IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HPHC INSURANCE COMPANY, INC. ,	)	
Plaintiff,	)	
v.	)	Case No. 17-87C
	)	Judge Lydia Kay Griggsby
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

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

Plaintiff HPHC Insurance Company, Inc. ("Plaintiff" or "HPIC") 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 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

When it passed the Affordable Care Act ("ACA"), Congress created a new marketplace (or "exchanges") through which individuals may purchase health insurance.[1] 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 underinsured 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[2] (2014, 2015, and 2016) of the exchanges. Congress well knew that without such a measure, it could not likely achieve the ACA's twin goals of increased *and* affordable health insurance.

The RCP established a mandatory, temporary framework through which health insurers *and the Government* shared in the risk for the first three years while they collected the health costs data associated with this newly insured population. 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 these as yet unknown medical costs. The RCP accounts for this reality by requiring plans that realize lower-than-expected allowable costs in a benefit

[1] 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).
[2] 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 . . . .").

year to *pay* a portion of the differential *to the Government* ("payments in"), and, conversely, entitling plans that realize higher-than-expected allowable costs in a benefit year to payment of a portion of the differential *by the Government* ("payments out"). The RCP is limited to the first three years of the exchanges to "stabilize" the market, during which time it smoothed out "gains" and "losses" to give insurers and the Government time to obtain sufficient experience and data to appropriately price coverage beginning with the 2017 benefit year.

At issue in this case is the Government's obligation to make "payments out" to insurers like HPIC. The RCP does not discriminate between the Government and insurers: both have payment obligations under the statutory formula. Insurers have dutifully made full "payments in," as the RCP requires, when they have realized lower-than-expected costs. On the other hand, although the Government has required, and accepted, full "payments in" from insurers, it has refused to make full "payments out" to insurers, including HPIC, when they experienced "losses" triggering the Government's payment obligations. The Government has made only partial payment toward its 2014 RCP obligations and conceded that the remaining amount owed to HPIC is an "obligation of the United States Government for which full payment is required," but it has refused to make full payment. *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33).[3] CMS has made no payment at all to HPIC for benefit year 2015 and has publicly stated none will be forthcoming, at least anytime soon (if ever). The Government's withholding of payments owed to HPIC is an abject violation of the ACA. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014) ("April 2014 Memo") (Add. A at 19-20).

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

The Government's position in this case can be summarized as follows: If HPIC's participation in the exchanges yields gains within the specified RCP thresholds, the allowable costs are viewed in retrospect as too low, and the Government will require "payment in." But if HPIC yields losses within the specified RCP thresholds, and the allowable costs are retrospectively viewed as too high, HPIC shoulders the losses. This contradicts the fundamental risk-sharing nature of the RCP.

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 Congress wrote the law, 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 HPIC 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 positions; 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 scheme would do nothing to "stabilize" the exchanges; it would instead create the very *instability* the RCP was designed to prevent.

HPIC brought high-quality, affordable health insurance to the people of Massachusetts 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 HPIC payments for those years based on overall higher-than-budgeted costs. There are two questions to answer in this case: (1) how much does the Government owe HPIC; and (2) when does it owe it? Based on the undisputed facts, the first answer is that the Government owes HPIC $19,117,853.55.[4] The second answer is that the Government owes HPIC now (*i.e.*, it is presently due).

STATEMENT OF RELEVANT BACKGROUND

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

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 ACA's goals is to prioritize the consumer by promoting affordability and competitiveness in the health insurance marketplace. To this end, Congress, through the ACA, implemented its risk mitigation programs, including the RCP, to entice insurers to enter the individual and small group markets served by the exchanges, where individuals can purchase health plans that meet

[4] As of the date of filing, CMS owes HPIC $1,033,744.52 (for 2014) and $18,084,109.23 (for 2015) for a total of $19,117,853.55. Am. Compl. ¶¶ 97-98.

