IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BLUE CROSS OF IDAHO HEALTH SERVICE, INC.,	:	No. 16-1384C
Plaintiff,	:	Judge Lettow
v.	:	
THE UNITED STATES OF AMERICA,	:	
Defendant.	:	

THE UNITED STATES' MOTION TO DISMISS

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Pursuant to Rule 12(b)(1), the United States moves the Court to dismiss the Complaint of Blue Cross Of Idaho Health Service, Inc. ("BCI") for lack of subject matter jurisdiction. Should the Court determine that it has jurisdiction over BCI's claims, the United States moves for dismissal under Rule 12(b)(6).

INTRODUCTION

BCI brings this case seeking payments under section 1342 of the Affordable Care Act, 42 U.S.C. § 18062. Section 1342 directs the Secretary of Health and Human Services ("HHS") to establish and administer a three-year premium stabilization program known as "risk corridors," under which HHS collects risk corridors charges from relatively profitable qualified health plans ("QHPs") and then, out of these collections, makes payments to relatively unprofitable QHPs based on the plans' ratio of premiums to claims costs. BCI participated in the program in the 2014 and 2015 benefit years and claims to be entitled to more than $79 million in payments for those two years, having already received a portion of this amount. BCI seeks relief in this Court, but its claims fail as a matter of law. In all material respects, BCI's claims are identical to those considered and rejected by this Court in *Land of Lincoln Mutual Health Insurance Co. v. United States*, 129 Fed. Cl. 81 (2016), appeal docketed, No. 17-1224 (Fed. Cir. Nov. 16, 2016).

First, BCI has no claim to "presently due" money damages, as it must to establish jurisdiction under the Tucker Act, including for claims arising under a money-mandating statute. Nor does this Court have jurisdiction to grant the injunctive relief BCI seeks.

Second, BCI's claims fail on the merits. "No Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law." U.S. Const. art. I, § 9, cl. 7. In *Land of Lincoln*, this Court recognized that "[s]ection 1342 . . . does not . . . authorize the use of any appropriated funds" 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." 129 Fed. Cl. at 107, 106. That Congress did not appropriate money or authorize appropriations for risk corridors payments when it enacted section 1342 in 2010 demonstrates its understanding that the program would be self-funded, *i.e.*, payments out would be derived solely from collections. If there were any doubt as to Congress's intent under section 1342, it was removed by subsequent appropriations legislation—enacted before any risk corridors payments were due—that expressly prohibited HHS from using other appropriated funds to make risk corridors payments, leaving only collections. In enacting that funding limitation, Congress emphasized 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 (daily ed. Dec. 11, 2014). Insurers such as BCI cannot circumvent Congress's power of the purse by demanding billions of dollars that Congress never authorized or appropriated.

Third, Counts II-VI fail for the same reasons articulated by this Court in *Land of Lincoln* when it considered and dismissed the same contract and takings claims presented in BCI's Complaint. These claims fail as a matter of law because risk corridors payments are a statutory benefit, not a contractual obligation. No contract requiring risk corridors payments could be formed because Congress neither established the risk corridors program as one based in contract nor conferred authority on HHS to bind the United States in contract for such payments. And without either a statutory or contractual right to risk corridors payments, BCI cannot state a claim under the Takings Clause.

STATEMENT OF THE ISSUES

1. Whether BCI's Complaint should be dismissed for lack of jurisdiction or a justiciable claim where, in light of HHS's three-year payment framework for risk corridors payments, BCI is not entitled to "presently due money damages" and HHS has not finally determined BCI's total risk corridors payments under the program.

2. Whether BCI's statutory claim fails as a matter of law because Congress did not obligate the government to make payment beyond amounts collected under the risk corridors program or appropriate funds for that purpose, and prohibited HHS from using funds other than collections to make risk corridors payments.

3. Whether BCI's contract and takings claims, which are derivative of the statutory claim, fail as a matter of law where BCI alleges no facts that would plausibly support an inference that HHS is contractually obligated to make risk corridors payments.

STATEMENT OF THE CASE

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

A. The Health Benefit Exchanges

In 2010, Congress enacted the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010) (the "ACA"), seeking to guarantee the availability of affordable, high-quality health insurance coverage for all Americans. *See generally King v. Burwell*, 135 S. Ct. 2480, 2485 (2015) (discussing the ACA's key reforms).[1] To implement the

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

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

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

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

To ensure that issuers operating on the Exchanges comply with these requirements, Congress required Exchanges to establish annual certification procedures. 42 U.S.C. § 18031(d)(4); 45 C.F.R. part 156. HHS conducts the certification process for Federally-facilitated Exchanges and, as part of this process, requires issuers to attest that they will comply with federal and state insurance laws, including those governing QHPs, and to execute an agreement known as a "Qualified Health Plan Certification Agreement and Privacy and Security Agreement," or "QHP Agreement" for short. In the QHP Agreement, issuers agree to adhere to privacy and security standards when conducting transactions on the Federally-facilitated Exchange. 45 C.F.R. § 155.260(b)(2). Notwithstanding these requirements, an issuer's decision to offer QHPs on an Exchange in any given year does not commit the issuer to doing so, and merely reflects a business decision by the issuer that is accompanied by regulatory consequences.

B. The Risk Corridors Program

The ACA introduced millions of previously uninsured individuals into the insurance markets. The entry of these individuals created valuable business opportunities for health insurance companies electing to sell plans on the Exchanges. *See, e.g.*, Milliman, Ten Critical Considerations for Health Insurance Plans Evaluating Participation in Public Exchange Markets (Dec. 2012) (noting "an expectation of expansive consumer participation in the exchange providing additional market opportunities" and that "the opportunity to reach a new market by participating in the exchange land grab could be a very quick way to increase the size of an insurer's covered population."), Appendix at A43, A49. Nevertheless, it also created pricing uncertainty arising from the unknown health status of an expanded risk pool and the fact that insurers could no longer charge higher premiums or deny coverage based on an enrollee's health. *See* 42 U.S.C. §§ 300gg, 300gg-1; 45 C.F.R. §§ 147.104-147.110. To mitigate the pricing risk

and incentives for adverse selection arising from these changes, the Act established three premium stabilization programs modeled on similar programs established under the Medicare Program. *See* Complaint ¶¶ 5-7, 34. Informally known as the "3Rs," these programs began with the 2014 benefit year and consist of reinsurance, risk adjustment, and risk corridors. *See generally* 42 U.S.C. §§ 18061-18063.

The 3Rs program at issue in this case is the temporary risk corridors program established under section 1342 of the ACA. Section 1342 requires the Secretary of HHS to "establish and administer a program of risk corridors" under which issuers offering individual and small group QHPs between 2014 and 2016 "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. § 18062(a). Following the conclusion of the calendar year, if "for any plan year" an issuer's "allowable costs" (essentially, claims costs reduced by payments received for that year under the reinsurance and risk adjustment programs) are less than a "target amount" (premiums minus allowable administrative costs) by more than three percent, the plan must pay a percentage of the difference (referred to here as a "charge" or "collection") to HHS. 42 U.S.C. § 18062(b)(2).[3] Conversely, if "for any plan year" an issuer's allowable costs exceed the target amount by more than three percent, the issuer receives a percentage of the difference (referred to as a "payment"). 42 U.S.C. § 18062(b)(1). The payment and charge percentage is set by statute: either 50% or 80%, depending on the degree of loss or gain realized by the issuer. 42 U.S.C. § 18062(b). HHS regulations incorporate this payment methodology in substantially similar terms. *See* 45 C.F.R. § 153.510.

[3] "Allowable administrative costs" include profits of up to three percent subject to an overall cap. *See* 45 C.F.R. § 153.500.

All QHP issuers are statutorily required to participate in the risk corridors program; there are no risk corridors contracts, and a QHP need not have entered any agreement with HHS to owe risk corridors charges or receive payments.[4] Instead, HHS administers the risk corridors program solely pursuant to statutory and regulatory requirements and guidance. Under the regulations, after the close of each benefit year, which run on a calendar year, issuers of QHPs must compile and submit premium and cost data and other information underlying their risk corridors calculations to HHS no later than July 31 of the next calendar year. 45 C.F.R. § 153.530(d). Using these data, HHS calculates the charges and payments due to and from each issuer for the preceding benefit year. *See* 45 C.F.R. § 153.530(a)-(c); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473-74 (March 11, 2013). Within 30 days of HHS's announcement of final charge amounts, issuers must remit payment to HHS. 45 C.F.R. § 153.510(d). Neither the ACA nor the implementing regulations set a deadline by which HHS must make payments to issuers, *see generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510, although HHS has made payments annually to the extent of collections.

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

In July 2011, HHS published a proposed rule stating that when the Congressional Budget Office ("CBO") performed a cost estimate contemporaneously with ACA's passage, it "assumed [risk corridors] collections would equal payments to plans in the aggregate." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,948 (July 15, 2011). In March 2012, HHS published a regulatory impact analysis again stating that "CBO . . . assumed collections would equal payments to plans and would therefore be budget neutral." Centers for

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

Medicare & Medicaid Services, Regulatory Impact Analysis, Establishment of Exchanges and Qualified Health Plans, Exchange Standards for Employers (CMS-9989-FWP) and Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (CMS-9975-F) (Mar. 16, 2012), Appendix at A140; *see also* Centers for Medicare & Medicaid Services, Preliminary Regulatory Impact Analysis (CMS-9989-P2) (July 2011) ("CBO . . . assumed aggregate collections from some issuers would offset payments made to other issuers."), Appendix at A138.

On March 11, 2014, HHS issued a final rule stating that "[w]e intend to implement th[e] [risk corridors] program in a budget neutral manner, and may make future adjustments, either upward or downward to this program . . . to the extent necessary to achieve this goal." HHS Notice of Benefit and Payment Parameters for 2015 Final Rule, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014); *see also id.* at 13,829 ("HHS intends to implement this program in a budget neutral manner."); Exchange and Insurance Market Standards for 2015 and Beyond Proposed Rule, 79 Fed. Reg. 15,808, 15,822 (Mar. 21, 2014) (same). On April 11, 2014, HHS released guidance explaining that in order to implement budget neutrality, it would make risk corridors payments to the extent of collections and that any shortfall would result in a pro-rata reduction of all payments. Centers for Medicare & Medicaid Services, Risk Corridors and Budget Neutrality (Apr. 11, 2014) ("April 11 Guidance"), Appendix at A1. That shortfall would then be paid from collections in the second and (if necessary) third years of the program. *Id.* Under this three-year framework, final payments under the risk corridors program are not due until the end of the program. *Id.* HHS reiterated and expanded upon this guidance in final rules issued in May 2014 and February 2015. *See* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) Appendix at A148-50; HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) Appendix at A151-53.

