IN THE UNITED STATES COURT OF FEDERAL CLAIMS

MONTANA HEALTH CO-OP, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 16-1427C Judge Victor J. Wolski

PLAINTIFF'S MOTION FOR PARTIAL SUMMARY JUDGMENT AND MEMORANDUM OF LAW IN SUPPORT

Plaintiff Montana Health CO-OP ("Plaintiff" or "Montana Health") respectfully submits this Motion for Partial Summary Judgment and Memorandum of Law in Support of its complaint for damages against the Defendant the United States of America ("Government"), acting through the Centers for Medicare & Medicaid Services ("CMS") (and CMS's parent agency, the U.S. Department of Health and Human Services ("HHS")). This motion relates only to Count I of the Plaintiff's complaint: the Government's violations of Section 1342 of the Patient Protection and Affordable Care Act ("Section 1342") and 45 C.F.R. § 153.510(b) ("Section 153.510").

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INTRODUCTION

With the Affordable Care Act ("ACA"), Congress created a new health insurance marketplace—so-called health insurance "exchanges"—through which individuals may purchase health insurance.[2] The creation of the exchanges, among other things, dramatically increased the number of individuals purchasing health insurance. One of the foundational elements of these new exchanges was that nobody, including the Government, knew how much it would cost to insure large numbers of previously uninsured and under-insured individuals. Recognizing this uncertainty, Congress created the "risk corridors program" ("RCP"). Congress designed the temporary (three-year) RCP as a mitigation measure to ensure that both the Government and the insurers would be protected against the massive uncertainty associated with the new exchanges in each of the first three benefit years (2014, 2015, and 2016)[3] for insurance coverage available through exchanges. Congress well knew that without such a measure, it could not likely achieve the ACA's twin goals of both increased *and* affordable health insurance.

The RCP created a mandatory (albeit temporary) framework through which health insurers and the Government shared in the risk. Neither the insurers nor the Government had sufficient data or tools to accurately predict the needs of the newly insured individuals signing up for plans starting in 2014. Nor did they have a model to confidently price these ACA plans to reflect the medical costs associated with this new and untested marketplace. The RCP

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[2] The Affordable Care Act (the "Act" or the "ACA") is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (March 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (March 30, 2010).

[3] 45 C.F.R. § 153.20 (defining "benefit year" with reference to 45 C.F.R. § 155.20); 45 C.F.R. § 155.20 ("*Benefit year* means a calendar year for which a health plan provides coverage for health benefits.").

accounts for this reality by requiring plans that realize lower-than-expected allowable costs in a benefit year to *pay* a portion of the differential to the Government ("payments in"), and, conversely, by requiring the Government to *pay* a portion of the differential to plans that realize higher-than-expected allowable costs in a benefit year ("payments out"). The RCP is limited to the first three years of the ACA. In this way, the RCP was designed to "stabilize" the market by smoothing out "gains" and "losses" in the critical first years of the exchanges to give insurers and the Government time to obtain sufficient experience and data to appropriately price coverage for the 2017 benefit year and beyond.

At issue in this case is the Government's obligation to make "payments out" to insurers, including Montana Health, that realize higher-than-expected allowable costs in a benefit year. The ACA does not discriminate between the Government and insurers: Insurers have dutifully "paid in" as the RCP requires when they realized lower-than-expected costs. The Government must also meet its statutory obligations.

Yet, although the Government has required, and accepted, payment in full from insurers under the RCP when their "gains" have met the statutory "payments in" threshold, the Government has refused to pay insurers in full, including Montana Health, when they experienced "losses" triggering "payments out." The Government has made partial payment toward its 2014 RCP obligation (about 12.6 percent of the amount due) and conceded that the remaining amount owed to Montana Health is an "obligation of the United States Government for which full payment is required," but it has refused to make full payment. *See* Letter from Kevin Counihan, Chief Exec. Officer, Health Insurance Marketplaces, to Jerry Dworak, Chief Exec. Officer, Montana Health CO-OP (Oct. 26, 2015) ("Letter from Kevin Counihan to Jerry Dworak") (Add. A at 29-30); *see also* CMS, "Risk Corridors Payments for the 2014 Benefit

Year" (Nov. 19, 2015) (Add. A at 32).[4] No payment at all has been made to Montana Health for benefit year 2015 and CMS's public statements have made it clear that none will be forthcoming, at least anytime soon (if ever). The Government's decision to withhold the payments owed to Montana Health is an abject violation of the ACA. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (Add. A at 18-19). Its actions are particularly egregious because Montana Health is a non-profit, consumer-sponsored plan, which was specifically created under the ACA to operate on the exchanges to expand coverage for uninsured and under-insured populations. Unlike traditional insurers, Montana Health has no other lines of business, such as large group insurance sold to employers, on which it can rely to offset the costs of operating in the untested waters of the exchanges; indeed, the sole reason for its existence is to operate on the new exchanges.

Because of the Government's refusal to make payments, Montana Health faces a lose-lose scenario: If its participation in the exchanges yields gains within the specified RCP thresholds, the allowable costs are viewed in retrospect as too low, and the Government requires "payment in." But if Montana Health yields losses within the specified RCP thresholds, and the allowable costs are retrospectively viewed as too high, Montana Health alone shoulders the losses.

For a small non-profit like Montana Health, the Government's refusal to make RCP payments owed under the law triggers an existential crisis. More than half of the non-profit insurers—which, like Montana Health, were created as a direct response to the ACA's call to expand health insurance coverage to tens of millions of Americans—have failed due in part to

[4] Attached to this Memorandum for the Court's convenience is Addendum A ("Add. A"), which contains all of HHS's public statements cited in this Memorandum, all of which this court may take judicial notice. *See* Fed. R. Evid. 201.

the Government's actions. But Montana Health has fought to continue operating to increase the accessibility of healthcare coverage to individuals who traditionally lacked sufficient coverage. Montana Health has lived up to its obligations under the ACA. It brings this case to require the Government to live up to its RCP obligations, too.

STATEMENT OF THE ISSUE

Congress created the RCP to attract health insurers into the exchanges and keep premiums stable and affordable for Americans. The program was designed to "stabilize" the market by limiting the effects of adverse selection and limiting the uncertainty inherent in establishing rates for new, unquantifiable health insurance risks. For good and obvious reason, the RCP mandates that full "payments in" and "payments out" be made on an annual basis, once costs from the previous benefit year have been calculated. This is how the law was written, and it is how HHS originally construed, and announced it would administer, the program. But HHS reversed course following fierce criticism from ACA opponents in Congress, and adopted evolving positions regarding the Government's obligation to pay insurers like Montana Health the full amount they are owed under the RCP.

The Government's current rationale is that the RCP must be administered in a budget-neutral manner, *i.e.*, "payments out" cannot exceed "payments in." This novel position is not reflected in the text of the ACA; was never raised for public comment during the notice-and-comment rulemaking process on HHS's implementing regulations for the RCP; directly contradicts HHS's earlier position; and has never been acknowledged or explained by HHS, despite its flip-flop. It also violates the logical premise of the RCP: A "heads-the-Government-wins, tails-the-insurer-loses" payment obligation would do nothing to "stabilize" the exchanges; it would instead create the very *instability* the RCP was designed to prevent.

Montana Health brought high-quality, affordable health insurance to the people of Montana and Idaho in 2014 and 2015, just as Congress envisioned when it crafted the ACA's complex system of requirements and incentives. Under the RCP, the Government owes Montana Health payments for those years, due to Montana Health realizing overall higher-than-budgeted costs. There are two questions to answer in this case: (1) how much does the Government owe Montana Health; and (2) when does it owe it? Based on the undisputed facts, the answer to the first question is that the Government owes Montana Health $42,193,378.14.[5] The answer to the second question is that the Government owes Montana Health now (*i.e.*, it is presently due).

STATEMENT OF RELEVANT BACKGROUND

I. THE ACA CREATED NEW MARKETPLACES TO PROVIDE AFFORDABLE HEALTHCARE TO PREVIOUSLY UNDERINSURED AND UNINSURED POPULATIONS.