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. CONGRESS CREATED THE RCP INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS HPIC 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 the ACA sought to bring into the health insurance marketplace, 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, was a temporary program for 2014-2016, the first three benefits years under the exchanges); and (3) a permanent risk adjustment program. *See* CMS, "The Three Rs: An Overview" (Oct. 1, 2015) *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html. Only the RCP is at issue in this case.

Congress expressly modeled the ACA RCP on Medicare Part D's RCP. *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 RCP 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); GAO, 15-447, Patient Protection and Affordable Care Act (Apr. 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. 45 C.F.R. § 153.510. HHS also requires QHP issuers to submit 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. *Id.* §§ 153.510, 153.530.

HHS made no mention of budget neutrality when it proposed its RCP implementing regulations—but it *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. 41,930, 41,938 (July 15, 2011) (Proposed RCP Rule) (Add. A at 5). And the final, codified regulations do not reflect a budget-neutral RCP. Indeed, in its preamble, 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. 17,220, 17,238-39 (Mar. 23, 2012) (Add. A at 10-11). A year later, in its first "Payment Rule," an annual rulemaking articulating the payment policies and requirements for marketplace participation, HHS stated:

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

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11,

2013) (2014 Payment Rule) (emphasis added) (Add. A at 14).

III. HPIC IS A QHP ISSUER THAT PARTICIPATED IN THE MASSACHUSETTS EXCHANGE.

HPIC is a corporation organized under the laws of the Commonwealth of Massachusetts, with its principal place of business in Wellesley, Massachusetts. Harvard Pilgrim Health Care ("HPHC"), HPIC's parent company, is a nonprofit QHP issuer with subsidiary QHP issuers, including HPIC, participating on the exchanges in Massachusetts, Maine, and New Hampshire. It offers comprehensive health insurance benefits to individuals, families, and businesses. Its stated mission is to "improve the quality and value of health care for the people and communities we serve." It is Massachusetts' oldest nonprofit health maintenance organization, providing affordable, high-quality health plans since 1969. Since commencing business, HPHC has expanded to three additional New England states and covers 1.3 million members.

HPHC has conducted and participated in countless outreach and educational sessions throughout its service area on the availability of ACA coverage, the mechanics of the marketplace, and the benefit plans offered by HPHC and its subsidiaries. By any account, HPHC has pursued the ACA's goal of connecting the people in its service area to insurance coverage opportunities with the understanding that a broader base of insured is better for the individuals within the pool and the overall functioning of the marketplaces.

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

HPIC, like many of its peers in the industry, faced the ACA's new and untested health insurance market. 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 HPIC from accurately setting premiums. Without provisions to hedge the risk posed, HPIC 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 HPIC's decision to enter the market offering 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.

ACA opposition has existed from the outset, strengthening in 2011 when control of the U.S. House of Representatives changed hands.[5] To date, Congress has introduced at least 29 bills to repeal the ACA in its entirety. Congress has also considered at least six bills to impose budget neutrality on the RCP specifically and at least eight to repeal it altogether.[6]

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.[7] It stated in response to a commenter that the RCP "is not statutorily required to be budget neutral" and HHS would make payments "regardless of the balance of payments and receipts." 2014

[5] *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).

[6] *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).

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

Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). QHP issuers submitted their rates for review and their participation in the exchanges was fixed and irrevocable in or around September 2013. *See* CMS, "Letter to Issuers on Federally-facilitated and State Partnership Exchanges" at 22-23 (Apr. 5, 2013), *available at* https://www.cms.gov/CCIIO/Resources/ Regulations -and- Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

HHS's comment 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 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, he pledged that he would refuse to sign any forthcoming annual appropriation unless it defunded the ACA.[8]

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.[9] 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. 13,744, 13,787 (Mar. 11, 2014) (2015 Payment Rule) (Add. A at 17). This reversal occurred after HPIC had already set premiums and enrolled members for the 2014 benefit year. And as noted above, HHS never expressed this "new" point

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

of view during its notice-and-comment rulemaking on its RCP implementing regulations, and did not even *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* April 2014 Memo (describing how payments would be calculated) (Add. A at 19-20).