HHS also stated that although it would strive to achieve budget neutrality consistent with the CBO's projections, it interpreted section 1342 to require full payments to issuers and that, if necessary, at the conclusion of the program, it would use sources of funding other than risk corridors collections, subject to the availability of appropriations. *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. at 30,260 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In [the event that risk corridors collections are insufficient to fund payments over the three-year life of the program], HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."), Appendix at A150; HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. at 10,779 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In the unlikely event that risk corridors collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."), Appendix A153; HHS Notice of Benefit and Payment Parameters for 2014 Final Rule, 78 Fed. Reg. 15,410, 15,473 (March 11, 2013) ("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."), Appendix at A154-56. Similarly, on September 9, 2016, HHS announced, "As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of

the United States Government for which full payment is required." Centers for Medicare & Medicaid Services, Risk Corridors Payments for 2015 (Sept. 9, 2016), Appendix at A39; *see also* April 11 Guidance.

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

Although Congress appropriated funds in the ACA for many programs and authorized funding for others, Congress did not include in the ACA either an appropriation or an authorization of funding for risk corridors. The absence of such a provision sets the ACA risk corridors program apart from the statutory provisions governing the Medicare Part D risk corridors program, which authorize the appropriation of "moneys in the Treasury" for Part D payments, 42 U.S.C. § 1395w-116(c)(3), and which provide for "budget authority in advance of appropriations Acts" and create an express "obligation of the Secretary to provide for the payment of amounts provided under this section," 42 U.S.C. § 1395w-115(a).

Each year, Congress generally makes a CMS Program Management appropriation, "for carrying out" enumerated programs administered by CMS, such as Medicare and Medicaid, and for "other responsibilities of [CMS]." The Program Management appropriation includes a lump sum amount derived from specified trust funds, as well as "such sums as may be collected from authorized user fees and the sale of data." *See generally* Pub. L. No. 113-76, div. H, title II, 128 Stat. 5, 374 (Jan. 17, 2014), Appendix at A105. While the appropriated user fees collected during one fiscal year remain available for the next five fiscal years, *id.*, the lump sum amount expires at the end of the fiscal year. *See* Pub. L. No. 113-76, div. H, title V, § 502, 128 Stat. 408 ("No part of any appropriation contained in this Act shall remain available for obligation beyond the current fiscal year unless expressly so provided herein."), Appendix at A110. Nothing in the CMS Program Management appropriation explicitly mentions risk corridors payments.

In February 2014, Members of Congress asked the Government Accountability Office ("GAO") for an opinion regarding the availability of appropriations to HHS to make payments to QHPs under the risk corridors program. *See Dept. of Health & Human Servs.-Risk Corridors Program*, B-325630 (Comp. Gen.), 2014 WL 4825237, at *1 (Sept. 30, 2014) ("*GAO Op.*"), Appendix at A157. The GAO solicited the views of HHS, which identified collections from insurance issuers as the only source of funding, explaining that collections could be spent pursuant to a provision of the "CMS Program Management appropriation" pertaining to authorized user fees. Letter of May 20, 2014, Appendix at A3. Shortly thereafter, Members of Congress sent a similar inquiry to HHS regarding available budget authority to make risk corridors payments, and HHS again identified collections from insurance issuers—*i.e.*, the user fee authority—as the only source of funding for risk corridor payments. Letter of June 18, 2014, Appendix at A6.

In its opinion released on September 30, 2014, the GAO recognized that "Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1)." *GAO Op.*, 2014 WL 4825237, at *2. The GAO then considered HHS's fiscal year 2014 appropriations then in effect, and identified only the 2014 CMS Program Management appropriation (*i.e.*, the lump sum amount and user fees) as a potential source of funding for risk corridors payments. *Id.* at *3-*4. While the GAO concluded that the term "other responsibilities" in that appropriation was broad enough to encompass risk corridors payments, it did not conclude that the 2014 Program Management appropriation *was* available for risk corridors payments. Instead, the GAO merely concluded that it "*would have been* available for making the payments pursuant to section 1342(b)(1)." *Id.* at *3 (emphasis added). The GAO agreed with HHS that risk corridors collections would constitute "user fees," *id.* at *4, but noted that HHS would not begin collections or payments under section 1342 until fiscal year 2015. *Id.* at *5 n.7. The GAO

concluded that, because "[a]ppropriations acts, by their nature, are considered nonpermanent legislation," the "other responsibilities" language or the use of authorized user fees would need to be included in future appropriations acts in order for the Program Management appropriation to supply a source of funds in future fiscal years for risk corridors payments. *GAO Op.* 2014 WL 4825237, at *5.[5]

On December 16, 2014—months before any payments could have been claimed or made under the risk corridors program—Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015 ("the 2015 Spending Law") specifically addressing funding for the risk corridors program. As with previous appropriations, the 2015 Spending Law provided a lump sum amount for CMS's Program Management account for fiscal year 2015 to be derived from CMS trust funds. Pub. L. No. 113-235, div. G, title II, Appendix at A124. Congress included a rider, however, to the 2015 Spending Law that expressly limited the availability of Program Management funds for the risk corridors program, as follows:

> None of the funds made available by this Act from [CMS trust funds], or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid

[5] The 2014 fiscal year ended and the 2014 CMS Program Management appropriation expired on September 30, 2014. *See* Pub. L. No. 113-76, div. H, title V, § 502, 128 Stat. 408, Appendix at A105. Congress funded government operations, including HHS, past this date through a continuing resolution, which appropriated "[s]uch amounts as may be necessary . . . for continuing projects or activities . . . that were conducted in fiscal year 2014" as provided in the 2014 fiscal year appropriation, including the 2014 CMS Program Management appropriation. Pub. L. No. 113-164, § 101, 128 Stat. 1867 (Sept. 19, 2014), Appendix at A111. The continuing resolution further provided that "no appropriation or funds made available or authority granted pursuant to section 101 shall be used to initiate or resume any project or activity for which appropriations, funds, or other authority were not available during fiscal year 2014." *Id.* § 104. The funds made available in the continuing resolution were only available until the earlier of (1) the enactment into law of an appropriation for any project or activity provided for in this joint resolution; (2) the enactment into law of the applicable appropriations Act for fiscal year 2015 without any provision for such project or activity; or (3) December 11, 2014. *Id.* § 106. Congress twice extended the December 11 deadline until December 17, 2014. *See* Pub. L. No. 113-202, 128 Stat. 2069 (Dec. 12, 2014), Appendix at A122; Pub. L. No. 113-203, 128 Stat. 2070 (Dec. 13, 2014), Appendix at A123

> Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Id. § 227, Appendix at A130. The GAO had identified only the Program Management appropriation as the potential source of available funding for risk corridors payments, and the effect of this rider was to eliminate the lump sum amount as a source, leaving only the user fees. An accompanying Explanatory Statement stated that the rider was added "to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." 160 Cong. Rec. H9838 (2014), Appendix at A136. The Explanatory Statement further 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." *Id.*[6]

On December 18, 2015, Congress enacted an identical funding limitation in the annual appropriations act for fiscal year 2016 (the "2016 Spending Law"). Pub. L. No. 114-113, div. H, title II, § 225, Appendix at A142. The Senate Committee Report to the 2016 Spending Law states:

> The Committee is proactively protecting discretionary funds in the bill by preventing the administration from transferring these funds to bail out ACA activities *that were never intended to be funded through the discretionary appropriations process*. * * * * The Committee continues bill language requiring the administration to operate the Risk Corridor program *in a budget neutral manner* by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program.

[6] Section 4 of the 2015 Spending Law refers to the Explanatory Statement and provides that it "shall have the same effect with respect to allocation of funds and implementation of [the Act's provisions] as if it were a joint explanatory statement of a committee of conference." Pub. L. No. 113-235, § 4, 128 Stat. 2132, Appendix at 127.

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74, at 12 (2015) (emphasis added), Appendix at A134.[7]

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

On July 31, 2015, issuers submitted their risk corridors data for the 2014 benefit year pursuant to the schedule established by HHS. Centers for Medicare & Medicaid Services, Preliminary Risk Corridors Program Results (Aug. 7, 2015), Appendix at A41. On October 1, 2015, HHS announced that collections under the program for 2014 were expected to total $362 million, while payments calculated totaled $2.87 billion. Centers for Medicare & Medicaid Services, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015), Appendix at A42. HHS explained that, because payments exceeded collections, it estimated it could pay only 12.6% of these payments in the 2015 payment cycle. *Id.* Shortly thereafter, HHS released the 2014 benefit year risk corridors charges and payments for each issuer, which assumed full collection of charges. Centers for Medicare & Medicaid Services, Risk Corridors Payment and Charge Amounts for 2014 Benefit Year (Nov. 19, 2015), Appendix at A9. The same day, HHS released a guidance document explaining that it would make the pro-rated payments in late 2015, with "[t]he remaining 2014 risk corridors payments . . . made from 2015 risk corridors collections [in 2016], and if necessary, 2016 collections [in 2017]." Centers for Medicare & Medicaid Services, Risk Corridors Payments for the 2014 Benefit year (Nov. 19, 2015), Appendix at A8 ("November 19 Guidance"). HHS also

[7] The time period from September 30, 2015, (the expiration of the 2015 Spending Law) until the enactment of the 2016 Spending Law on December 18, 2015, is covered by continuing resolutions, which incorporate the rider in the 2015 Spending Law. *See* Pub. L. No. 114-53 § 101(a) (Sept. 30, 2015); Pub. L. No. 114-96 (Dec. 11, 2015); Pub. L. No. 114-100 (Dec. 16, 2015). Continuing resolutions enacted since the September 30, 2016 expiration of the 2016 Spending Law incorporate that law's rider as well. *See* Pub. L. No. 114-223, div. C (Sept. 29, 2016); Pub. L. No. 114-254 (Dec. 10, 2016).