Enacted in March 2010, the ACA changed the healthcare industry landscape in an effort to bring high-quality, affordable healthcare to scores of otherwise uninsured individuals. Its provisions require, among other things: individuals to carry health insurance; states to facilitate online exchanges for buying and selling insurance; and private health insurance companies to guarantee coverage and provide myriad essential health benefits to insured individuals at no cost. One of the goals of the ACA is to prioritize the consumer by promoting affordability and competitiveness in the health insurance marketplace. ACA Section 1322 established the Consumer Operated and Oriented Plan ("CO-OP") model to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans" and promote the entry of competing entities into the markets, with the goal of giving individuals more choice and

[5] $5,943,248.14 (for 2014) and $36,250,130 (for 2015). Dworak Decl. ¶¶ 5, 6 (Attach. 1 at 2).

controlling the cost of premiums. CO-OPs are required to derive substantially all of their business from the individual and small group markets served by the exchanges, where individuals can purchase health plans that meet certain standards established by CMS and the exchanges ("qualified health plans" or "QHPs"). A "QHP issuer" is any health insurer selling a QHP on the exchanges.

II. THE RCP WAS CREATED INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS MONTANA HEALTH INTO THE MARKETPLACE.

Expanding healthcare coverage comes at a cost. Under the ACA, QHP issuers must cover a variety of essential health benefits at no additional cost to enrollees. These mandates by themselves, when coupled with the uncertainty of a new and untested pool of health insurance enrollees, would have led the QHP issuers under normal market conditions to set high premiums to compensate for that uncertainty (assuming they would have decided to enter the market in the first place). Congress knew that. So, to mitigate that risk and prevent unaffordable premiums for the millions of Americans for whom the ACA was designed to encourage to obtain health insurance, Congress included three marketplace premium stabilization programs, commonly referred to as the "Three Rs": (1) the RCP; (2) a transitional reinsurance program (which, like the RCP, is a temporary program for 2014-2016, the first three benefits years under the exchanges); and (3) a permanent risk adjustment program. Only the RCP is at issue in this case.

Congress expressly modeled Section 1342 on Medicare Part D's risk corridors program. *See* § 1342(a) ("The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 . . . [which] shall be based on [the Medicare Part D risk mitigation program]."). Medicare Part D's program is not budget neutral and payments (both in and out) are annual. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a

year . . ."); 42 C.F.R. § 423.336 (same); U.S. Gov't Accountability Off., GAO-15-447, Patient Protection and Affordable Care Act (2015) ("GAO Part D Rep.") at 14, *available at* http://www.gao.gov/assets/670/669942.pdf ("the payments that CMS makes to issuers [under the Medicare Part D program] are not limited to issuer contributions.").

As it was directed to do by ACA Section 1342, HHS implemented the RCP in the Code of Federal Regulations through notice-and-comment rulemaking. The resulting regulations largely parroted the statute itself as it related to the payment provisions and formulas. 45 C.F.R. § 153.510. HHS also requires QHP issuers to submit data regarding their revenue and cost data on an annual basis, at which point QHP issuers are eligible to receive payment under the RCP's payment methodology. 45 C.F.R. §§ 153.510, 153.530.

HHS made no mention of budget neutrality with respect to the RCP when it proposed its implementing regulations—this is especially telling because HHS *did* indicate at the outset in the preamble to the proposed rule that RCP's companion program, the *risk adjustment program*, was, in fact, budget neutral. Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41930, 41938 (July 15, 2011) (Proposed RCP Rule) (Add. A at 5). And the final regulations as codified do not reflect a budget-neutral RCP. Indeed, in the preamble to the final regulations, HHS said just the opposite—that HHS anticipated making ***prompt*** payment to QHP issuers after making the annual determination of the amount due (or owed by the QHP issuer). *See* Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (Final RCP Rule), 77 Fed. Reg. 17220, 17238-39 (March 23, 2012) (Add. A at 9-10). HHS then elaborated upon this principle a year later, in its first Notice of Benefit and Payment Parameters

("Payment Rule"), an annual rulemaking articulating the payment policies and requirements for participation in the ACA marketplaces. In that publication, HHS observed that:

> The risk corridors program is not statutorily required to be budget neutral. *Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act*.

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15473 (Mar. 11, 2013) (2014 Payment Rule) (emphasis added) (Add. A at 13).

III. MONTANA HEALTH IS A CO-OP QHP ISSUER THAT PARTICIPATED IN THE MONTANA AND IDAHO EXCHANGES.

Montana Health is a member-led non-profit QHP issuer and the only CO-OP insurer in Montana and Idaho. But for its existence, there would have been only two carriers on Montana's individual marketplace in 2014. Montana Health was created specifically in response to the ACA's call for expanded and affordable health insurance and is required to participate on the exchanges. Its mission is to partner with members, employers, and healthcare providers to create affordable, high-quality benefits that promote health and well-being. Montana Health exemplifies the ACA's objectives to bring affordable coverage to more individuals, particularly those individuals who are most in need. It has actively educated the public regarding the availability of coverage under the ACA, how marketplaces work, and Montana Health's available benefit plans.

As a CO-OP, Montana Health targeted particular groups and industries that have typically lacked insurance coverage or have been underinsured, including tribal communities and highly uninsured rural populations without employer-based health systems. In both Montana and Idaho, Montana Health met with community leaders, navigators, citizen groups, insurance producers and health care providers to educate them about the benefits of the new marketplaces and encourage enrollment, thus promoting the success and objectives of the ACA.

Unsurprisingly, Montana Health attracted 40 percent of the exchange enrollment in Montana in its first year of operations. In just one year after it began providing health plans in Montana, Montana Health's enrollment grew to 42,302 members. Currently, Montana Health insures 19 percent of Montana's individual Marketplace. Doing business as Mountain Health CO-OP, Montana Health started providing the same affordable and high-quality coverage in Idaho in 2015, where it now enrolls nearly 18 percent of the State's exchange membership. In further service of ACA objectives, Montana Health in 2014 was the only carrier on the Montana exchange to offer Platinum-level coverage, providing the most comprehensive coverage to the sickest enrollees. As a result, Montana Health incurred the highest costs by covering the enrollees who need the most expensive care in 2014.

IV. MONTANA HEALTH OFFERED AFFORDABLE PREMIUMS RELYING ON THE RCP AS A HEDGE AGAINST MARKET INSTABILITY.

Montana Health, like many of its peers in the industry, faced a new and untested health insurance market created by the ACA. The ACA's success depended on QHP issuers participating in the market at a reasonable price point for the millions of uninsured Americans Congress intended to obtain insurance. Congress knew that a new and vastly expanded health insurance market for which there was a lack of sufficient data would prevent entities like Montana Health from accurately setting premiums. Without provisions to hedge the risk posed, Montana Health at the very least would have had to set premiums at dramatically higher rates to account for market uncertainty (if not decline to enter the market altogether, which would have reduced competition and driven up premiums in its own right). That of course would have undermined the ACA's very purpose. The RCP was therefore key to the decision of Montana Health (and other newly created CO-OPs) to enter the market at competitive premiums for high-quality health benefits to individuals, families, and businesses.

V. IN CONJUNCTION WITH POLITICAL MACHINATIONS AIMED AT UNDERMINING THE RCP, THE GOVERNMENT'S POSITION ON ITS RISK CORRIDORS OBLIGATIONS HAS FLUCTUATED.

Opposition to the ACA has existed from the outset.[6] The opposition to the ACA only strengthened when control of the House changed hands in 2011. To date, Congress has introduced at least 29 bills to repeal the ACA in its entirety. Short of full repeal, Congress has also set its sights directly on the RCP, introducing at least six bills to impose budget neutrality on the RCP and at least eight to repeal it altogether.[7]

In March 2013, HHS issued its first Payment Rule to set the payment parameters for the Three Rs (*i.e.*, the ACA's three risk mitigation programs) for the forthcoming year.[8] It stated in response to a commenter, "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." 2014 Payment Rule, 78 Fed. Reg. at 15473 (emphasis added) (Add. A at 13).