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.[10] 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.

Unsuccessful at substantively repealing the ACA either in whole or in part, Congress took aim at undermining the law through the appropriations process. In the FY 2015 and 2016

[10] *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond ("Exchange Establishment Rule"), 79 Fed. Reg. 30,240, 30,260 (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 23). 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 26); 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 33); 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") (emphases added) (Add. A at 35); Energy Committee Press Release (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 38-39).

appropriations bills, passed after QHP issuers like HPIC had again set and submitted their premiums for benefit years 2015 and 2016 (in the fall of 2014 and 2015, respectively),[11] Congress prohibited CMS and HHS from using two specified funds, as well as funds transferred from other accounts funded by congressional appropriations, to make RCP payments.[12] The Spending Laws did not nullify or modify the Government's RCP obligations.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. HPIC is a corporation organized under the laws of Massachusetts, with its principal place of business in Wellesley, Massachusetts.

2. HPHC, HPIC's parent company, is a nonprofit QHP issuer with subsidiary QHP issuers, including HPIC, participating in the Massachusetts, Maine, and New Hampshire exchanges.

3. In 2014 and 2015, HPIC provided health insurance to its members on the Affordable Care Act-compliant Massachusetts state-based Marketplace.

4. Pub. L. No. 111-148, § 1342 (ACA Section 1342), 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 [the Medicare Part D program].
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary shall provide under the program established

[11] CMS, "2015 Letter to Issuers in the Federally-facilitated Marketplaces," at 8 (Mar. 14, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-final-issuer-letter-3-14-2014.pdf (2015 Issuer Letter) (QHP agreements expected to be signed in October/November 2014); CMS, "FINAL 2016 Letter to Issuers in the Federally-facilitated Marketplaces," at 8 (Feb. 20, 2015), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2016-Letter-to-Issuers-2-20-2015-R.pdf (QHP agreements expected to be signed in September 2015).

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

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 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 (emphases 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 "payments out" and "payments in," the statute defines "allowable costs" and "target amount." *Id.* § 1342(c).

5. HHS recognized in the preamble to its proposed RCP implementing regulations that the RCP "serves to protect against uncertainty in the Exchanges by limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930.

6. HHS implemented the RCP at 45 C.F.R. § 153.510. In relevant part, it states (emphases added):

(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 that rule, HHS recognized that "QHP issuers who are owed these amounts will want ***prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***" Final RCP Rule, 77 Fed. Reg. at 17,238-39 (Add. A at 10-11). And it reiterated 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***." *Id.* at 17,220 (Add. A at 8).

8. In the 2014 Payment Rule (published on March 11, 2013) HHS stated in the preamble: "The risk corridors program is not statutorily required to be budget neutral. *Regardless of*

the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473 (emphasis added) (Add. A at 14).

9. On May 27, 2014, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and committed to "***use other sources of funding for the risk corridors payments***, subject to the availability of appropriations" if there is a shortfall. *See* Exchange Establishment Rule, 79 Fed. Reg. at 30,260 (emphases added) (Add. A at 23).

10. On February 27, 2015, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and indicated that "***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations." *See* 2016 Payment Rule, 80 Fed. Reg. at 10,779 (emphases added) (Add. A at 26).

11. On October 26, 2015, HHS stated in a letter to HPIC that it would only pay 12.6 percent of the RCP amounts due, 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***."

12. On November 19, 2015, HHS stated that "HHS 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." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33). HHS stated further that it "will explore other sources of funding for the risk corridors payments, subject to the availability of appropriations. This includes ***working with Congress on the necessary funding for outstanding risk corridors payments***." *Id.* (emphasis added).

13. On September 9, 2016, in a memorandum, HHS recognized that the ACA "requires . . . ***full payments*** to issuers" and it 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) (emphases added) (Add. A at 35).