advised that, "[i]n the event of a shortfall for the 2016 program year, [HHS] will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments." *Id.*

In November 2015, HHS began collecting risk corridors charges for the 2014 benefit year. Appendix at A9. In December 2015, HHS began remitting risk corridors payments to issuers, including BCI. *Id.* Issuers submitted their benefit year 2015 risk corridors data to HHS by August 1, 2016. *See* 45 C.F.R. § 153.530(d). On November 18, 2016, HHS announced that it would pay additional risk corridors amounts toward 2014 benefit year payment requests based on collections for benefit year 2015. Centers for Medicare & Medicaid Services, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016), Appendix at A87. HHS began paying those amounts in December 2016, consistent with its administrative guidance.[8]

ARGUMENT

I. The Court Lacks Jurisdiction Under the Tucker Act Because BCI Has No Substantive Right to "Presently Due Money Damages"[9]

The Tucker Act, under which BCI asserts jurisdiction, Complaint ¶ 12, waives sovereign immunity for certain non-tort claims against the United States founded upon the Constitution, a federal statute or regulation, or a contract. 28 U.S.C. § 1491(a)(1). The Tucker Act "does not

[8] With the close of calendar year 2016, the risk corridors program has ended. 42 U.S.C. § 18062(a). Issuers will submit their 2016 benefit year risk corridors data by the end of July 2017, and HHS intends to announce charges and payments in Fall 2017.

[9] The United States acknowledges that in *Land of Lincoln*, this Court concluded that it had jurisdiction and that the insurer's claims were ripe. 129 Fed. Cl. at 97. The United States' jurisdictional and ripeness arguments were also rejected in *Health Republic Insurance Co. v. United States*, No. 16-259C, -- Fed. Cl. --, 2017 WL 83818 (Fed. Cl. Jan. 10, 2017) (Sweeney, J.) and *Moda Health Plan, Inc. v. United States*, No. 16-649C, -- Fed. Cl. --, 2017 WL 527588 (Fed. Cl. Feb. 9, 2017) (Wheeler, J.). The United States includes its jurisdictional argument to preserve the issue.

create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). "Thus, jurisdiction under the Tucker Act requires the litigant to identify a substantive right for money damages against the United States separate from the Tucker Act itself." *Todd v. United States*, 386 F.3d 1091, 1094 (Fed. Cir. 2004) (citing *Testan*, 424 U.S. at 398). In meeting this burden, it is not enough for a plaintiff to point to a law requiring the payment of money in the abstract. Instead, the law must "fairly be interpreted as mandating compensation for damages sustained as a result of *a breach of . . . duties [it] impose[s]*." *United States v. Mitchell*, 463 U.S. 206, 219 (1983) (emphasis added).

Further, the law must entitle the plaintiff to "actual, *presently due* money damages from the United States." *Todd*, 386 F.3d at 1093-94 (quoting *King*, 395 U.S. at 3) (emphasis added); *Johnson v. United States*, 105 Fed. Cl. 85, 94 (2012) ("Under the Tucker Act, the court's jurisdiction extends only to cases concerning actual, presently due money damages from the United States.") (internal quotation omitted); *see also Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 689 (Fed. Cir. 1991) ("[T]he word 'claim' carries with it the historical limitation that it must assert a right to presently due money."), *superseded by statute on other grounds*, Pub. L. No. 102-572, Title IX, §§ 902(a), 907(b)(1), 106 Stat. 4506, 4516, 4519 (1992). Thus, where a plaintiff has received all the money it is currently due, the Court must dismiss the complaint for lack of jurisdiction. *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 179 (2009).

BCI's claim of Tucker Act jurisdiction rests on its mistaken assertion that HHS "has refused to make full and timely risk corridors payments to BCI for CY 2014 as required by Section 1342." Complaint ¶ 83; *see also* Complaint ¶¶ 8-9, 23. But section 1342 does not obligate HHS to make annual payments. *Land of Lincoln*, 129 Fed. Cl. at 107. Rather, section 1342 requires

HHS to *calculate* risk corridors payments and charges based on claims and other costs "for" a "benefit year," but it does not require HHS to *pay* those calculated amounts on an annual basis. Instead, it delegates to HHS the responsibility to "establish and administer" the risk corridors program, 42 U.S.C. § 18062(a), thereby conferring "broad discretion" to HHS "to tailor [the] . . . program to fit both its needs and its budget." *Contreras v. United States*, 64 Fed. Cl. 583, 599 (2005), *aff'd*, 168 F. App'x 938 (Fed. Cir. 2006). In the absence of a contrary statutory provision, "agencies, not the courts, . . . have primary responsibility for the programs that Congress has charged them to administer." *McCarthy v. Madigan*, 503 U.S. 140, 145 (1992), *superseded by statute on other grounds*, Pub. L. No. 104-134, § 803, 110 Stat. 1321 (Apr. 26, 1996). The Federal Circuit has stated that "the *Chevron* standard of deference applies" where, as here, "Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)).

HHS exercised the discretion conferred by Congress by establishing a three-year payment framework to govern circumstances where collections from issuers are insufficient to fund calculated payments. Under this framework, if risk corridors claims exceed collections for a given benefit year, as they did for years 2014 and 2015, payments are temporarily reduced so as not to exceed HHS's funding for that year. However, further payments for that benefit year are made in subsequent payment cycles (after charges for a later benefit year have been collected), with final payment not due until the final payment cycle in 2017. *See* April 11 Guidance; November 19 Guidance.

In sum, HHS's three-year payment framework reasonably accounts for the fact that collections are the only authorized source of funding for risk corridors payments, while also ensuring that HHS pays out as much as it can each year within the statutory and programmatic constraints. Because section 1342 does not require—and, in light of the shortfall in collections, the Spending Laws do not permit—full payment on an annual basis, the Court must defer to HHS's three-year framework as a reasonable construction of these laws. Under that framework, additional payments are not presently due, and the Court lacks jurisdiction to consider BCI's claims.[10]

In any event, this Court lacks jurisdiction to award BCI non-monetary and special relief, including a "declar[ation] . . . [that] the Government must make full and timely CY 2015 and/or CY 2016 risk corridor payments to Plaintiff if it experiences qualifying losses during that year," Complaint at Prayer for Relief ¶ (7). *See Land of Lincoln*, 129 Fed. Cl. at 99. The Court's jurisdiction to grant equitable or declaratory relief is limited to cases in which such remedies are "incident of and collateral to" and necessary "to complete the relief afforded by" a monetary or procurement judgment within the Court's primary jurisdiction. 28 U.S.C. § 1491(a)(2), (b)(2). That encompasses three statutorily defined circumstances: (i) "orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records" where "incident of and collateral to" a money judgment, 28 U.S.C. § 1491(a)(2); (ii) actions brought under the Contract Disputes Act of 1979, *id.*; and (iii) bid protests, *id.* at

[10] BCI's claims also should be dismissed because they are not ripe. HHS has not yet finally determined the total amount of payments that BCI (or any other issuer) will receive under the risk corridors program. Moreover, whether sufficient funds will be available to make full risk corridors payments for any particular benefit year, and for all three years combined, is therefore presently unknown. HHS may collect sufficient funds this year to pay risk corridors claims in full. Alternatively, Congress may appropriate additional funds for the program to pay all risk corridors amounts as calculated under section 1342(b). In short, it is too soon to determine whether BCI will receive less than the full amount of its risk corridors claims, much less the extent of any such underpayment.

§ 1491(b)(2). *See, e.g.*, *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 181-82. None of these circumstances applies here.

II. On the Merits, Count I Fails as a Matter of Law Because BCI Has No Statutory Right to Payment in Excess of Collections

If the Court declines to dismiss this case on jurisdictional or prudential grounds, it must dismiss the Complaint under Rule 12(b)(6) for failure to state a claim. To avoid dismissal, a plaintiff must "provide the grounds of [its] entitle[ment] to relief" in more than mere "labels and conclusions." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007) (citation and quotation marks omitted); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009). A "formulaic recitation of the elements of a cause of action" is insufficient. *Twombly*, 550 U.S. at 555. Rather, the complaint must "plead factual allegations that support a facially 'plausible' claim to relief." *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009). The Court must dismiss a claim "when the facts asserted by the claimant do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002).[11]

In *Land of Lincoln*, this Court, on the plaintiff's request, ordered the United States to produce an administrative record, recognizing that the plaintiff's "fundamental claim is that HHS has misconstrued [s]ection 1342 of the Act," 129 Fed. Cl. at 103, in implementing the statute in a budget neutral manner and "mak[ing] payments only from fees collected, to the extent such fees are available, on a proportional basis to those owed payment." 129 Fed. Cl. at 88. In granting the United States' motion for judgment on the administrative record, the Court first looked to section 1342 to determine whether Congress required HHS to make full payments annually. *Id.* at 103-

[11] Alternatively, summary judgment in favor of the United States under Rule 56 is also appropriate with respect to Count I. There are no disputed issues of material fact regarding Count I, and the United States is entitled to judgment as a matter of law for the reasons set forth in this brief. *See* Rule 12(d).

06. Noting (1) that "payments in" is the "only statutory source of funding for the risk-corridors program," *id.* at 104; (2) that Congress relied on the CBO's scoring, which omitted the risk corridors program, when enacting the ACA, *id.*; (3) that Congress appropriated or authorized appropriations for other ACA programs but not for risk corridors, *id.* at 104-05; and (4) that Congress omitted specific appropriations and obligating language from section 1342 that it had included in the Medicare Part D risk corridors program, *id* at 105-06, the Court concluded that section 1342 "does not obligate HHS to make annual payments or authorize the use of any appropriated funds." *Id.* at 107. The Court then considered whether HHS's three-year, budget-neutral implementation of the program was reasonable, and, concluding that it was, granted the United States' motion for judgment on the administrative record under Rule 52.1. *Id.* at 107-08.