That comment by HHS in the 2014 Payment Rule, which is consistent with the plain text of the 2010 law, caused the ACA's opponents in Congress to threaten to defund the ACA entirely. Of particular note, in November 2013, Senator Marco Rubio introduced legislation

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[6] *See*, *e.g.*, Cunningham, Paige W., "Rubio: Defund ACA for spending deal" (July 11, 2013), *available at* http://www.allsides.com/news/2013-07-11-1202/marco-rubio-says-he-wont-back-spending-deal-without-obamacare-cut (describing Republican pledge that "I will not vote for a continuing resolution unless it defunds Obamacare"); Press Release, "Rubio Introduces Bill Preventing Taxpayer-Funded Bailouts of Insurance Companies Under ObamaCare" (Nov. 19, 2013), *available at* http://www.rubio.senate.gov/public/index.cfm/press-releases?ID=64576752-4106-41a2-9c50-f0cf0c5cc3c7 (describing introduction of bill to repeal RCP).

[7] *See* Add. B at 3 (providing selected examples of congressional attempts to repeal or modify the ACA or the RCP); *see also* Redhead, C. Stephen and Janet Kinzer, Congressional Research Serv., "Legislative Actions to Repeal, Defund, or Delay the Affordable Care Act" (Feb. 5, 2016).

[8] The "Payment Rule" is an annual CMS omnibus rule that identifies any changes CMS intends to make in the next year with respect to, among other things, the three premium stabilization programs.

seeking to strike the RCP from the ACA. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013). Citing HHS's commitment to meeting its statutory obligations, Senator Rubio pledged that he would refuse to sign any forthcoming annual appropriation unless it defunded the ACA.[9]

Senator Rubio's sentiment was shared by other Members of Congress, and a historic budget impasse ensued that shut down the Government for over two weeks.[10] Only months later, in March 2014, HHS indicated *for the first time* in the preamble to its 2015 Payment Rule that it intended to administer the risk corridors program in a budget-neutral manner, and would offset current-year liabilities with future collections, directly contradicting its statement in the preamble to the 2014 Payment Rule it had issued a year earlier. HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13787 (Mar. 11, 2014) (2015 Payment Rule) (Add. A at 16). This reversal occurred after Montana Health had already set premiums and enrolled members for the 2014 benefit year. And as noted above, this "new" point of view had never been expressed as part of HHS's notice-and-comment rulemaking on its implementing regulations for the RCP, and the agency did not so much as *acknowledge* that it was reversing its earlier position. In a follow-up Q&A guidance letter, HHS stated that it anticipated RCP "payments in" would be sufficient to cover "payments out," but that it would "establish in future guidance or rulemaking" what it would do if that assumption proved wrong. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (describing how payments would be calculated) (Add. A at 18-19).

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[9] Marco Rubio, The Wall Street Journal, "Marco Rubio: No Bailouts for ObamaCare" (Nov. 18, 2013), *available at* http://www.wsj.com/articles/SB10001424052702303985504579205743008770218.

[10] *See, e.g.*, Weisman, Jonathan and Jeremy W. Peters, The New York Times, "Government Shuts Down in Budget Impasse" (Sept. 30, 2013), *available at* http://www.nytimes.com/2013/10/01/us/politics/congress-shutdown-debate.html.

Even then, however, CMS soon after acknowledged that, notwithstanding its newly announced intent to administer the RCP in a budget-neutral manner, *full payment* remained due to QHP issuers.[11] Exactly *when* full payment would be remitted has never been clarified. Indeed, despite stating in its April 11, 2014 letter that it would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed, HHS has never done so.

For its part, not successful at substantively repealing the ACA either in whole or in part, Congress took aim at crippling the law through the appropriations process. In the appropriations bills for the 2015 and 2016 fiscal years, Congress prohibited CMS and HHS from using the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, as well as funds transferred from other accounts funded by congressional appropriations, to fund the obligated risk corridors payments.[12] As discussed in more detail

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[11] *See e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond ("Exchange Establishment Rule"), 79 Fed. Reg. 30240, 30260 (May 27, 2014) (emphasis added) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 22). That acknowledgment would be repeated numerous times over the next two-and-a-half years. *See* HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10750, 10779 (Feb. 27, 2015) (2016 Payment Rule) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 25); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added) (Add. A at 35); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("[T]he Affordable Care Act requires the Secretary to make ***full payments*** to issuers" and HHS will "record payments due as an obligation of the United States Government for which ***full payment*** is required") (emphasis added) (Add. A at 37); *See* Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 14, 2016) (quoting Acting Administrator of CMS's testimony as part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight"), *available at* https://energycommerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (Add. A at 40-41).

[12] The Consolidated and Further Continuing Appropriations Act of 2015 (Pub. L. No. 113-235) ("2015 Spending Bill") and the Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113)

below, the Spending Bills did not nullify or modify the Government's RCP obligations.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. Montana Health is a non-profit corporation organized under the laws of Montana. Declaration of Jerry Dworak ¶ 2 ("Dworak Decl.") (Attach. 1 at 1).

2. Montana Health is a CO-OP QHP issuer under the ACA. Dworak Decl. ¶ 2 (Attach. 1 at 1).

3. In 2014 and 2015, Montana Health provided health insurance to its members on the federally facilitated Marketplace in Montana. Dworak Decl. ¶ 2 (Attach. 1 at 1).

4. In 2015, Montana Health provided health insurance to its members on the federally facilitated Marketplace in Idaho, where it does business as Mountain Health CO-OP. Dworak Decl. ¶ 2 (Attach. 1 at 1).

5. Pub. L. No. 111-148, § 1342 (Section 1342 of the Affordable Care Act, or ACA), as codified at 42 U.S.C. § 18062, created the risk corridors program. In relevant part that Section states:

   (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.

   (b) PAYMENT METHODOLOGY.—

   (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—

   (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

   (B) a participating plan's allowable costs ***for any plan year*** are more than 108

("2016 Spending Bill") (collectively, the "Spending Bills").

> percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.

Pub. L. No. 111-148, § 1342 (emphasis added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans' actual costs are less than its targeted costs. *Id.* § 1342(b)(2). For both the "payments out" and "payments in" provisions, the terms "allowable costs" and "target amount" are defined by the statute. *Id.* § 1342(c).

6. HHS implemented the risk corridors program in the Code of Federal Regulations at 45 C.F.R. § 153.510. In relevant part, Section 153.510 states:

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

7. In the preamble to the 2014 Payment Rule, which was published on March 11, 2013, HHS stated: "The risk corridors program is not statutorily required to be budget neutral. *Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act*." 2014 Payment Rule, 78 Fed. Reg. at 15473 (emphasis added) (Add. A at 13).

8. On May 27, 2014, HHS stated that "HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . . ." *See* Exchange Establishment Rule, 79 Fed. Reg. at 30260 (emphasis added) (Add. A at 22).

9. On February 27, 2015, HHS stated that "HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . . ." *See* 2016 Payment Rule, 80 Fed. Reg. at 10779 (emphasis added) (Add. A at 25).

10. On October 26, 2015, HHS sent a letter to Montana Health stating that it would only pay 12.6 percent of the amounts due to Montana Health under the risk corridors program, while acknowledging that the ACA "***requires*** the Secretary to make full payments to issuers," and that the unpaid amounts would be recorded as "obligations of the United States Government for which ***full payment is required***." Letter from Kevin Counihan to Jerry Dworak (Oct. 26, 2015) (Add. A at 30).

11. On November 19, 2015, HHS stated that "HHS is recording those amounts that remain unpaid following our 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which ***full payment is required***." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (emphasis added) (Add. A at 35).

12. On September 9, 2016, HHS issued a memorandum stating: "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.***" *See* CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) (emphasis added) (Add. A at 37).

13. On September 14, 2016, in testimony before the House Energy and Commerce Committee, in response to a question regarding whether CMS must make RCP payments even in the absence of an appropriation, the Acting Administrator of CMS Andrew Slavitt testified: "Yes, ***it is an obligation*** of the federal government.") (emphasis added). *See* Press Release,

The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme, (Sept. 14, 2016), *available at* https://energycommerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (Add. A at 37-38).