14. 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." *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 (emphasis added) (Add. A at 38-39).

15. HPIC timely submitted its 2014 premiums to HHS by May 2013. CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) (Add. A at 30-31).

16. HPIC's commitment to participate on the Massachusetts exchange was fixed and irrevocable by October 2013. *See* Am. Compl. ¶ 37.

17. Pursuant to its obligations under the ACA and 45 C.F.R. § 153.500 *et seq.*, HPIC submitted all data required for the RCP payment and charge calculations for the 2014 benefit year 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 30-31).

18. CMS has conceded that it owes HPIC $1,214,623.20 under the RCP for its participation in the Massachusetts exchange for benefit year 2014. In addition, CMS has conceded that it owes HPIC $18,084,109.23 for its participation in the Massachusetts exchange for benefit year 2015.

19. CMS has publicly stated in sub-regulatory guidance that it will not make full payment for benefit years 2014 and 2015 until a later—but as-of-yet undetermined—date, if at all.

20. HPIC's commitment to participate on the Massachusetts exchange was fixed and irrevocable in or around November 2014. *See* 2015 Issuer Letter at 8.

21. For benefit year 2015, HPIC submitted to HHS on or about July 31, 2016 all ACA-required data demonstrating HPIC's higher-than-expected allowable costs under to the RCP, entitling HPIC to $18,084,109.23 (as calculated pursuant to the statutory formula prescribed in ACA Section 1342).

22. For benefit year 2015, HHS stated in sub-regulatory guidance that it would implement the RCP in a budget-neutral fashion and use any funds received from QHP issuers to first pay down the $2.5 billion shortfall in 2014 benefit year payments. 2015 Payment Rule, 79 Fed. Reg. at 13,787 (Add. A at 17); April 2014 Memo (Add. A at 19-20). HHS anticipated that "payments in" would match "payments out" over the three-year RCP period, but "***will establish in future guidance*** or rulemaking how [it] will calculate risk corridors payments" if that does not turn out to be the case. *Id.*

23. To date, HPIC has received only $180,878.68 of the $1,214,623.20 the Government owes HPIC under the RCP for the 2014 benefit year. The Government still owes HPIC $1,033,744.52 for the 2014 benefit year. Am. Compl. ¶¶ 61, 79, 97.

24. To date, HPIC 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 Tucker Act jurisdiction because the ACA's RCP is an act of Congress that (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." 28 U.S.C. § 1491(a)(1); *See United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472-73 (2003); *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted). The Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). The RCP mandates that HHS "shall pay" to QHP issuers certain statutorily dictated amounts. And since HPIC 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. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008).

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). HPIC 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) (jurisdiction existed where plaintiff had fulfilled all statutory conditions for payment). HPIC has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under the formula contained in Section 1342 of the ACA.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. HPIC has pled that the ACA is money-

mandating, required full and timely payment, set forth statutory requirements for receipt of payment that HPIC fulfilled, and requires payment the Defendant has not made. *See, e.g.*, Am. Compl. ¶¶ 21, 58, 59, 88, 90, 98. Accordingly, this Court's jurisdiction is beyond dispute. *See, e.g., Moda Health Plan, Inc., v. United States*, No. CIV 16-649C, 2017 WL 527588 (Fed. Cl. Feb. 9, 2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 95-98 (2016).

SUMMARY OF ARGUMENT

Judgment in HPIC's favor is appropriate because the ACA is clear: For each year, a QHP issuer's costs are to be calculated; if there is a cost overrun, the Government owes the issuer money and if there is a cost savings, the issuer owes money to the Government—and both calculations are governed by the statutory formula. *Moda*, 2017 WL 527588, at *22 (holding that the Government was liable to Moda Health as a QHP issuer because the ACA RCP requires full annual payments as evidenced by: the text of Section 1342; HHS's implementing regulations; Congress's obvious object and purpose in creating the RCP; and Congress's modeling of Section 1342 on Medicare Part D's annual RCP).

