); C.A. App. 546 (similar). Even the Court of Federal Claims, which ruled in Moda's favor, noted that "HHS stated repeatedly that it 'intended to administer risk corridors in a budget neutral way over the three-

year life of the program, rather than annually.'" Pet. App. 120 (brackets and citation omitted). "In other words," that court observed, "HHS announced that it would not make full annual payments." *Ibid.* (emphasis omitted).

Second, HHS could not have made a binding contractual commitment to petitioners because HHS did not have authority to make contracts for risk-corridors payments in excess of appropriations. "A law may be construed * * * to authorize making a contract for the payment of money in excess of an appropriation only if the law specifically states that * * * such a contract may be made." 31 U.S.C. 1301(d). Without such "special authority," this Court has held, an "officer cannot bind the Government in the absence of an appropriation." *Cherokee Nation* v. *Leavitt*, 543 U.S. 631, 643 (2005). Section 18062 did not give HHS authority to contract for risk-corridors payments in excess of appropriations, and HHS did not purport to do so. Petitioners note that HHS recorded unpaid risk-corridors amounts as obligations. See 18-1028 Pet. 10. But it is well established that, "[i]f a given transaction is not sufficient to constitute a valid obligation, recording it will not make it one." 2 GAO, *Principles of Federal Appropriations Law* 7-8 (3d ed. 2006); see also *Office of Personnel Mgmt.* v. *Richmond*, 496 U.S. 414, 424 (1990).

In these circumstances, Moda's and Blue Cross's repeated invocations of a multibillion-dollar "bait-and-switch" (18-1028 Pet. i, 1, 2, 16, 18) ring hollow. Congress did not "lure private parties into expensive undertakings with clear promises, only to renege after private parties have relied to their detriment and incurred actual losses." *Id.* at 17. The ACA itself provided no funding for risk-corridors payments, leaving that determination

to the judgment of future Congresses. And HHS had no authority to make payments, or to commit the government to making such payments, beyond the sums (if any) Congress ultimately appropriated. One would not reasonably expect an insurer to base a decision to participate in the Exchanges on the assumption that, if its costs exceeded a certain threshold, it would be entitled by law to receive partial subsidies reimbursing a portion of those costs—given that Congress had provided no funding for those subsidies in the ACA itself and future Congresses might elect never to provide full or any funding.

It is more probable that insurers like petitioners elected to sell plans on the Exchanges as a result of the powerful business incentives they had to do so. The Exchanges are the only commercial channel through which insurers can reach consumers receiving federal subsidies, see 26 U.S.C. 36B (2012 & Supp. V 2017), a market segment that numbers in the millions.[8] Notably, insurers continued to sell plans on the Exchanges and still do so today, even though the risk-corridors program ended in 2016. In any event, whatever petitioners' subjective reasons for participating in the Exchanges, under well-settled law neither Congress nor HHS made any contractual commitment to make subsidy payments to petitioners in excess of funds Congress appropriated. Further review is not warranted.

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[8] See, *e.g.*, CMS, HHS, *First Half of 2018 Average Effectuated Enrollment Data*, https://www.cms.gov/sites/drupal/files/2018-11/11-28-2018%20Effectuated%20Enrollment%20Table.pdf (indicating 8.9 million individuals received advance premium tax credits during the first half of 2018).

CONCLUSION

The petitions for writs of certiorari should be denied.

Respectfully submitted.

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