14. Montana Health timely submitted its premiums for the 2014 benefit year to HHS by May 2013. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) (Add. A at 32-33).

15. Montana Health's commitment to participate on the Montana exchange was fixed and irrevocable by September 2013.

16. Pursuant to its obligations under the ACA and 45 C.F.R. § 153.500 *et seq.*, Montana Health submitted all data required for the risk corridors payment and charge calculations for the 2014 benefit year on by the statutory deadline of July 31, 2015. *See* 45 C.F.R. § 153.530(d); CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) (Add. A at 32-33).

17. For benefit year 2014, Montana Health is owed $6,754,127.62 under the RCP for higher-than-expected allowable costs in the Montana individual market. CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) (Add. A at 30); Letter from Kevin Counihan to Jerry Dworak (Oct. 26, 2015) (Add. A at 30).

18. For the same benefit year, Montana Health is also owed $62,383.51 for higher-than-expected allowable costs in the Montana small group market as a result of RCP. *Id.*

19. On October 26, 2015, the Government stated in a letter to Montana Health that it would pay Montana Health $860,098.28 (or 12.6 percent) of the total $6,816,511.13 it owed Montana Health in the under the RCP for the 2014 benefit year. Letter from Kevin Counihan to Jerry Dworak (Oct. 26, 2015) (Add. A at 29-30); *see also* CMS, "Risk

Corridors Payment Proration Rate for 2014" (Oct. 1, 2015) (Add. A at 27) (stating that HHS would pay only 12.6 percent of the total owed to each QHP issuer).

20. On October 26, 2016 and again on November 19, 2015, HHS stated that it "is recording those amounts that remain unpaid following [its] 12.6 percent payment this winter ***as a fiscal year 2015 obligation of the United States Government for which full payment is required***." Letter from Kevin Counihan to Jerry Dworak (Oct. 26, 2015) (Add. A at 30); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (emphasis added) (Add. A at 35).

21. For benefit year 2015, Montana Health submitted to HHS on or about July 31, 2016 all data required by the ACA demonstrating that Montana Health experienced higher-than-expected allowable costs under to the RCP, entitling Montana Health to payment by HHS in the amount of $36,250,130 (as calculated pursuant to the statutory formula prescribed in ACA Section 1342). Montana Health applied the same the statutory formula prescribed in ACA Section 1342 as it had applied in calculating the 2014 amount owed (which CMS confirmed). Dworak Decl. ¶ 6 (Attach. 1 at 2).

22. For benefit year 2015, HHS has stated in sub-regulatory guidance that it will attempt to implement the RCP in a budget-neutral fashion and will use any funds received from QHP issuers under the RCP for benefit year 2015 to first pay down the $2.5 billion shortfall in payments to QHP issuers from benefit year 2014. 2015 Payment Rule, 79 Fed. Reg. at 13787 (Add. A at 16); CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) (Add. A at 18-19).

23. To date, Montana Health has received only $860,098.28 (about 12.6 percent) of the $6,816,511.13 the Government owes Montana Health under the RCP for the 2014 benefit

year, plus an additional $13,164.71[13] received in October 2016, for a total of $873,262.99. Dworak Decl. ¶ 5 (Attach. 1 at 2).

24. To date, Montana Health has not received any RCP payment from HHS for the 2015 benefit year.

25. HHS has not announced a date by which it intends to make any remaining payments for benefit years 2014 and 2015.

JURISDICTION

This Court has jurisdiction under the Tucker Act, which confers jurisdiction and waives the United States' sovereign immunity for money damage claims founded on acts of Congress, such as the ACA's RCP. 28 U.S.C. § 1491(a)(1); *See United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472 (2003); *Fisher v. United States*, 402 F.3d 1167, 1172 (Fed. Cir. 2005) (en banc in relevant part). The Tucker Act requires Montana Health to identify a statute pursuant to which money damages is sought that it (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." *Fisher*, 402 F.3d at 1173-74 (citations omitted); *see also White Mountain*, 537 U.S. at 472-73. The ACA's RCP meets these requirements.

The RCP mandates that payments "shall" be made. *See Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007). In *Greenlee Cty.*, the court held that a statute was "reasonably amenable" to a reading that it is money-mandating because it provides that "the Secretary of the Interior *shall make a payment*" to local governments to compensate them for losses due to the presence of tax-exempt federal land. 487 F.3d at 876-77 (emphasis added).

[13] The payment did not indicate if it related to individual or small group amounts owed.

"We have repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Id.* at 876-77 (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). Similarly, the RCP mandates that HHS "shall pay" to QHP issuers certain amounts consistent with a specified methodology. Montana Health has identified a statute that mandates compensation and recovery of damages from the Government. And since Montana Health is a QHP issuer under the ACA, it falls within "the class of plaintiffs entitled to recover under the money-mandating source [and] the Court of Federal Claims has jurisdiction." *Jan's Helicopter Serv., Inc. v. F.A.A.*, 525 F.3d 1299, 1307 (Fed. Cir. 2008); *see also Albino v. United States*, 104 Fed. Cl. 801, 813 (2012).

Tucker Act jurisdiction is also "limited to actual, presently due money damages from the United States." *See Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations and quotations omitted). Montana Health is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100 F.3d 1576, 1580, 1582 (Fed. Cir. 1996) (taking jurisdiction where plaintiff had fulfilled all statutory conditions for payment). Montana Health has submitted all required information to HHS demonstrating its entitlement to payment specific amounts under the formula contained in Section 1342 of the ACA. Accordingly, this Court has jurisdiction over Montana Health's claim.[14]

SUMMARY OF ARGUMENT

Judgment in Montana Health's favor is appropriate because the ACA is clear: For each year, a QHP issuer's costs are to be tallied; if there is a cost overrun the Government owes the

[14] Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. Montana Health has pled that the ACA is money-mandating, required full and timely payment, set forth statutory requirements for receipt of payment that Montana Health fulfilled, and requires payment the Defendant has not made. Compl. ¶¶ 20, 22, 31-37, 71, 73, 79-80, 85-89.

issuer money in accordance with the formula; if there is a cost savings, the insurer owes money to the Government in accordance with the formula.

With respect to "how much" money the Government owes Montana Health, the plain text of the statute answers that question. Section 1342 of the ACA speaks in mandatory terms, stating *if* a QHP issuer's allowable costs are more than a specified percentage above the target amount, the Government "shall" reimburse the QHP pursuant to the prescribed formula. It is a long-accepted principle of statutory interpretation that when Congress uses the term "shall," it creates a mandatory obligation that the Government cannot, in its discretion, dispense with. *See Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Not surprisingly, HHS has acknowledged on multiple occasions that full payment is due.[15]

As for the question of "when" the money that the Government owes Montana Health comes due, the answer is also provided by the statute. The RCP's entire purpose is to *stabilize* insurance premiums for each of the first three years of the exchanges' existence. The express language of Section 1342 states that if a plan's allowable costs "for any ***plan year***" exceeds the target amount, the Secretary "***shall pay to the plan***" the amounts set forth in the ACA. Although Section 1342 does not expressly state that payments, either into or out of the Government, must be made on an annual basis, the statute cannot logically be read to require anything other than payment at the conclusion of the "plan year."[16] *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) ("[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme." (quoting *Utility Air Regulatory Group v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations omitted))).

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[15] *See supra* note 11.

[16] The implementing regulations at 45 C.F.R § 153.510 reiterate when a QHP's allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the amounts set forth in the ACA. (emphasis added).

The Government has taken the position that it can short-pay Montana Health and other plans (approximately 12.6 percent) for 2014, and that payment of amounts due for 2015 is an open question. In fact, under the Government's evolving view of the statute, payment is due to health plans *either* sometime after the end of the three-year risk corridors program *or* perhaps never. Because it is evolving, the Government's position on when (or even whether) it intends to make payment is entirely unclear, other than it is *not now*. But the Government's position ignores other terms used in Section 1342 that evince Congress's intent. Section 1342 directs HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. The term "plan year" means 12 consecutive months under the ACA,[17] and Congress's use of the plural "corridors" was intentional. *See Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing" (quotation and citations omitted)). Furthermore, the statute specifically models the RCP on the Medicare Part D risk corridors program, which establishes annual risk corridors that operate without regard to budget neutrality. *See* GAO Part D Rep. at 14.