The Court's reasoning in *Land of Lincoln* was correct, and notwithstanding the differing procedural posture, the same result should obtain here.[12] BCI's statutory and regulatory claim asserted in Count I presents a pure question of law which the Court can resolve now: does section 1342 obligate HHS to make full payments. As this Court has concluded, it does not, and BCI's statutory claim fails as a matter of law.

[12] BCI disagrees that administrative record review is appropriate in these cases and has informed the Federal Circuit that it will not seek an administrative record in this case. *See* Br. for Highmark Inc., Highmark BCBSD Inc., Highmark West Virginia Inc., Blue Cross and Blue Shield of North Carolina, Blue Cross of Idaho Health Service, Inc., and Blue Cross and Blue Shield of Kansas City as Amici Curiae Supporting Appellant at 3-4, *Land of Lincoln Mut. Health Ins. Co. v. United States*, No. 17-1224 (Fed. Cir. Feb. 7, 2017).

A. Section 1342 Does Not Mandate Risk Corridors Payments In Excess of Amounts Collected

1. Congress Intended that Risk Corridors Payments Would Be Funded Solely from Collections

"Section 1342 . . . does not obligate HHS to make annual payments or authorize the use of any appropriated funds." *Land of Lincoln*, 129 Fed. Cl. at 107. Rather, as is evident from section 1342's text, structure, and subsequent history, Congress planned the program to be self-funding: insurers that have lower-than-expected costs for a given year are required to make contributions to the program, and those contributions are used to fund payments to insurers that have higher-than-expected costs. Subsection (a) of section 1342 requires HHS to establish and administer a temporary "payment adjustment system" based on the ratio of a plan's allowable costs to the plan's aggregate premiums. HHS fulfills that role by collecting charges from plans whose allowable costs are less than the threshold and distributing those funds to plans whose allowable costs exceed the threshold. But nothing in section 1342 requires, much less permits, HHS to make up a shortfall in collections. To the contrary, section 1342 creates a program with only "payments in" and "payments out." 42 U.S.C. § 18062(b) (capitalization altered). Insurers are assessed charges or receive payments "under the program," 42 U.S.C. § 18062(b)(1) and (2), and HHS distributes the monies accordingly.

BCI relies heavily on the language of subsection (b), which, in setting forth the "payment methodology," states that "the Secretary shall pay" amounts calculated in specified fashion. 42 U.S.C. § 18062(b)(1); *see* Complaint ¶¶ 61, 188, 203. But subsection (b) merely describes the "methodology" to be applied by HHS as it adjusts funds between plans "under the program"; it nowhere states that HHS (or the United States) must provide additional funds to insurers when the funds available "under the program" fall short of the statutory amounts. *See Land of Lincoln* at

106 (recognizing the absence of an authorization to make up a shortfall in the "payments in" to cover all of the "payments out"). Under BCI's interpretation, HHS would be the uncapped insurer of the insurance industry itself, under criteria—the ratio of a plan's allowable costs to its aggregate premiums—which are wholly dependent upon issuers' business judgment. Congress did not impose that result. To the contrary, Congress withheld the budgetary language that would make full risk corridors payments an obligation of the United States.

The Federal Circuit has repeatedly recognized that statutory language providing that an agency "shall pay" amounts calculated under a statutory formula (or words to that effect) does not, standing alone, create an obligation on the part of the government to provide for full payment. *See Prairie County, Montana v. United States*, 782 F.3d 685, 689 (Fed. Cir. 2015); *Greenlee County v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007); *Star-Glo Associates, LP v. United States*, 414 F.3d 1349, 1355 (Fed. Cir. 2005); *Highland Falls-Fort Montgomery Central School District v. United States*, 48 F.3d 1166, 1170 (Fed. Cir. 2000). The threshold inquiry is whether Congress obligated the government to make full payment without regard to appropriations, and as with all statutory questions, the touchstone of that inquiry is congressional intent. *See Prairie County*, 782 F.3d at 690 ("Absent a contractual obligation, the question here is whether the statute reflects congressional intent to limit the government's liability for [Payment in Lieu of Taxes Act (PILT)] payments, or whether PILT imposes a statutory obligation to pay the full amounts according to the statutory formulas regardless of appropriations by Congress.").

As this Court has recognized, Congress did not clearly intend that section 1342 would require HHS to make full payments. First, when Congress enacted section 1342, it did not appropriate money for risk corridors payments. *See Land of Lincoln*, 129 Fed. Cl. at 91-92 (citing *GAO Op.*, 2014 WL 4825237, at *2) ("Section 1342, by its terms, did not enact an appropriation

to make the payments specified in section 1342(b)(1)")). By its terms, "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. . . . No other source of funds is mentioned or specified." *Land of Lincoln*, 129 Fed. Cl. at 104. In contrast, "Congress provided appropriations or authorizations of funds for other programs within the Act, but it never has done so for the risk-corridors program." *Land of Lincoln*, 129 Fed. Cl. at 104-105 (citing 42 U.S.C. §§ 18031(a)(1), 18054(i)).[13] "Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally." *Id*. (quoting *National Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2583 (2012)).

Congress's decision not to provide for any other source of funding also marks a distinct contrast with the risk corridors program under Medicare Part D, under which Congress expressly authorized appropriations and obligated the government "in advance of appropriations." *See* 42 U.S.C. § 1395w-115(a)(2) (conferring "budget authority in advance of appropriations Acts and represent[ing] the obligation of the Secretary to provide for the payment of amounts provided under this section"); *id.* § 1395w-116(c)(3) (authorizing appropriations).[14] "When Congress omits

[13] For examples of other ACA provisions appropriating funds, *see*, *e.g.*, Pub. L. No. 111-148, §§ 1101(g)(1), 1311(a)(1), 1322(g), 1323(c). For provisions authorizing appropriations, *see*, *e.g.*, *id.* § 2705(f), ("There are authorized to be appropriated such sums as are necessary to carry out this section."); *see also*, *e.g.*, *id.* §§ 1002, 2706(e), 3013(c), 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(h), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), 5309(b).

[14] Congress used similar language of obligation in at least one other section of the ACA. *See* Pub. L. No. 111-148, § 2707(e)(1)(B), 124 Stat. 327 (2010) ("Budget Authority.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph."). Again, Congress used no such language in section 1342.

from a statute a provision found in similar statutes, the omission is typically thought deliberate." *Land of Lincoln*, 129 Fed. Cl. at 105 (quoting *Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002)). The "differences between the two statutes," as this Court recognized, indicates that Congress did not intend to "require HHS to make full payments annually." *Id.* at 105-06. [15]

In addition, in March 2010, while Congress was considering the ACA, the CBO provided Congress with an estimate of how the Act would affect future government spending and revenue, and the CBO omitted any budgetary estimate for the risk corridors program. *See* Letter from Douglas Elmendorf, Director, Congressional Budget Office, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 2 (Mar. 20, 2010), Appendix at A51.[16] The CBO's cost estimate was critical to ACA's passage. As this Court recognized, "Congress explicitly relied upon the CBO's findings when enacting the Affordable Care Act." *Land of Lincoln*, 129 Fed. Cl. at 104 & n.21. In the ACA itself, in a provision entitled "Sense of the Senate Promoting Fiscal Responsibility," Congress indicated, "[b]ased on Congressional Budget Office (CBO) estimates," that "this Act will reduce the federal deficit between 2010 and 2019." ACA § 1563(a). The CBO's projection was crucial to the Act's passage. *See* David M. Herszenhorn, *Fine-Tuning Led to Health Bill's $940 Billion Price Tag*, N.Y. Times, Mar. 18, 2010, Appendix at A100. And it was predicated on the understanding that risk corridors payments would not increase the deficit.

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[15] In *Moda*, Judge Wheeler mistakenly believed that the "the Medicare Part D statute provides only that the Government 'shall establish a risk corridor,' not that the Secretary of HHS 'shall pay' specific amounts to insurers." *Moda Health Plan*, 2017 WL 527588, at *15. In fact, the Medicare Part D statute expressly provides that "the Secretary *shall provide for payment*," 42 U.S.C. § 1395w-115(a) (emphasis added), and provides that "the Secretary *shall increase the total payments* . . . under this section" by specified amounts, 42 U.S.C. § 1395w-115(e)(2)(B).

[16] Available at http://www.cbo.gov/ftpdocs/113xx/doc11379/amendreconProp.pdf.

2. BCI's Alleged Reliance on HHS's Statements Is Irrelevant

BCI's alleged reliance on public statements by HHS regarding potential payments or obligations under section 1342 is irrelevant to the question of liability. *See, e.g.*, Complaint ¶¶ 81-82, 100, 102-05. In fact, HHS often recognized that its authority to make such payments is subject to appropriations. *See*, *e.g.*, 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). In at least one public statement, however, HHS did not do so. *See* 78 Fed. Reg. 15,410, 15,493 (Mar. 11, 2013) (stating that "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act"). It is well-established that "an agency may not spend more money for a program than has been appropriated for that program." *Highland Falls*, 48 F.3d at 1171. Thus, whether or not HHS explicitly mentioned appropriations, no issuer could have relied on a statement that HHS would pay without recognizing that HHS's ability to pay depended upon the action of Congress.

BCI's reliance on other statements is also unavailing. As BCI notes, HHS stated that the ACA "requires the Secretary to make full payments to issuers," Complaint ¶ 83 (quoting 78 Fed. Reg. at 15,473), and HHS described risk corridors payments as "an obligation of the United States Government," Complaint ¶ 199 (quoting "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015); Complaint Exhibit 24 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts . . . as fiscal year 2015 obligation [*sic*] of the United States Government for which full payment is required.").

As set forth above, however, Congress did not authorize HHS to make risk corridors payments an obligation of the United States government. The Supreme Court has held that an

agency's statements cannot create a payment obligation on the part of the Treasury beyond what Congress has authorized by statute. *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 416 (1990) ("We hold that payments of money from the Federal Treasury are limited to those authorized by statute."). The Supreme Court emphasized that "[i]f agents of the Executive were able, by their unauthorized oral or written statements to citizens, to obligate the Treasury for the payment of funds, the control over public funds that the Clause reposes in Congress in effect could be transferred to the Executive," a result that could "render the Appropriations Clause a nullity." *Richmond*, 496 U.S. at 428. In short, congressional intent as provided in the statute, not statements by the agency, govern issuers' rights under section 1342. And as for recording risk corridor payment amounts as obligations, "[i]f a given transaction is not sufficient to constitute a valid obligation, recording it will not make it one." GAO, *Principles of Federal Appropriations Law* ("*GAO Redbook*") (Vol. II) at 7-8 (3d ed. 2004), Appendix at A103.