With respect to "how much" money the Government owes HPIC, 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.[13]

The statute also answers the question of "when" the Government's RCP obligations are due. Section 1342's express language states that if a plan's allowable costs "for any ***plan year***" exceed the target amount, the Secretary "***shall pay to the plan***" the statutorily specified amounts. Although it does not expressly state that payments 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."[14] *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 *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations omitted))).

The Government posits that it can short-pay HPIC and other plans (paying approximately 12.6 percent) for 2014 and not pay them anything at all for 2015. 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 RCP *or* perhaps never. 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 requires this Court to ignore Section 1342's terms that evince Congress's intent. Most notably, Congress specifically modeled the ACA RCP on the Medicare Part D RCP, which establishes full annual payments. *See* GAO Part D Rep. at 14. In the ACA RCP, Congress also directed HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. "[P]lan year" means 12 consecutive months under the ACA[15] and Congress *intentionally* used the plural "corridors." *See Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296

[13] *See supra* note 10.
[14] HHS reiterated that when allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the specified amounts. 45 C.F.R § 153.510 (emphasis added).
[15] *See* 45 C.F.R. § 155.20.

(1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing" (quotation and citations omitted)).

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 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).

Congress's efforts to undermine the RCP through the appropriations process have not negated the Government's obligation to make the required payments under a money-mandating statute. First, Congress's intent in 2010 when it passed the ACA is unambiguous; Congress said the United States "shall pay" when QHP issuers satisfied the statutory "payments out" trigger. Second, as a matter of law, that payment obligation was not dependent on Congress simultaneously specifying the source for the obligated payments. Third, in any case, there was an appropriation available to fund the Government's RCP obligations when it first incurred them in 2014, the first year of the exchanges. Congress's subsequent efforts to bar RCP payments from specific sources through the annual appropriations process merely hampered HHS's ability to make payment but did not abridge the underlying legal obligations. Despite their many efforts, subsequent Congresses have failed to substantively modify the law, let alone repeal it. *See* Addendum B ("Add. B") at 3. The Government's liability to HPIC remains in full force.

SUMMARY JUDGMENT STANDARD

This case presents a 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 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (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 motion for summary judgment." *Id.* 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.

HPIC is entitled to summary judgment because, based on the undisputed facts and as a matter of law, the Government owes it an unpaid balance of 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 ACA's structure require (1) full payment, rather than payments subject to budget neutrality, and (2) annual payment.

A. Congress Intended QHP Issuers to Receive *Full* Payment.

The enacting Congress effectuated the RCP's risk mitigating purpose by plainly and unambiguously mandating full payment to QHP issuers as defined in its "Payment

Methodology" without regard to budget neutrality. First, the text mandates that the Government "***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "[T]he 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 a 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 HPIC in full. Unsurprisingly, HHS agreed and acknowledged that the RCP "is not statutorily required to be budget neutral" and promised payment "[r]egardless of the balance of payments and receipts." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). Judge Wheeler accordingly found that the RCP's directive that HHS "*shall pay*" pursuant to a statutorily specified formula, particularly in the absence of any express language conditioning "payments out" on "payments in," renders "the unambiguous language of Section 1342 dispositive." *Moda*, 2017 WL 527588, at *16-*17.[16]

Second, Congress expressly provided that the RCP was not budget neutral by modeling the ACA's RCP on the Medicare part D RCP, the only other risk mitigation program similar to the RCP in the healthcare industry, which is not budget neutral. ACA § 1342(a); *see* GAO Part

[16] In *Moda*, Judge Wheeler found, as HPIC has argued in this case, that the RCP is unambiguously *not* budget neutral under the plain meaning of Section 1342. Judge Wheeler also observed that HHS/CMS contemporaneously and repeatedly recognized, as did everyone in the industry, that the RCP is *not* budget neutral. *Moda*, 2017 WL 527588, at *15. HHS's multiple and consistent statements shortly after the ACA's passage buttress HPIC's proposed interpretation that the statute is unambiguously not budget neutral.