Congress knew what it was doing. The RCP's entire purpose is to *stabilize* insurance premiums in each of the first three years of the exchanges' existence. Withholding payment (if paying at all) until long after the year for which Congress intended the payment to be made only exacerbates premium rate inflation for subsequent years and thus vitiates the RCP's objective of *stabilizing* premiums. *See King*, 135 S. Ct. at 2494 ("It is implausible that Congress meant the Act to operate in this manner."); *see also Bob Jones Univ. v. United States*, 461 U.S. 574, 586 (1983) (statutory interpretations that frustrate the object and purpose of the statute are

[17] *See* 45 C.F.R. § 155.20.

disfavored); *Global Computer Enters. v. United States*, 88 Fed. Cl. 350, 406 (2009) (same); *Fluor Enters., Inc. v. United States*, 64 Fed. Cl. 461, 479 (2005) (same).

Efforts by Congress to cripple the RCP through the appropriations process do not constitute repeal or amendment of the RCP and the Government's related obligations. Despite their many efforts, subsequent Congresses that have been hostile to the ACA have failed to substantively modify the law, let alone repeal it. *See* Addendum B ("Add. B") at 3. Because the RCP as enacted in 2010 remains law, the Government's liability to make the payments that are presently due to Montana Health is not altered merely because subsequent Congresses have, in the last two budgeting cycles, curtailed the funds from which HHS would otherwise have made its RCP payments.

SUMMARY JUDGMENT STANDARD

This case presents a pure question of statutory interpretation appropriate for summary disposition, as all material facts are undisputed. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law." RCFC Rule 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-116 (2008). A fact is material if it "might affect the outcome of the suit under the governing law," and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party." *Johnson*, 80 Fed. Cl. at 116 (citing *Anderson v. Liberty Lobby*, *Inc.*, 477 U.S. 242 (1986)). "Issues of statutory interpretation and other matters of law may be decided on a motion for summary judgment." *Johnson,* 80 Fed. Cl. at 116 (quoting *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002)).

ARGUMENT

I. CONGRESS INTENDED RCP PAYMENTS TO BE MADE ANNUALLY AND IN FULL, WITHOUT REGARD TO BUDGET NEUTRALITY.

Montana Health is entitled to summary judgment in its favor because, based on the undisputed facts alone and as a matter of law, the Government owes Montana Health the unpaid balance of its RCP payments for 2014 and 2015.

This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted)). The RCP's text and the structure of the ACA require complete payment to QHP issuers, rather than payments subject to budget neutrality. Montana Health also is entitled to timely annual payments because both the text of the RCP and the structure of the ACA as a whole mandate at least annual payments to QHP issuers.

A. Congress Intended QHP Issuers to Receive Full Payment.

The enacting Congress effectuated the RCP's risk mitigating purpose by mandating full payment to QHP issuers as defined in its "Payment Methodology" without regard to budget neutrality. HHS's initial interpretation acknowledged this: "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." 2014 Payment Rule, 78 Fed. Reg. at 15473 (Add. A at 13).

More importantly, that statute plainly and unambiguously mandates full payments to QHP issuers. First, the text mandates that the Government "***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "The mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion." *Lexecon*, 523 U.S. at 35. Moreover, Congress used "shall" and "may" throughout the ACA, often within the same

section of the law, underscoring Congress's deliberate intent to invoke their distinct meanings. *Compare*, *e.g.*, ACA §§ 2713, 2717(a)(2), and 1104(h); *see also Lopez v. Davis*, 531 U.S. 230, 241 (2001) ("Congress' use of the permissive 'may' . . . contrasts with the legislators' use of the mandatory 'shall' in the very same section."). The enacting Congress used "shall" to signify mandatory obligations and "may" to impose discretionary ones. And its use of "shall" in the RCP imposed a mandatory obligation to pay Montana Health in full.

Second, Congress expressly provided that the RCP was not budget neutral by modeling the RCP on the Medicare part D risk mitigation program by reference, which is not budget neutral. ACA § 1342(a); *see* GAO Part D Rep. at 14 ("for the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers is not limited to issuer contributions."). By doing so, Congress expressed its intent to apply critical design features of the only other risk mitigation program similar to the RCP in the healthcare industry to the RCP it had just legislated. And Congress expressed no limitation in ACA Section 1342 that one of the central pillars of the Medicare Part D provision was inapplicable to the RCP. The risk corridor programs of Medicare Part D and the ACA were both specifically designed to hedge risk in new healthcare markets to enable insurers to affordably offer essential health benefits.[18] Part D's non-budget neutrality undoubtedly is a critical design feature applicable to the RCP because (1) non-budget neutrality is a foundational and essential component to its effectiveness as an incentive to QHP issuers to enter the exchanges and offer affordable premiums, and (2) the ACA does not otherwise declare that such a crucial component of the program on which it

[18] MedPAC, "Chapter 6: Sharing Risk in Medicare Part D," Report to the Congress: Medicare and the Health Care Delivery System (June 2015) at 140, *available at* http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-.pdf?sfvrsn=0 ("Also, risk corridors limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending.").

modeled the RCP should not apply. By comparison, a budget-neutral program would effectively hedge no risk at all. If "payments out" were subject to "payments in" and issuers experienced losses across the board, issuers would not receive the intended risk-mitigation benefit. *Cf. Engel v. Davenport*, 271 U.S. 33, 38–39 (1926) ("The adoption of an earlier statute by reference makes it as much a part of the later act as though it had been incorporated at full length." (citations omitted)).[19]

Third, the enacting Congress's repeated and specific statements upwards of 15 times applying or exempting various ACA provisions from budget neutrality illustrate that Congress was aware of the implications of modeling the RCP on Medicare Part D. *See*, *e.g.*, ACA § 3007(p)(4)(C) ("The payment modifier established under this subsection shall be implemented in a budget neutral manner."). To suppose that Congress carefully considered budget neutrality throughout the ACA yet neglected to do so in connection with the RCP is patently unreasonable; it would insert into Section 1342 a budget-neutrality requirement that Congress chose not to insert. Courts "may not add terms or provisions where Congress omitted them . . . ." *Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993).[20]

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[19] We note that *Land of Lincoln Mutual Health Insurance Co., v. United States* (No. 16-744C, Lettow) dismissed the relevance of the Part D scheme because Congress purportedly omitted certain text. Dkt. No. 47 (Nov. 11, 2016). For reasons that are unclear, that case was considered deferentially on the "administrative record" (RCFC 52.1) despite there being no agency proceeding below. Regardless, that decision not only ignores how Congress operates when it bases a new scheme on an existing scheme, *see Lorillard v. Pons*, 434 U.S. 575, 580-581 (1978) (Congress is presumed to legislate with awareness of how a program on which later-enacted legislation is based is administered), it also renders the reference to Part D nugatory. If the court reads out of Section 1342 the Part D annual risk corridors payment obligation, then the reference to Part D is utterly meaningless—that is the essence of the "based on" reference.