In sum, Congress retained its power to control funding for the risk corridors program. Nothing in the ACA requires, or even suggests, that Congress intended risk corridors payments to be funded out of the general fund of the Treasury. Thus, BCI's entitlement to risk corridors payments is only to the extent of amounts collected under the program. Because 1342 does not give insurers a right to risk corridors payments in excess of collections, BCI's claims fail as a matter of law.

B. Congress Prohibited HHS from Using Appropriated Funds Other than Collections to Make Risk Corridors Payments

If there were any doubt as to Congress's intent to establish a self-funded program, it was removed by the 2015 and 2016 Spending Laws that barred HHS from using appropriated funds, other than collections, to make risk corridors payments. These express restrictions ensured 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 (daily ed. Dec. 11, 2014), and they corroborate Congress's original intent that payments under section 1342 would be funded solely by collections. Indeed, the 2015 and 2016 Spending Laws (including the continuing resolutions enacted since September 30, 2016) are the only laws that have appropriated any funds to HHS to permit risk corridors payments at all. And in any event, the riders—enacted many months before the first risk corridors payments could have been made—definitively capped payments to the extent of collections.

1. Congress Has Never Appropriated Funds for Risk Corridors Payments Other Than Collections

Under the Appropriations Clause, Congress controls the power of the purse. U.S. Const. art. I, § 9, cl. 7. Congress exercises that power by providing "budget authority," which grants federal agencies authority to incur financial obligations that are binding on the United States. *See* 2 U.S.C. § 622(2); *GAO Redbook* at 2–1; *see also id.* at 2-55 ("Agencies may incur obligations only after Congress grants budget authority."). Appendix at A144. The Congressional Budget Act defines four kinds of "budget authority:"

> **(i)** provisions of law that make funds available for obligation and expenditure (other than borrowing authority), including the authority to obligate and expend the proceeds of offsetting receipts and collections;
>
> **(ii)** borrowing authority, which means authority granted to a Federal entity to borrow and obligate and expend the borrowed funds, including through the issuance of promissory notes or other monetary credits;
>
> **(iii)** contract authority, which means the making of funds available for obligation but not for expenditure; and
>
> **(iv)** offsetting receipts and collections as negative budget authority, and the reduction thereof as positive budget authority.

2 U.S.C. § 622(2)(A). Obligations on the United States Treasury arising under a statute thus require two independent but equally critical elements: (1) authorization of a particular expenditure,

and (2) an appropriation to make that expenditure. *See, e.g.*, *Andrus v. Sierra Club*, 442 U.S. 347, 361 & n.18 (1979) (noting that "appropriations . . . have the limited and specific purpose of providing funds for authorized programs") (quotation omitted). Indeed, "appropriations do not merely set aside particular amounts of money; they define the character, extent, and scope of authorized activities." Kate Stith, *Congress' Power of the Purse*, 97 Yale L.J. 1343, 1356 (1988). Accordingly, a claimant seeking to enforce a money-mandating statute or regulation generally "must identify not just a command to make [payment] but an appropriation of . . . money that . . . may [be] use[d] for that purpose." *Nevada v. Dep't of Energy*, 400 F.3d 9, 13 (D.C. Cir. 2005).

In the absence of either a permanent appropriation or a statement of intent to obligate the government in advance of an appropriation, *see Land of Lincoln*, 129 Fed. Cl. at 107, Congress retained its authority to control spending on the risk corridors program through the annual appropriations process. Without its own appropriation or other budget authority, section 1342 could not require any "Payments Out."

Judge Wheeler erred in concluding the 2014 CMS Program Management appropriation was "available for [risk corridors] payments," but that HHS "chose not to use the Program Management appropriation for 2014 risk corridors payments." *Moda Health Plan*, 2017 WL 527588, at *16. Making risk corridors payments was not an "other responsibilit[y]" of CMS in fiscal year 2014. Under section 1342, risk corridors charges and payments are based on the ratio of allowable costs to the target amount "for any plan year." 42 U.S.C. § 18062(b). Indeed, "allowable costs" for "any plan year" must be reduced by any reinsurance and risk adjustment payments, which are not made until after the end of the calendar year. 42 U.S.C. § 18062(c)(1)(B). Risk corridors collections and payments could not become an "other responsbilit[y]" until sometime in calendar year 2015 at the earliest. Accordingly, because risk corridors payments were

not a responsibility of HHS until after the lump sum amount expired, the 2014 CMS Program Management appropriation did not appropriate any funds for risk corridors payments.

The GAO did not conclude otherwise. Rather, it noted that the 2014 Program Management appropriation "*would have been* available for making the payments pursuant to section 1342(b)(1)," *GAO Op.*, 2014 WL 4825237, at *3, but concluded that because "[a]ppropriations acts, by their nature, are considered nonpermanent legislation," the "other responsibilities" language would need to be included in future appropriations acts in order for the Program Management appropriation to supply a source of funds for risk corridors payments made in future fiscal years. *Id.* at *5.[17]

2. In the Spending Laws, Congress Confirmed that Risk Corridors Payments Would Be Funded Solely from Collections

Well before risk corridors payments could be calculated or paid, Congress exercised its constitutional authority over the Federal fisc in the 2015 and 2016 Spending Laws by capping HHS's ability to make payments to the extent of collections. Congress's intent is clear: the risk corridors program is to be self-funded. Indeed, HHS announced its budget-neutral framework in the spring of 2014, 79 Fed. Reg. at 13787; 79 Red. Reg. at 30,260; April 11 Guidance, and Congress understood that framework to mean that "the federal government will never pay out more

[17] In *Moda*, Judge Wheeler also erroneously concluded that several continuing resolutions enacted in the Fall of 2014 appropriated funds for risk corridors payments. *Moda Health Plan*, 2017 WL 527588, at *17, n.13. Those continuing resolutions provided that "no appropriation or funds made available or authority granted [herein] shall be used to initiate or resume any project or activity for which appropriations, funds, or other authority were not available during fiscal year 2014." Pub. L. No. 113-164, § 104, 128 Stat. 1867, 1868 (Sept. 19, 2014). As set forth above, the 2014 CMS Program Management appropriation did not appropriate funds for risk corridors payments, and the continuing resolutions, therefore, could not provide an appropriation for those payments either. Moreover, the continuing resolutions made funds available only until the enactment of the 2015 Spending Law on December 16, 2014, *id.* § 106, and no right to risk corridors claim arose until calendar year 2015. Moreover, Judge Wheeler's reliance on *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181 (2012), is misplaced because the Federal Circuit has rejected the argument that *Ramah Navajo* extends to statutory claims. *See Prairie County*, 782 F.3d at 689-90.

than it collects from issuers over the three year period risk corridors are in effect," 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). In light of the GAO's September 2014 opinion suggesting that the lump sum amount could potentially serve as a source of funding for risk corridors payments, Congress enacted the restriction "to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." *Id.* And the following year, Congress again made clear that no funds other than collections would be used, stating:

> The Committee is proactively protecting discretionary funds in the bill by preventing the administration from transferring these funds to bail out ACA activities *that were never intended to be funded through the discretionary appropriations process*. * * * * The Committee continues bill language requiring the administration to operate the Risk Corridor program *in a budget neutral manner* by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program.

Departments of Labor, Health and Human Services, and Education, and Related Agencies Appropriation Bill, 2016, S. Rep. No. 114-74, at 12 (2015) (emphasis added), Appendix at A134.

The Spending Laws corroborate Congress's original intent that payments under section 1342 would be funded solely by collections; and to the extent there were a question as to Congress's original intent, the Spending Laws definitively capped payments to the extent of collections. "[I]t is a well-established doctrine that Congress can authorize a deviation from pre-existing law by a provision in an appropriations act." *Bickford v. United States*, 228 Ct. Cl. 321, 329 (1981); *see, e.g.*, *United States v. Dickerson*, 310 U.S. 554, 555-56 (1940) (Congress can "suspend or repeal [an] authorization contained in [its own acts] . . . by an amendment to an appropriation bill, or otherwise"); *Republic Airlines, Inc. v. U.S. Dep't of Transp.*, 849 F.2d 1315, 1320 (10th Cir. 1988) ("Congress can amend substantive legislation through a provision in an appropriations act."); *Envirocare of Utah Inc. v. United States*, 44 Fed. Cl. 474, 482 (1999) (appropriations laws are "'just as effective a way to legislate as are ordinary bills relating to a

particular subject'") (citation omitted); *GAO Redbook* at 2-62 – 2-63 ("Congress may enact a subsequent appropriation that makes a smaller payment than was contemplated in the permanent legislation . . . as long as the intent to reduce the amount of the payment is clear."), Appendix at A165-66. When Congress does not appropriate sufficient funds to permit an agency to pay under a formula provided by statute or regulation, Courts must use all the ordinary tools of statutory interpretation to discern Congress's intent. *Dickerson*, 310 U.S. at 562 ("The meaning to be ascribed to an Act of Congress can only be derived from a considered weighing of every relevant aid to construction.").

In *Highland Falls*, for example, section 2 of the Impact Aid Act provided that school districts "shall be entitled" to amounts calculated under a statutory formula and further specified that, in the event of a shortfall in appropriations for various programs, the Secretary "shall first allocate" to each school district 100% of the amount due under section 2. 48 F.3d at 1168. Congress subsequently earmarked certain amounts for entitlements under various sections of the Act, and the earmarked amount was insufficient to pay 100% of the amounts due under section 2. *Id*. at 1169. In light of that clear limit on appropriations, the Federal Circuit held that the school districts were entitled to only a *pro rata* share of the amounts calculated under the statutory formula. *Id*. at 1170-71.