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."). Part D's non-budget neutrality undoubtedly is a critical design feature applicable to the ACA's RCP because (1) non-budget neutrality is a foundational and essential component to an RCP's 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 modeled the RCP should not apply. Both RCPs were specifically designed to hedge risk in new healthcare markets to enable insurers to affordably offer essential health benefits.[17] 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)).[18] Where Congress expressly modeled the ACA RCP on the Medicare Part D RCP, if it intended to omit its defining characteristic, surely Congress would have said so explicitly. It did not.

In other RCP cases, Government counsel has treated Congress's specific direction that Section 1342 be "based on" Medicare Part D as surplusage. *See, e.g.*, *Land of Lincoln*, 129 Fed.

[17] 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.").

[18] We note that *Land of Lincoln* dismissed the Part D scheme's relevance because Congress purportedly omitted certain text. 129 Fed. Cl. at 105. 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, it ignores that Congress is presumed to legislate with awareness of how a program on which later-enacted legislation is based is administered. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978).

Cl. at 105; Transcript of Oral Argument ("Montana Tr.") at 125:1-3, 13-19, *Montana Health CO-OP v. USA*, No 16-1427C (Fed. Cl. Feb. 9, 2017) ("I don't know . . . that Congress had anything specific in mind . . . I don't think it does much other than to say there is supposed to be this program."). The Government ignores this express directive and conveniently reads out of Section 1342 its obligation to make full, annual RCP payments as Medicare Part D requires—the essence of the "based on" reference.

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 has omitted them . . . ." *Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993).[19]

[19] Although the Government has elsewhere argued that the Congressional Budget Office (CBO) assumed that government payments would not exceed amounts collected under the RCP, CBO statements do not bear on congressional intent. *See* Proposed RCP Rule, 76 Fed. Reg. at 41,948. 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) (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. In any event, in the only report in which the CBO actually addressed the issue, it concluded the RCP was *not* budget neutral. *See* CBO, "The Budget and Economic Outlook: 2014 to 2024" at 9 (Feb. 2014), *available at* https://www.cbo.gov/sites/default/files/113thcongress-2013-2014/reports/45010-outlook2014feb0.pdf.

Fourth, Congress's *exclusion* of words specifically limiting RCP payments to appropriated funds underscores its intent to accomplish the opposite. Congress often uses explicit language, such as "subject to the availability of appropriations," to limit a statute's budget impact. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2188-89 (2012) (noting that certain payments were "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 *N.Y. Airways v. United States*, 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 required "payments of the remainder of the total compensation payable under this section out of appropriations made to the Board for that purpose." 369 F.2d 743, 745-46 (Ct. Cl. 1966) (quoting 49 U.S.C. § 1376(c)). This Court relied on the statute's text and 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 elsewhere within the ACA itself. *See, e.g.*, 42 U.S.C. § 280k(a) ("The Secretary . . . shall, ***subject to the availability of appropriations***, establish a 5-year national, public education campaign . . . ." (emphasis added)). Especially when read in the context of the ACA as a whole, the lack of any language of budgetary limitation in Section 1342 confirms that Congress did not intend the RCP to be budget neutral. *See United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) (citations omitted) ("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 the permissible meanings produces a substantive effect that is compatible with the rest of the law."); *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 infra* Section II.C. 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 10.[20]

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, DOJ has argued that Congress believed it was far more likely for the RCP to generate funds or

[20] In the RCP litigation, the Department of Justice has attempted to "walk back" these numerous concessions. *E.g.*, Montana Tr. at 176:1-12 ("I don't think there's been a change in position insofar as timing goes, and that's the only thing we're talking about with respect to deference. And, so, I don't think that's really relevant. But, again, it's only relevant to—if relevant at all, it's relevant only to jurisdiction, not to the merits."). Of course, this reversal comes only after the Government has been sued for its refusal to make statutorily required RCP payments. To the extent the Government asserts in this case that it is not obligated to make full payment under the RCP to HPIC, 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 Univ. Hospital*, 488 U.S. 204, 212 (1988))).