[20] Although the Congressional Budget Office (CBO) assumed that government payments would not exceed amounts collected under the RCP, that was a budget-scoring expedient and does not bear on congressional intent. *See* Proposed RCP Rule, 76 Fed. Reg. at 41948. As the Federal Circuit has noted, "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent." *Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009)

Fourth, Congress's decision to exclude words specifically limiting RCP payments to appropriated funds underscores its intent. Congress often uses explicit language, such as "subject to the availability of appropriations" to render a provision budget neutral. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189 (2012) (noting that certain payments were to be paid "subject to the availability of appropriations" under the statute at issue); *see also Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 199 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015) ("the language 'subject to the availability of appropriations' is commonly used to restrict the government's liability to the amounts appropriated by Congress for the purpose." (citing *Greenlee Cty*, 487 F.3d at 878-79)). In *New York Airways*, the Court of Claims found that the Government was liable for subsidy payments where Congress failed to appropriate sufficient funds, even where the enacting statute provided that the agency "make payments of the remainder of the total compensation payable under this section out of appropriations made to the Board for that purpose." *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 745-746 (Ct. Cl. 1966) (quoting 49 U.S.C. § 1376(c)). This Court relied on the text of the statute as well as its legislative and regulatory history, which illustrated Congress's intent that the payments be made without regard to budget neutrality. *Id.*

By contrast, in the RCP, Congress chose not to include such limiting language in any form, despite having done so in myriad other statutory contexts, and despite having done so elsewhere within the ACA itself, as noted above. "A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear, or because only one of

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(recognized as repealed by implication by statute on unrelated grounds). A CBO budget score might thus be relevant to the question of what Congress may have assumed to be the economic impact of a law with new budget implications, but that is an entirely different question from what Congress intended to be the substantive impact of the law.

the permissible meanings produces a substantive effect that is compatible with the rest of the law." *United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) (citations omitted); *see also Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("Ambiguity is a creature not of definitional possibilities but of statutory context."); *McCarthy v. Bronson*, 500 U.S. 136, 139 (1991) (statutory language must be read in its proper context and not viewed in isolation); *Castillo v. United States*, 530 U.S. 120, 124 (2000) (same).

Finally, congressional opponents of the RCP have repeatedly introduced (and failed to pass) legislation intended to *make* the RCP budget neutral. *See* §II.A *infra*. Obviously, if the RCP were budget neutral, such legislative efforts would have been unnecessary. The RCP's sole purpose was to induce participation in an uncharted healthcare insurance market by mitigating the enormous risk that would otherwise lead a reasonable QHP issuer under normal market conditions to either steer clear or charge an exorbitant premium. That the Government realizes it is obligated to QHP issuers for the full payment is demonstrated by HHS's acknowledgment of this fact on multiple occasions. *See supra* note 11.[21]

The Government should be held to the same standard it applies to insurers. It can hardly be doubted that if the tables were turned and more money was due into the program than owed out, the Government would demand full payment. Indeed, the Government said just this in its guidance letter of April 11, 2014. *See* CMS, "Risk Corridors and Budget

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[21] Curiously, the Department of Justice (representing HHS) in litigation over the RCP, has attempted to "walk back" these numerous concessions in recent court filings. *E.g.*, *Land of Lincoln*, Dkt. No. 22 (Sept. 23, 2016) at 20-21. Of course, this reversal comes only after the Government has been sued for its refusal to make statutorily required risk corridors payments. To the extent the Government asserts in this case that it is not obligated to make full payment under the RCP to Montana Health, the Court should disregard the argument as a mere "convenient" litigating position. *See Parker v. Office of Pers. Mgmt.* 974 F.2d 164, 166-67 (Fed. Cir. 1992) ("[d]eference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate." (citing *Bowen v. Georgetown University Hospital,* 488 U.S. 204, 212 (1988))).

Neutrality" (Apr. 11, 2014) (pointing out in Example 1 that if the Government collected more for a year than it owed, it would "retain" the remainder for future use) (Add. A at 18).

B. Congress Intended QHP Issuers to Receive or Remit Timely Annual Payments.

The text and structure of the ACA unambiguously anticipates that RCP payments—both "in" and "out"—will be made on an annual basis. And, tellingly, this is exactly how HHS originally understood and stated it would apply its congressional mandate. *See* RCP Final Rule, 77 Fed. Reg. at 17239-17238 (identifying that the same deadlines should apply to both "payments in" and "payments out") (Add. A at 9-10); 2014 Payment Rule, 78 Fed. Reg. at 15473 (setting a 30-day deadline from determination of charges for QHP issuers to make "payments in") (Add. A at 13).

1. The Text and Structure of the ACA Require Annual RCP Payment.

The RCP's text requires HHS to pay QHP issuers the amount owed annually. First, the RCP explicitly states that "for any plan year . . . [HHS] shall pay to the plan" the delineated amounts. "Plan year" means 12 consecutive months under the ACA. 45 C.F.R. § 155.20 (in related Exchange Establishment Rule, defining "*Plan year*" as a "consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise.").[22]

[22] Application of the definition in a related regulation implementing the same statute is appropriate. In the absence of a statutory definition, the Supreme Court "construe[s] a statutory term in accordance with its ordinary or natural meaning." *F.D.I.C. v. Meyer*, 510 U.S. 471, 476 (1994). In determining the definition of a particular term, courts look to whether that word or term has an accepted meaning under a particular statute. *See*, *e.g.*, *Sullivan v. Stroop*, 496 U.S. 478, 483 (1990) (holding that "child support" is a term defined by its specialized use in the Child Support program under the Social Security Act."). In response to a specific comment requesting that "benefit year" be defined on a calendar year basis, the RCP's implementing regulations define "benefit year" as a calendar year by cross-referencing the definition contained in the parallel implementing regulations establishing exchanges under the ACA ("Exchange

Second, the enacting Congress, by referencing the plural "corridors" when it directed that HHS "shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," did so intentionally to create separate risk corridor**s** for each of the calendar year**s** referenced. ACA § 1342(a) (emphases added); *see Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing") (quotation and citations omitted); *Dakota, Minnesota & E. R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) (finding that Congress's use of the plural was evidence of its intent). Congress is presumed to draft law purposefully. *See Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absent-minded duplication and omission are possible, but Congress is not presumed to draft its laws that way."). Congress intended to create three distinct risk corridors, one for each year of the ACA's RCP.

Third, the RCP's "Payment Methodology" also constructs an annual program by predicating the determination of appropriate payment amounts on figures that are calculated annually. The RCP mandates payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount." *See* ACA § 1342(b). The RCP defines "allowable costs" and the "target amount" in section (c) with reference to "a plan for any year" and the "amount of a plan for any year." *See* ACA § 1342(c)(1)(A), 1342(c)(2), 1342(b). "Target amounts" necessary to calculating RCP payments are based on payments and receipts under the related risk adjustment and reinsurance provisions, which are annual.[23] 45 C.F.R. § 153.510(a)-(d), (g). The scheme is unmistakably annual.

Establishment Rule"). Final RCP Rule, 77 Fed. Reg. at 17222 (Add. A at 8); *see also* 45 C.F.R. § 153.20 (defining "benefit year" with reference to 45 C.F.R. § 155.20, establishing exchanges under the ACA); 45 C.F.R. § 155.20 ("*Benefit year* means a calendar year for which a health plan provides coverage for health benefits.").

[23] In fact, the government has required or remitted payment annually in connection with the risk

Fourth, Congress further underscored the annual payment structure dictated by the RCP's plain text by mandating that the RCP "shall be based on the program for regional participating provider organizations under [the Medicare Part D risk mitigation program]," which provides for a distinct risk corridor in each year, to be paid annually. *See* ACA § 1342(a). Medicare Part D explicitly provides for a "risk corridor" specific to each year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); *see also* 42 C.F.R. § 423.336(a)(2)(i) (same). Part D also requires payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) (CMS makes payments "in the following payment year . . . ."). Congress reinforced its explicit provision for annual payments in the text of the RCP by reference to the only other comparable risk mitigation program—a program premised on annual payments.[24]

2. *Originally, HHS Correctly Interpreted the RCP to Require Timely Annual Payments Be Made to QHP Issuers.*

HHS's original interpretation of Congress's clear intent was consistent with the text of the law and Montana Health's expectation of annual payment, and it is the only interpretation that is consistent with the RCP's purposes. First, HHS immediately recognized that the RCP "serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government" and will do so by "limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41930 (Add. A at 4). It reiterated that principle in its final rule, and accordingly indicated that it would "address the risk corridors

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adjustment and reinsurance programs. And in 2014, CMS made an annual RCP payment, albeit an incomplete one.

[24] *See, e.g.*, HHS Office of Inspector General, "Medicare Part D Reconciliation Payments for 2006 and 2007" (September 2009) at 14, *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf.

payment deadline in the HHS notice of benefit and payment parameters," noting that:

> HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. *QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.*

77 Fed. Reg. at 17239-17238 (emphasis added) (Add. A at 9-10).

In its first Payment Rule, HHS set a 30-day deadline for issuers to remit payment upon notification of charges. 2014 Payment Rule, 78 Fed. Reg. at 15473 (Add. A at 13). And, as HHS stated in its implementing regulations, it believed the same deadline should apply to both payments in and payments out of the program. Significantly, HHS requires issuers to submit their data to HHS annually to facilitate calculation of risk corridor payments. 45 C.F.R. § 153.530(d).