Similarly, in *Star-Glo*, Congress had established a temporary program directing the Secretary of Agriculture to "[pay] 'Florida commercial citrus and lime growers $26 for each commercial citrus or lime tree removed to control citrus canker" and appropriated $58 million for these payments." 414 F.3d at 1351-52. Growers brought suit seeking additional payments for trees removed after the $58 million appropriation had been exhausted. *Id.* at 1352-53. The Federal Circuit noted that the statute did not contain any "capping" language like "not to exceed" and "not

more than," but, based on the legislative history, the Court concluded that Congress intended to cap total payments at $58 million. *Id.* at 1354. The application of *Highland Falls* and *Star-Glo* is clear: Congress has, by expressly restricting the use of Program Management funds, removed any doubt that the Secretary is only obligated to make risk corridors payments to the extent of collections. Indeed, as in *Highland Falls*, it is difficult "imagining a more direct statement of congressional intent than the instructions in the appropriations statutes at issue here." 48 F.3d at 1170. The United States is not liable for any shortfall.

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

Similarly, in *United States v. Will*, 449 U.S. 200 (1980), the Supreme Court held that appropriations language providing that "[n]o part of the funds appropriated for the fiscal year ending September 30, 1979 . . . may be used to pay" salary increases mandated by earlier legislation "indicate[d] clearly that Congress intended to rescind these raises entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear intent of Congress

. . . *was to stop for that year the application of the . . . Act*." *Id.* at 224 (emphasis added); *see also United States v. Mitchell*, 109 U.S. 146, 148 (1883) (holding that "by the appropriation acts which cover the period for which the appellee claims compensation, congress expressed its purpose to suspend the operation of [a prior statute fixing salaries] and to reduce for that period the salaries of the appellee and other interpreters of the same class from $400 to $300 per annum"); *Matthews v. United States*, 123 U.S. 182, 186 (1887) (appropriations law capping salaries "in full compensation" for services "repealed, by necessary implication[,] . . . previous enactments" setting higher compensation).[18]

In *Moda*, Judge Wheeler, having erroneously concluded that the "shall pay" language in subsection 1342(b) alone mandated full payment, analogized the riders in the Spending Laws to restrictions wholly dissimilar to this case. *See Moda Health Plan*, 2017 WL 527588, at *18-*20. In *New York Airways v. United States*, 369 F.2d 743 (Ct. Cl. 1966), the court addressed a shortfall in appropriations to compensate helicopter companies for delivering the U.S. mail. The court held that "the particular wording of the [Federal Aviation] Act empowers the [Civil Aeronautics] Board

[18] Other circuits have reached similar conclusions. For example, in *Republic Airlines*, an annual appropriation law stated that "notwithstanding any other provision of law, none of the funds appropriated by this Act shall be expended under section 406 [of the Federal Aviation Act of 1958] for [certain] services provided after ninety-five days following the date of the enactment of this Act." 849 F.2d at 1317 (citing Pub. L. No. 97-102). The Tenth Circuit held that the appropriations restriction substantively amended the previously existing subsidy program under section 406 of the Act, thereby limiting the Civil Aeronautics Board's power to pay subsidies. *Id.* at 1319-22 (citing *Will*, 449 U.S. at 223; *American Fed'n of Gov't Employees, AFL–CIO v. Campbell*, 659 F.2d 157, 157 (D.C. Cir. 1980)). In so holding, the court rejected the airlines' argument that "Congress intended in section 406(b) to create an entitlement which was to survive appropriations actions," concluding that the "appropriations act directly addressed, and limited, the subsidy payable by the Board under section 406 and, perforce, altered any 'entitlement' to which the Airlines refer." *Id.* at 1319. *See also Am. Fed'n of Gov't Emp., AFL-CIO*, 659 F.2d at 161 ("the [appropriations act] in this case contains words that by clear implication, if not express statement, modified *pro tanto* the previous substantive law. Consequently, we conclude that Congress, by express reference to the earlier statute, effectively modified the prevailing rate statute to provide that wages for prevailing rate employees could not be increased by more than 5.5% for fiscal year 1979.").

to obligate the United States for the payment of an agreed subsidy in the absence or deficiency of a congressional appropriation." *Id*. at 804. The court noted that "key congressmen who spoke on the subject fully understood that the commitment to pay [in the permanent legislation] was a binding obligation of the Government in the courts even in the failure of Congress to appropriate funds." *Id.* at 815. Indeed, Congress expressly recognized that it was appropriating funds for "Liquidation of Contract Obligations," which could not be abrogated by a shortfall in funding. *Id.* at 812. In contrast, nothing in the text or legislative history of the Spending Laws or section 1342 itself suggests that Congress understood risk corridors payments to be contractual, nor is there any indication that the United States would be liable for any shortfall in collections.

Gibney v. United States, 114 Ct. Cl. 38 (1949), is likewise inapposite. There, the Court of Claims was faced with a single spending restriction intended to prevent appropriated funds from being used to pay overtime to immigration inspectors "other than as provided in the Federal Employees Pay Act of 1945." *Id.* at 48-49. In fact, as the Court of Claims recognized, the Federal Employees Pay Act of 1945 itself exempted immigration inspectors from its overtime pay provisions. *Id.* at 53. The court concluded that the restriction "did not prevent the premium payment to immigration inspectors" by its own terms, *id.*, and the sponsoring Senator stated the following year that he had been mistaken in his understanding of the permanent legislation (providing for compensation of immigration inspectors) to which he had directed the restriction, *id.* at 54. To analogize to risk corridors, it would be as if Congress restricted the use of appropriated funds that were not otherwise available to make risk corridors payments in the first place. Instead, Congress, in two consecutive years, directly restricted the one source of discretionary appropriations funding (other than collections) that had been identified as a potential source for risk corridors payments, thus leaving collections as the sole remaining source. *Accord Belknap v.*

United States, 24 Ct. Cl. 433, 441-42 (1889), *aff'd*, 150 U.S. 588 (1893) (holding that "Congress persistently determined each year to fix the compensation of Indian agents by annual appropriations" and thus "the claimant has received all he is entitled to."). *Gibney* provides no authority to disregard Congress's express restrictions on risk corridors funding.

To be sure, Judge Wheeler contrasted cases where Congress stated that "no funds" or "no part of any appropriation" would be available for a specified payment. *Moda Health Plan*, 2017 WL 527588, at *19-*20. Judge Wheeler also noted that Congress used similar "no funds" language in the Spending Laws directed at other programs. *Id.* at *21. But in those cases and for those programs, Congress intended that no federal funds whatsoever be used for the specified programs. *See, e.g.*, *Dickerson*, 310 U.S. at 561. Here, Congress did not intend to repeal section 1342 or prohibit risk corridors payments altogether. Instead, Congress, while providing HHS with the authority to make risk corridors payments, merely sought to ensure that only risk corridors collections would be available to make risk corridors payments, and that the United States Treasury would not be liable to make up the resulting multi-billion dollar shortfall. Thus, by the time any payments could be made, Congress had "directly spoken" to the issue by restricting the use of HHS funds to support the risk corridors program. *Highland Falls*, 48 F.3d at 1170. Issuers' remedy "must lie with Congress." *Richmond*, 496 U.S. at 432.

Accordingly, Count I must be dismissed for failure to state a claim upon which relief may be granted.[19]

[19] Alternatively, if the Court concludes that section 1342 is ambiguous, then the Court can dismiss Count I under Rule 12(b)(6) on the basis that HHS's implementation of the statute is reasonable and consistent with the enacted Spending Laws. *Land of Lincoln*, 129 Fed. Cl. at 106-08.

III. BCI's Contract Claims (Counts II-V) Fail to State a Claim

In Counts II, III, IV, and V, BCI alleges that, by making partial rather than full risk corridors payments for the 2014 benefit year, HHS breached express and implied contracts, that it is in anticipatory breach of its payment obligations for the 2015 benefit year, and that these breaches violate the implied covenant of good faith and fair dealing. In *Land of Lincoln*, in considering a nearly identical complaint to BCI's Complaint, this Court concluded that the contract theories fail to state a claim upon which relief can be granted, and dismissed the claims under Rule 12(b)(6). *Land of Lincoln*, 129 Fed. Cl. at 108-14. This Court's reasoning in *Land of Lincoln* is sound and equally applicable here: Counts II through V should be dismissed for failure to state a claim.[20]

A. Count II Fails Because the Express Agreement at Issue Is Wholly Unrelated to the Risk Corridors Program

BCI contends that the QHP Agreement gives rise to an express contractual right to receive risk corridors payments. But as this Court held, the QHP Agreement does not create "a valid express contract pertaining to risk corridors payments." *Land of Lincoln*, 129 Fed. Cl. at 110.

The Court must begin with the plain language of the agreement. *Coast Fed. Bank, FSB v. United States*, 323 F.3d 1035, 1038 (Fed. Cir. 2003) (en banc). The Court need go no further: the QHP Agreement does not mention risk corridors, section 1342, or 45 C.F.R. § 153.510, and nothing in the Agreement relates in any way to the risk corridors program. Rather, the Agreement is focused on the electronic transmission of enrollee data through the Exchanges and the protection

[20] In addition to the defects set forth in *Land of Lincoln* and in this section, Counts II-V are entirely derivative of Count I in that they presume some entitlement to full risk corridors payment under section 1342. Because section 1342 does not require full, annual payments, no contract incorporating section 1342 could require such payments and no issuer could have a vested property interest in such payments. Accordingly, should the Court determine that section 1342 does not require full annual payments, Counts II-V necessarily fail as a matter of law.

of personally identifying information in those transmissions. *See Land of Lincoln*, 129 Fed. Cl. at 108-09.

Consistent with this focus, in Section II of the Agreement—entitled "Acceptance of Standard Rules of Conduct"—an issuer agrees that, in order "to gain and maintain access to the 'CMS Data Services Hub Web Services,'" it will abide by rules relating to HIPAA compliance, secure transaction formats, transaction testing, and laws governing the use and storage of personally identifiable information.[21] QHP Agreement § II.a. HHS, in turn, agrees to "undertake all reasonable efforts to implement systems and processes that will support QHP[] functions" and, in the event of system failure, to "work with QHP[s] in good faith to mitigate any harm caused by such failure." *Id.* § II.d.