"payments in" based upon HHS's experience with the Medicare Part D RCP, as reflected in its guidance letter of April 11, 2014. *See* April 2014 Memo (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 19). The Government should be held to the same standard applied to insurers.

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

The ACA's text and structure unambiguously anticipate that RCP payments—both "in" and "out"—will be made on an annual basis. And this is exactly how HHS originally understood and stated it would apply its congressional mandate. *See* RCP Final Rule, 77 Fed. Reg. at 17,238-39 (identifying that the same deadlines should apply to both "payments in" and "payments out") (Add. A at 10-11); 2014 Payment Rule, 78 Fed. Reg. at 15,473 (setting a 30-day deadline from determination of charges for QHP issuers to make "payments in") (Add. A at 14).

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.");[21] *see Moda*, 2017 WL 527588, at *14, *15 (holding that requiring the

[21] Application of the definition in a related regulation implementing the same statute is appropriate. The Supreme Court "construe[s] a statutory term in accordance with its ordinary or natural meaning." *FDIC v. Meyer*, 510 U.S. 471, 476 (1994). 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."). 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

calculation of payment amounts, both in and out of the program, on a "plan year" basis rather than over the life of the program reflects an annual program).

Second, 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.[22] 45 C.F.R. § 153.510(a)-(d), (g). The scheme is unmistakably annual.

Third, 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*, 515 U.S. at 296 ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing") (quotation and citations omitted); *Dakota, Minn. & 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); *Moda*, 2017 WL 527588, at *12 (holding that Section 1342 requires *annual* payments and finding that

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Establishment Rule"). Final RCP Rule, 77 Fed. Reg. at 17,222 (Add. A at 9); *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 . . . .").

[22] In fact, the government has required or remitted annual payment under the risk adjustment and reinsurance programs. And in 2014, CMS made an annual (albeit incomplete) RCP payment.

Section 1342 "offer[s] clues as to Congress's intent" by requiring an RCP for "calendar years 2014, 2015, and 2016" rather than "calendar years 2014-2016"). Congress is presumed to draft law purposefully. *See Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absentminded 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.

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 . . . ."). *See Moda*, 2017 WL 527588, at *12 (noting Congress's explicit directive that the RCP be "based on" the Medicare Part D's annual RCP). 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.[23]

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

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

the law and HPIC'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 41,930 (Add. A at 4). It reiterated that principle in its final rule, and accordingly indicated that it would "address the risk corridors 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 17,238 (emphasis added) (Add. A at 10-11).

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 15,473 (Add. A at 14). 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 RCP 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 the very "death spiral" the Supreme Court recognized, and that the RCP was intended to avoid, has resulted from Congress's failure to appropriate sufficient funds to satisfy the Government's RCP obligations.[24] HHS's current position that, despite its acknowledgment that the RCP requires full payment to HPIC and others, the Government can delay those payments until some indefinite time in the future, if at all, betrays Congress's intent. 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 less credible by its continued expectation that QHP issuers with lower-than-expected allowable costs dutifully make complete annual payment, as statutorily required. The Government's obligation to make timely payments is no different.

[24] *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 average premium increase of 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 . . . .").

II. THE GOVERNMENT'S LIABILITY DOES NOT DEPEND ON HOW CONGRESS INTENDED THE LIABILITY TO BE FUNDED.

Based on the positions it has taken in other RCP litigations, the Government will likely contend in this case that that the "shall pay" directive in Section 1342 actually means "shall pay *subject to a specific appropriation*," and that Congress never provided an appropriation to fund the RCP. In so arguing, the Government will likely invoke Congress's 2014 and 2015 efforts to cut off funding for the RCP as confirming it has no liability to pay. The Government is wrong.