Thus, not so long ago, there was no dispute that Congress intended both RCP payments to the Government and from the Government be made annually. And for good reason: That is the only reading that is consistent with the overall purpose and structure of the ACA. A premium rate stabilization program would not do much good if insurers could not rely on complete and timely payment. As the Supreme Court pointed out, Congress designed the ACA to prevent an economic "death spiral," in which "premiums rose higher and higher, and the number of people buying insurance sank lower and lower, [and] insurers began to leave the market entirely." *King*, 135 S. Ct. at 2486. Such a hedge for risk was necessary to incentivize health insurance companies to enter and remain in the market.

HHS's original interpretation is fully supported by the fact that Congress's failure to appropriate sufficient funds for the Government to satisfy its RCP payment obligations has

contributed to the very "death spiral" the RCP was intended to avoid.[25] HHS's current position that, despite its acknowledgment that Montana Health and others are owed full payment under the RCP, the Government can put off making those payments until some indefinite time in the future, if at all, betrays Congress's intent in creating and mandating the RCP. A small CO-OP like Montana Health cannot afford to wait out the Government's ambivalence. And to suggest, as HHS has, that QHP issuers of all sizes which sustain significant short-term losses, and which report on their costs and receipts on an annual basis as the ACA requires them to do, can readily bear those losses over multiple years, all while keeping premiums affordable for enrollees in each successive year, is anathema to the structure and purpose of the ACA. "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494 (citations omitted); *Bob Jones*, 461 U.S. at 586 (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters.*, 88 Fed. Cl. at 406 (same); *Fluor Enters*, 64 Fed. Cl. at 479 (same).

The Government's position is made even more incredible by the fact that it continues to expect QHP issuers that are realizing lower-than-expected allowable costs to dutifully make complete payment on an annual basis, as statutorily required. The Government's obligation to make timely payment under the RCP is no different than that of the insurers.

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[25] *See* HHS, ASPE Research Brief, "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace" at 6 (Oct. 24, 2016), *available at* https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf (predicting that premiums will increase, on average, 25 percent); Kaiser Family Foundation, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces," (Oct. 25, 2016), *available at* http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/ ("As a result of losses in this market, some insurers . . . have announced their withdrawal from the ACA marketplaces or the individual market in some states").

II. THE 2015 AND 2016 APPROPRIATIONS LEGISLATION DID NOT NULLIFY OR MODIFY THE GOVERNMENT'S RCP OBLIGATIONS.

That Congress has substantially curtailed HHS's ability to make RCP payments through appropriations legislation in the last two budget cycles does *not* alter the Government's RCP *liability*. The Government's legal obligation remains. Indeed, as noted, the very fact that Congress has tried on multiple occasions to modify or repeal the ACA as a whole and the RCP specifically, and yet failed every time, highlights the important distinction between appropriations legislation (for annual funding of discretionary government operations) and substantive legislation (which fixes rights and obligations, including of the United States itself).

A. Congress Has Not Amended the RCP.

To date, Congress has neither repealed nor amended the RCP, despite at least 43 unsuccessful attempts to do so. *See* Add. B at 3. And while it is true that, through CMS's appropriation in the 2015 and 2016 Spending Bills, Congress has curtailed CMS's funding sources to make RCP payments, that fact is irrelevant to this lawsuit by Montana Health.

"It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (citing *N.Y. Airways*, 369 F.2d at 748). "[I]t can be strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *United States v. Fausto*, 484 U.S. 439, 453 (1988). Restricting appropriations alone, without more, does not amend the underlying substantive legislation. *See Greenlee Cty.*, 487 F.3d at 877. Nor does it absolve the Government of its obligation to make payments otherwise mandated by law. *See id.*

The Spending Bills did not amend the RCP. Relevant precedent illustrates this basic

point. In *United States v. Langston*, the diplomatic representative to Haiti sued when Congress failed to appropriate sufficient funds to pay his statutorily set salary. 118 U.S. 389, 390 (1886). Under the original statute, "[t]he representative at Ha[i]ti shall be entitled to a salary of $7,500 a year" and a subsequent appropriation set the salary "for the service of the fiscal year ending June 30, 1883, out of any money in the treasury, not otherwise appropriated, for the objects therein expressed" at $5000. *Id.* at 390-91. The Supreme Court emphasized the importance of clear language repealing or amending a statute. For example, it distinguished the language of the appropriation at issue from one in which Congress clearly indicated an intent to repeal previously set salaries, because the subsequent appropriation explicitly set out a new compensation system designed to replace the prior one. *Id.* at 392-93. The Court reasoned that the appropriation at issue did not contain "any language to the effect that such sum shall be 'in full compensation' for those years" or other provisions "from which it might be inferred that congress intended to repeal the act." *Id.* at 393. Reiterating that "[r]epeals by implication are not favored," the Supreme Court held that it must give effect to both provisions where possible and:

> While the case is not free from difficulty, the court is of opinion that, according to the settled rules of interpretation, a statute fixing the annual salary of a public officer at a named sum, without limitation as to time, should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount for the services of that officer for particular fiscal years, and which contained no words that expressly, or by clear implication, modified or repealed the previous law.

Id. at 393-94; *see also Gibney v. United States*, 114 Ct. Cl. 38, 49-50 (1949) ("There is nothing in the wording of the [appropriations] proviso . . . which would warrant a conclusion that it was intended to effect the repeal of the [original] codified provisions of the act . . . .").

Congress knows how to amend or repeal laws it does not like. But it is fundamental to the separation of powers that if Congress does not have the support of the President or sufficient votes to override a veto, it cannot pass new legislation. And appropriations bills may not be

manipulated to allow the Government to shirk its legal obligations to make full and annual RCP payments to QHP issuers where owed, and to accomplish what it did not have sufficient votes to achieve: an amendment to the RCP.

Indeed, construing the 2015 and 2016 Spending Bills as a modification of the Government's RCP obligations, whether in whole or in part, would render our constitutional system of checks and balances a nullity. Those Spending Bills were the end result of multiple failed attempts to amend or repeal RCP. The 113th Congress, which passed the 2015 Spending Bill, directly confronted proposed legislation to amend the ACA to limit or eliminate RCP payments. Senator Rubio proposed a bill to amend the RCP to "ensur[e] budget neutrality." Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). He also sought to eliminate the program entirely. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013). Neither bill passed.

During the 2016 budget process, Senator Mitch McConnell proposed amendment language expressly indicating that "Effective January 1, 2016, the Secretary shall not collect fees and shall not make payments under this section." 161 Cong. Rec. S. S8420-S8421 (daily ed. Dec. 3, 2015) (statement of Sen. McConnell). Senator Patty Murray spoke against the amendment, raising a point of order to strike the proposed amendment, because RCP "is a vital program to make sure premiums are affordable and stable for our working families. Repealing it would result in increased premiums, more uninsured, and less competition in the market." *Id.* at S8354. The Senate then voted against the amendment.

In other words, Congress tried—and *failed*—to actually repeal the RCP. In fact, Congress also considered more narrow legislation that would have required the RCP to be administered on a budget-neutral basis. *See, e.g.*, S. Rep. 114-74, 12 (June 25, 2015) ("requir[e]

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."); *see also id.* at 121, 126. These efforts, too, failed. But Congress's effort to render the RCP budget neutral highlights what is patently clear about the RCP as enacted in 2010 and which remains unmodified to date: *it was not intended to be budget neutral*.

Congress could have repealed the ACA. It did not. Congress could have amended the RCP. It did not. It was only when all available routes to permanently end or modify the RCP failed that the Congress settled for tampering with CMS's funding authority to make RCP payments. But that is a mere administrative point; it did not modify the Government's legal obligation. *See Blanchette v. Connecticut Gen. Ins. Corps.*, 419 U.S. 102, 134 (1974) ("Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end . . . ." (citations and quotations omitted)).