Section II does not, as BCI asserts, also require HHS to make risk corridors payments. "HHS's obligation 'to implement systems and processes' . . . must be read in the context of the agreement as a whole." *Land of Lincoln*, 129 Fed. Cl. at 109. The term "systems and processes," as used here, "must relate to the electronic system that HHS and the qualified health plan will be using, and the processes that support this electronic system." *Id.* Section II cannot plausibly be read to relate in any way to the risk corridors program.[22] *See Land of Lincoln*, 129 Fed. Cl. at 109

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

[22] The QHP Agreement specifically incorporates by reference, at § II.b(3), a "Companion Guide" created for issuers that sets forth the detailed electronic data transmission requirements that issuers must follow to effectuate eligibility, enrollment, and federal insurance subsidy transactions with the Exchanges through the Hub Web Services. The official title of the Companion Guide is "CMS Standard Companion Guide Transaction Information: Instructions related to the ASC X12 Benefit Enrollment and Maintenance (834) transaction, based on the 005010X220 Implementation Guide and its associated 005010X220A1 addenda for the Federally facilitated Exchange (FFE), Companion Guide Version Number 1.5 (March 22, 2013). *See* Appendix A1. As set forth in the Companion Guide, the systems and processes that use the Hub Web Services include the: "testing process" (at 3), "validation processes" (at 4-5), "Centers for Medicare and Medicaid Services

(finding, after considering the text, surrounding provisions, context, and Companion Guide, that the "'systems and processes' language [in the QHP Agreement] does not give rise to any risk corridors obligations").[23]

BCI also relies on section V.g. of the QHP Agreement, which provides that the Agreement is governed by federal law. As in *Land of Lincoln*, BCI argues that this reference to federal law necessarily incorporates section 1342 (and presumably the vast corpus of other federal laws applicable to BCI—whether ACA-related or not) by reference into the Agreement as a contractual commitment. Complaint ¶¶ 220-21. But as this Court held, "[s]ection V.g[] does not incorporate the risk-corridors program into the agreement." *See Land of Lincoln*, 129 Fed. Cl. at 109. A court may not "find that statutory or regulatory provisions are incorporated into a contract with the government unless the contract *explicitly* provides for the incorporation." *St. Christopher Associates, L.P. v. United States*, 511 F.3d 1376, 1384 (Fed. Cir. 2008) (citation omitted) (emphasis added); *see also Northrop Grumman Info. Tech., Inc. v. United States*, 535 F.3d 1339, 1344 (Fed. Cir. 2008); *Precision Pine & Timber, Inc. v. United States*, 596 F.3d 817, 826 (Fed. Cir. 2010).

The QHP Agreement fails this test. "Here, the general reference to federal law and HHS regulations does not expressly or clearly incorporate the specific risk-corridors provisions upon

(CMS) Enterprise File Transfer (EFT) System" (at 7, 33), "Federal Exchange Program System (FEPS) Enrollment Data Store (EDS)" (at 9-10), "enrollment process" (at 27-26), termination process (at 32-35), monthly reconciliation process (at 35), "HHS Reconciliation Process Flow" (at 33), "QHP Issuer Reconciliation Process Flow" (at 32) and the "comparison process" (at 34). The Companion Guide thus illustrates that the types of "systems and processes" referred to in the QHP Agreement are far afield from the risk corridors program.

[23] If the term "systems and processes" were read to encompass the risk corridors program, it would also encompass any other ACA program that can plausibly be construed to "support" a QHP. Such a reading would necessarily transform the dozens of ACA programs operated by HHS from regulatory functions into contractual commitments. There is no limiting principle to such a construction, and nothing in the ACA, the QHP Agreement, or common sense supports it.

which [BCI] relies." *Land of Lincoln*, 129 Fed. Cl. at 110. Section V.g. states merely that the Agreement "will be governed by the laws and common laws of the United States of America, including . . . such regulations as may be promulgated . . . by [HHS]." It uses no "clear and express" language incorporating section 1342 by reference; indeed it uses no language of incorporation at all with reference to risk corridors. Section V.g. does not mention risk corridors, section 1342, or 45 C.F.R. § 153.510 or in any way imply that the Agreement has anything to do with risk corridors. *See, e.g.*, *Earman v. United States*, 114 Fed. Cl. 81, 104 (2013) (provision stating that a contract is governed by Federal laws, "which does not refer to any particular statutory or regulatory provision, cannot reasonably be read as incorporating the corpus of the [ ] statute into plaintiff's contract."); *Smithson v. United States*, 847 F.2d 791, 794 (Fed. Cir. 1988) (rejecting argument that provision that contract was "subject to" regulations promulgated by the Farmers Home Administration incorporated the agency's regulations). BCI's suggestion that Section V.g. creates a contractual right to risk corridors payments must be rejected.[24]

Finally, interpreting the QHP Agreement to encompass risk corridors obligations would create an absurd result in that BCI could seek to recover in contract for benefit year 2014, but not for 2015 or 2016. BCI executed a QHP Agreement with HHS for benefit year 2014, while BCI executed similar agreements with the Idaho State-Based Exchange for benefit years 2015 and 2016. *Compare* Complaint Exhibit 3 *with* Exhibits 4 & 5.[25] Thus, embracing BCI's theory that

[24] As noted above, the QHP Agreement incorporates the Companion Guide expressly and specifically into the Agreement. *See* Complaint Exhibit 3 § II.b.3. The use of specific incorporation language to incorporate the Companion Guide but not to incorporate section 1342 or 45 C.F.R. § 153.510 further indicates that the Agreement does not incorporate the provisions of the risk corridors program.

[25] QHPs sold only on Exchanges that do not use HHS's platform (such as many State-Based Exchanges), though equally subject to the risk corridors program, do not enter QHP Agreements with HHS.

the QHP Agreement with HHS creates a contractual right to risk corridors payments from HHS would mean that BCI could enforce its rights in contract only for benefit year 2014. The Supreme Court has held that a legal interpretation under which the rights of participants on federal and state Exchanges would fundamentally differ should be rejected. *King*, 135 S. Ct. at 2483 (rejecting textual interpretation under which "State and Federal Exchanges would differ in a fundamental way" because 42 U.S.C. § 18041(c) "indicates that State and Federal Exchanges should be the same"); *see also Land of Lincoln*, 129 Fed. Cl. at 109 n.26 (noting the "inconsistent and unintended result" that ensues from adopting this express contract theory). BCI identifies no reason why Congress would have designed the program in such a way, and there is none. The QHP Agreement does not require HHS to make risk corridors payments. Count II must be dismissed.

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

BCI's implied-in-fact contract theory—that "the Government entered into valid implied-in-fact contracts regarding the Government's obligation to make full and timely risk corridor payments to BCI for CY 2014 in exchange for BCI's agreement to become a QHP and participate in the Idaho ACA Exchanges," Complaint ¶ 229—was correctly rejected by this Court in *Land of Lincoln*, 129 Fed. Cl. 111-14. The elements of an implied-in-fact contract are the same as the elements of an express contract, namely: (1) mutuality of intent; (2) an unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the government's representative to bind the government in contract. *Hanlin v. United States*, 316 F.3d 1325, 1328 (Fed. Cir. 2003). BCI has not alleged and cannot allege facts plausibly establishing these requirements.

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

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

BCI cannot overcome this presumption. Like the issuer in *Land of Lincoln*, BCI points to section 1342, 45 C.F.R. § 153.510, and HHS's purported "admissions regarding their obligation to make risk corridors payments" as allegedly indicating both an intent to contract for, and an offer of, "full and timely" risk corridors payments. Complaint ¶¶ 230, 236. This does not suffice. "Although [section 1342] may mandate payment from HHS, albeit not annually, when a qualified health plan satisfied statutory and regulatory conditions, that alone does not demonstrate intent to contract." *Land of Lincoln*, 129 Fed. Cl. at 111-12 (citing *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 27 (2011)) ("[T]o overcome th[e] presumption [that general laws do not create private rights in contract], plaintiffs must point to specific language in [the statute or regulation]

or to conduct on the part of the government that allows a reasonable inference that the government intended to enter into a contract.").

The Federal Circuit has made clear that intent to contract in a statute is determined by looking first to the text and then to the legislative history. *Brooks v. Dunlop Mfg., Inc.*, 702 F.3d 624, 631 (Fed. Cir. 2012) ("In determining whether a statute creates a contract, the [Supreme Court] has instructed us to first look to the language of the statute. . . . We next look to whether circumstances surrounding the statute's passage manifested any intent by Congress to bind itself contractually."). In *Brooks*, the court considered a plaintiff's claim that the former *qui tam* provision of the patent marking statute was a unilateral offer by the government. 702 F.3d at 630-32; *see also* 35 U.S.C. § 292(b), *amended by* Pub. L. No. 112-29, § 16, 125 Stat. 284 (2011). The court concluded, based on the absence of any intent in the text or legislative history of the *qui tam* provision, that the plaintiff could not demonstrate an intent by Congress to contract. *Brooks*, 702 F.3d at 631.

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

Nor do HHS's statements regarding its risk corridors duties, Complaint ¶ 100, evince an intent to contract; they merely recognize HHS's understanding of its existing *statutory* duties. *See, e.g.*, 79 Fed. Reg. at 30,260, Appendix at A150 ("HHS recognizes that the *Affordable Care Act* requires the Secretary to make full payments to issuers."); 80 Fed. Reg. at 10,779, Appendix at A153 (same). An agency's description of a statutory duty is not evidence of an intent to contract. *AAA Pharmacy, Inc. v. United States*, 108 Fed. Cl. 321, 328 (2012). Thus, there is no support for BCI's contention that Congress or HHS intended the risk corridors program to operate as a contractual obligation. *Cf. Hanlin*, 316 F.3d at 1329-30 (noting that statute and regulation "set forth the [agency's] authority and obligation to act, rather than a promissory undertaking" and "[w]e discern no language in the statute or the regulation that indicates an intent to enter into a contract"); *AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 (finding no intent to contract in Medicare statute and regulations where statute "only provides for payment" and regulation "provides for a review process"); *ARRA Energy Co. I*, 97 Fed. Cl. at 28 (dismissing implied-in-fact contract claim because statute "simply provides that the government will make an outright payment to any applicant who meets specified conditions").