Because Congress has not amended or repealed the RCP, the Government remains liable for the full amount owed to Montana Health under the RCP for 2014 and 2015.[26]

[26] To be clear, if Congress *had* actually modified or repealed the RCP (which it did not), its actions would face scrutiny under the Due Process Clause:

> [T]he presumption against retroactive legislation is deeply rooted in our jurisprudence, and embodies a legal doctrine centuries older than our Republic. Elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct accordingly; settled expectations should not be lightly disrupted . . . .

Landgraf v. USI Film Prod., 511 U.S. 244, 265-66 (1994). In *Landgraf*, the Court recognized that "the Legislature's unmatched powers allow it to sweep away settled expectations suddenly and without individualized consideration. Its responsivity to political pressures poses a risk that it may be tempted to use retroactive legislation as a means of retribution against unpopular groups or individuals." *Id.* at 266. Courts' requirement that Congress must "make its intention clear helps ensure that Congress itself has determined that the benefits of retroactivity outweigh the potential for disruption or unfairness." *Id.* at 268. Because Congress has not modified or

B. Congress's Silence Should Not Be Construed as a Repeal.

Where Congress did not expressly amend the RCP, this Court should not find that it did so impliedly either. As a general rule, "[a]mendments by implication, like repeals by implication, are not favored." *United States v. Welden*, 377 U.S. 95, 102 n.12 (1964); *see also United States v. Will*, 449 U.S. 200 (1980) ("repeals by implication are not favored.") (citations omitted). The rule disfavoring repeal by implication "applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill" since it is generally presumed that appropriation laws do not alter substantive law. *TVA v. Hill*, 437 U.S. 153, 190 (1978); *see also Will*, 449 U.S. at 221-222. "A new statute will not be read as wholly or even partially amending a prior one unless there exists a 'positive repugnancy' between the provisions of the new and those of the old that cannot be reconciled . . . ." *Blanchette*, 419 U.S. at 134 (citations and quotations omitted). The 2015 and 2016 Spending Bills merit no effect beyond its express words: a decision by the current Congress to foreclose RCP funding through CMS's budget.

In *New York Airways*, the court held that Congress's 1965 appropriation deliberately underfunding subsidy payments authorized by the Federal Aviation Act (and pursuant to which helicopter companies had already rendered services) did not amend the original statute. 369 F.2d 743, 744-45 (Ct. Cl. 1966). The Court of Claims further held that the original statute empowered the implementing agency to obligate the United States for the payment of an agreed subsidy in the absence or deficiency of a congressional appropriation. *Id.* Similarly, here, in the absence of

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repealed the ACA generally or the RCP specifically, this Court need not confront this constitutional question. And, in fact, *stare decisis* counsels against it doing so. *See Almendarez-Torres v. United States*, 523 U.S. 224, 237-38 (1998) ("A statute must be construed, if fairly possible, so as to avoid not only the conclusion that it is unconstitutional but also grave doubts upon that score" (quoting *United States v. Jin Fuey Moy*, 241 U.S. 394, 401 (1916))).

explicit amendment, this Court should not find that Congress impliedly repealed or amended the RCP. Unless Congress amends the RCP, Congress has, at best, demonstrated an effort by some members to "curtail and finally eliminate" RCP payments. *See id.* at 751. The Government still owes Montana Health the money to which it is statutorily entitled.[27]

III. THE GOVERNMENT IS NOT ENTITLED TO DEFERENCE.

Any claim by the Government for deference to its position should be soundly rejected for multiple reasons. First, whether the RCP was intended to be administered in a budget-neutral manner is quintessentially a legislative matter that carries with it such "economic and political significance" that it would be odd, if not downright unconstitutional,[28] for Congress to delegate it to an agency. *See King*, 135 S. Ct. at 2489. Moreover, HHS itself is not a logical agency to which Congress would delegate a question of budget neutrality—it has no special expertise with budgeting policy—rendering it further unlikely that Congress would have delegated the question to HHS. *See id.* at 2488-89 (citing *DA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000)); *see also Gonzales v. Oregon*, 546 U.S. 243, 257-259 (2006) (finding that United States Attorney General did not have the expertise or experience to interpret the Controlled Substances Act).

Second, even if the question of budget neutrality could be and had been delegated to HHS, the Government still would not be entitled to deference because HHS only formulated its viewpoint on administering the RCP in a budget-neutral manner by way of sub-regulatory guidance, so, at most, its position would be entitled to limited "respect" under *Skidmore v. Swift*, to the extent that it has the power to persuade. *See* 323 U.S. 134, 139 (1944); *United States v.*

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[27] The law disfavoring repeal by implication echoes the same principles guiding the anti-retroactivity principle. *See supra* note 29.

[28] *See Panama Ref. Co. v. Ryan*, 293 U.S. 388, 430-431 (1935) (striking down a provision of the National Industrial Recovery Act, because it unconstitutionally delegated power to an agency without defining applicable criteria for its exercise).

Mead Corp., 533 U.S. 218, 219 (2001). But its position is not persuasive at all because it contradicts Congress's intent: it would undermine the entire premise and purpose of the RCP.

Third, the statute is clear and unambiguous, so even under a traditional *Chevron* analysis, deference would not be due, because Congress spoke directly to the matter. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984). By legislating that the United States "shall pay" a certain amount of cost overruns back to QHPs, Congress obligated the Government to pay QHP issuers the full amount as calculated pursuant to the statutory formula. And by directing HHS to administer the RCP program on a "plan year" basis, based expressly on Medicare Part D, Congress spoke directly to the question of "when" payment was due: every year, after the calculation had been made (no differently than when QHP issuers that realized cost savings were required to make a refund payment to the United States).

Fourth, to the extent Section 1342 is ambiguous, the Government's announced position giving rise to this lawsuit should still be rejected because, for the reasons stated already, it would vitiate the RCP's entire purpose. Moreover, the Government's position that the RCP was intended to be administered on a budget-neutral basis has none of the hallmarks of reasoned decision-making[29]: (1) it was never raised as part of the notice-and-comment rulemaking process, so on that ground alone it is procedurally defective;[30] (2) it is inconsistent with the agency's original position that the RCP should not, and would not, be administered in a budget-neutral manner, and the agency has not once to date offered any explanation for why it reversed its

[29] *See Encino Motorcars, LLC v. Navarro*, No. 15-415, slip op. at 9 (2016) ("One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions.").
[30] *See* discussion above at Background Part V.

original position;[31] and (3) it was announced as an about-face from its earlier position only after HHS's earlier position (of March 2013) drew the ire of Congress.[32]

IV. THIS COURT CAN GRANT MONTANA HEALTH THE RELIEF SOUGHT.

This Court's sole role is to determine whether the Government owes Montana Health money. "The judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them." *Gibney v. United States*, 114 Ct. Cl. 38, 52 (1949). The current Congress's decision to withhold funds merely reflects "the setting aside by Congress of a designated amount of public money for a designated purpose." *Id.* Accordingly, if this Court determines, as it should, that Montana Health is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

Montana Health respectfully requests that its motion for partial summary judgment be granted because, based on the undisputed facts, the Government owes Montana Health timely annual and complete RCP payments as a matter of law. Specifically, Montana Health requests monetary relief in the amounts to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b), *i.e.*, $5,943,248.14 (for benefit year 2014) and $36,250,130 (for benefit year 2015). Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

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[31] *See F.C.C. v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009) (where an agency changes course, it must at least "display awareness that it is changing position" and "show that there are good reasons for the new policy").

[32] *Cf. Sandifer v. U.S. Steel Corp.*, 678 F.3d 590, 599 (7th Cir. 2012) ("Naturally the Department of Labor does not acknowledge that its motive in switching sides was political; that would be a crass admission in a brief or in oral argument, and unlikely to carry weight with the judges.").

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CERTIFICATE OF SERVICE

I certify that on November 15, 2016, a copy of the forgoing "Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support," along with (1) Declaration of Jerry Dworak, (2) Addendum A, and (3) Addendum B, was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

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