In finding intent, Judge Wheeler announced a sweeping new rule for inferring congressional intent to contract based on a statute's structure: Congress intends to contract when it (1) creates a voluntary "incentive program" and (2) promises fixed payment to those parties if they perform the required services. *Moda Health Plan*, 2017 WL 527588, at *23-*24. This rule cannot be reconciled with Federal Circuit precedent. First, considering the "structure" of the statute instead of the text and legislative history is inconsistent with *Brooks*. *See also Wells Fargo Bank, N.A. v. United States*, 88 F.3d 1012, 1018 (Fed. Cir. 1996) (finding unilateral offer in "promissory words" that upon issuance of "Conditional Commitment for Guarantee" government

"will execute" agreement and loan guarantee). Second, the *qui tam* provision at issue in *Brooks* had the same "structure" Judge Wheeler found determinative in *Moda*—a voluntary incentive program whereby individuals could bring suit on behalf of the United States against false patent markers and a firm government promise to pay a fixed amount—but the Federal Circuit found no intent to contract in this "structure." *Brooks* 702 F.3d at 626 & 630-31. Absent any intent by the United States to contract for the payment of risk corridors, Count III must be dismissed.

2. Section 1342 Does Not Constitute an Offer in Contract that Can Be Accepted by Performance Alone

Contrary to BCI's allegations, an unambiguous offer and acceptance cannot be inferred from the language or circumstances of the risk corridors program. Complaint ¶¶ 230-31, 236. "Section 1342 and the implementing regulations make no explicit reference to an offer or contract." *Land of Lincoln*, 129 Fed. Cl. at 112 (citing *AAA Pharmacy, Inc.*, 108 Fed. Cl. at 329 and *ARRA Energy Co. I*, 97 Fed. Cl. at 27-28). And HHS's rulemaking and guidance similarly contain no language that can plausibly be construed as an unambiguous offer. HHS's statements in the context of proposed rulemaking cannot constitute an unambiguous offer because those statements, by their nature, are subject to change. Contrary to BCI's assertions, BCI became certified as a QHP before HHS announced final rules for risk corridors payments, demonstrating that neither party considered the risk corridors program to be a contractual, as opposed to a statutory, obligation.[26]

[26] BCI's Complaint contains no allegations regarding the purported consideration to the United States for BCI's choice to enter the ACA Exchange. To the extent the Complaint could be construed as alleging that furthering a policy goal of the United States constitutes contractual consideration, this theory has no limiting principle and lacks legal support.

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

Regarding authority to enter an implied contract with issuers, BCI again relies on HHS's representations and assurances. *See* Complaint ¶ 242 ("[t]he Government repeatedly acknowledged its obligations to make fully and timely risk corridors payments . . . through its conduct and statements to the public and to BCI and other similarly situated QHPs, made by representatives of the Government who had express or implied authority to bind the United States").[27] While BCI mentions the director of CCIIO, Complaint ¶ 237, it does not allege and cannot allege that Mr. Counihan enjoyed authority to bind the government in contract for risk corridors payments, as it must to avoid dismissal. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1327 (Fed. Cir. 1997) (the plaintiff "must allege facts sufficient to show that the Government representative who entered into its alleged implied-in-fact contract was a contracting officer or had implied actual authority to bind the Government").

Nothing in section 1342 or the ACA authorizes *any* federal official to enter into a contract to make risk corridors payments. "A government agent possesses express actual authority to bind the government in contract only when the Constitution, a statute, or a regulation grants it to that agent in unambiguous terms." *McAfee v. United States*, 46 Fed. Cl. 428, 435 (2000). Absent statutory authority, no federal official can form a binding contract. *See Schism v. United States*, 316 F.3d 1259, 1288 (Fed. Cir. 2002) (en banc) (holding that neither Secretaries of the Armed

[27] Not only were many of the representations relied upon by BCI made two or three years after the time of purported contract formation, at all times, HHS's assurances were expressly grounded in the statute—not a contract—and often were accompanied by the qualifying language "subject to the availability of appropriations." *See, e.g.*, Complaint Exhibits 26 & 40 (relying on 2015 and 2016 letters from CCIIO containing the qualifying language: "[i]n the event of a shortfall for the 2016 program year, HHS will explore other sources of funding for risk corridors, *subject to the availability of appropriations*") (emphasis added).

Forces nor the President had authority to contract with service members for free, lifetime healthcare).

Moreover, budget authority is a prerequisite to contract formation with the United States. The Anti-deficiency Act prohibits government officials from involving the "government in a[n] . . . obligation for the payment of money before an appropriation is made unless authorized by law." 31 U.S.C. § 1341(a)(1)(B). Without such authorization (or appropriation), a valid contract for the payment of money cannot be formed. *See, e.g.*, *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 643 (2005) (recognizing that "without . . . special authority, a[n] . . . officer cannot bind the Government in the absence of an appropriation") (citations omitted). As explained above, at 26-35, no appropriation for risk corridors payments was enacted until 2015 and 2016 Spending Laws. Accordingly, HHS lacked budget authority in fiscal years 2013 or 2014 to contract to make risk corridors payments in fiscal year 2015 because "[a]s far as government contracts are concerned," the Anti-Deficiency Act "'bars a federal employee or agency from entering into a contract for future payment of money in advance of, or in excess of, existing appropriation.'" *Cessna Aircraft Co. v. Dalton*, 126 F.3d 1142, 1449 (Fed. Cir. 1997) (quoting *Hercules, Inc. v. United States*, 516 U.S. 417, 426 (1996)). And, as noted above, HHS's "assurances" on which BCI allegedly relied are immaterial as a matter of law. An agency simply cannot bind itself to the payment of money through its oral or written statements—absent express authority bestowed by Congress. *See Richmond*, 496 U.S. at 428.

4. BCI Cannot Establish that HHS Breached any Contractual Obligation

Finally, even if the QHP Agreement incorporated risk corridors obligations (it does not) or an implied-in-fact contract for the payment of risk corridors was formed (it was not), BCI cannot establish that HHS breached a contractual obligation. *See Land of Lincoln*, 129 Fed. Cl. at 113.

For BCI to recover on a breach of contract claim, it must establish both the existence of a valid contract with HHS and a breach of a duty created by that contract. *See Anderson v. United States*, 73 Fed. Cl. 199, 201 (2006). BCI's contract theories seek to convert the risk corridors program into a contractual undertaking. But the program includes HHS's three-year payment framework. *See, e.g.*, Patient Protection and Affordable Care Act; Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240 30,260 (May 27, 2014). Because any contractual obligation could extend no farther than what is required by statute and regulation, HHS cannot have breached such an agreement by making pro-rated payments to the extent of collections in conformity with its three-year payment framework. *Land of Lincoln*, 129 Fed. Cl. at 113.

C. Count IV (Anticipatory Breach) and Count V (Breach of the Implied Covenant of Good Faith and Fair Dealing) Fail Because No Contract Exists for Risk Corridors Payments

In Count IV, BCI asserts that it is treating "the Government's repudiation of its risk corridors payment obligations under the CY 2015 Agreements as a total breach." Complaint ¶ 255. Count V alleges that HHS breached an asserted implied covenant of good faith and fair dealing by not making full risk corridor payments. Complaint ¶ 260. Both Counts fail because, as set forth above, HHS has no contractual obligations with respect to risk corridors. *See Danzig v. AEC Corp.*, 224 F.3d 1333, 1337 (Fed. Cir. 2000) ("anticipatory repudiation includes cases in which reasonable grounds support the obligee's belief that the obligor will breach the contract"); *HSH Nordbank AG v. United States*, 121 Fed. Cl. 332, 341 (2015) (When a plaintiff "fail[s] to establish either an express or implied contract with [the United States], its dependent claim for a breach of implied covenant of good faith and fair dealing also must be dismissed."). Accordingly, Count IV and Count V should be dismissed.

IV. Count VI (Takings Without Just Compensation) Fails Because BCI Has No Vested Property Right to Full, Annual Risk Corridors Payments

Count VI asserts that the United States' "action in withholding . . . full and timely CY 2014 and CY 2015 risk corridors payments owed to BCI constitutes a deprivation and taking of Plaintiff's property interests and requires payment to Plaintiff of just compensation under the Fifth Amendment of the U.S. Constitution." Complaint ¶ 227. Courts apply a two-part test when evaluating whether governmental action constitutes a taking without just compensation. "First, the court determines whether the claimant has identified a cognizable Fifth Amendment property interest that is asserted to be the subject of the taking. Second, if the court concludes that a cognizable property interest exists, it determines whether that property interest was 'taken.'" *Acceptance Insurance Cos., Inc. v. United States*, 583 F.3d 849, 854 (Fed. Cir. 2009) (collecting Federal Circuit cases). "If the claimant fails to demonstrate the existence of a legally cognizable property interest, the court's task is at an end." *Am. Pelagic Fishing Co. v. United States*, 379 F.3d 1363, 1372 (Fed. Cir. 2004).

At set forth above, BCI has no contractual right to receive risk corridors payments. *See also Land of Lincoln*, 129 Fed. Cl. at 114 (rejecting Takings claim because no contract relating to risk corridors payments exists). BCI's takings claim, therefore, must rest on its statutory or regulatory rights, if at all. An ordinary obligation on the part of the United States to pay money under a statutory benefits program, however, does not give rise to a takings claim. *Adams v. United States*, 391 F.3d 1212, 1224 (Fed Cir. 2004); *see also Nat'l Educ. Ass'n—Rhode Island v. Ret. Bd. of the Rhode Island Employees' Ret. Sys.*, 172 F.3d 22, 30 (1st Cir. 1999) (where an expectation of payment is insufficient to constitute an enforceable contract, it does not constitute property under the Takings Clause); *Kizas v. Webster*, 707 F.2d 524, 539-40 (D.C. Cir. 1983) ("A

'legitimate claim of entitlement' to a government benefit does not transform the benefit *itself* into a vested right.").

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

CONCLUSION

The Court should dismiss BCI's Complaint and enter judgment for the United States.

Dated: March 1, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on this 1st day of March 2017, a copy of the foregoing, *The United States' Motion to Dismiss*, was filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

/s/ Terrance A. Mebane
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