A. The Government's Liability Does Not Turn on the Availability of Funding.

As discussed above (*supra* at Section II.A), Congress did not limit the Government's RCP liability with the typical words of limitation ("subject to appropriations"). Nor, as a matter of fiscal law, does the Government's liability for full and annual RCP payments turn on whether Congress specifically appropriated funds for the RCP. The Government's error is its conflation of two distinct concepts: (1) Congress's creation of a legal "obligation" to pay in the first instance; and (2) the fiscal mechanics of the Government later fulfilling that obligation. *See, e.g.*, Def.'s Supp. Br. Regarding *Moda Health Plan, Inc. v. United States* at 3-5, 13-15, *Montana Health CO-OP v. United States*, No. 16-1427C (Fed. Cl. Feb. 23, 2017) (Wolski, J), ECF No. 25. The Government's position also ignores the role of the Judgment Fund. *See, e.g.*, *Moda*, 2017 WL 527588, at *22.

Under the Tucker Act, HPIC may recover unpaid funds when the Government fails to meet its obligation under a money-mandating statute. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United States*, 67 Fed. Cl. 292, 302-05 (2005). The RCP is unequivocally money-mandating because, *inter alia*, it dictates that the Government "shall pay" RCP payments. Whether, when, and how Congress appropriates the required funds are irrelevant to this Court's decision regarding the legal *obligation* to make the payments in the

first instance. There is no requirement for Congress to create a specific appropriation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389, 391-94 (1886) (finding the Government liable for its statutory promise of future payment despite the absence of a specific appropriation).

The Federal Circuit's seminal decision in *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (*en banc*), drives home the point. *Slattery* addressed whether the Government could be sued under the Tucker Act for breaches committed by a Government entity that was not funded by appropriations ("NAFI"). The Government, citing a tortured case history, argued that because a NAFI is not funded by appropriations, this Court lacks jurisdiction to entertain or pay claims for a NAFI breach. After canvassing the long line of cases from the Court of Claims, Federal Circuit, and Supreme Court, the Federal Circuit overruled its own contrary precedent[25] and held that the Tucker Act's broad grant of jurisdiction for any claim "founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort" was not limited to the sub-set of instances where a specific appropriation could be identified. It held, "the jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid." *See id.* at 1321. Critically, the Court ruled that any resulting judgment—despite the lack of appropriations involved in creating the original obligation—*could be satisfied by the Judgment Fund*. *See id.* at 1317 ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims.").

Slattery applies to this case, too. Although *Slattery* addressed jurisdiction over a claim for breach of a NAFI contract, its holding applies with equal force here, given that the Tucker

[25] *See Kyer v. United States*, 369 F.2d 714 (Ct. Cl. 1966) *abrogated by Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011).

Act itself draws no distinction between constitutional, statutory, or contract claims against the Government. And while the Government has framed this as a "merits" issue in its other RCP cases, the Government's attempts to force RCP plaintiffs to identify a specific appropriation to fund RCP payments as a predicate condition to state a claim under Section 1342 would amount to a second "jurisdictional" test of the very sort rejected in *Slattery* and *Dickerson*. *See id*. at 1316 (citing *Dickerson* for the proposition that once Tucker Act jurisdiction is determined by identification of a money-mandating statute, there is no need to identify a specific appropriation for what in essence would amount to a "second waiver" of sovereign immunity). The point is this: because Congress did not condition payments out on payments in (for the reasons explained above), the only limitation on HPIC's right to payment on its statutory claim is its ability to demonstrate, as a factual matter, that it performed as a QHP issuer on the exchanges and qualifies for RCP payments under the Section 1342 formula (as echoed in CMS's implementing regulation). If it can make that showing (as it has), then judgment may be awarded and executed against the Judgment Fund. *See, e.g.*, *Moda*, 2017 WL 527588, at *22 ("The Judgment Fund pays plaintiffs who prevail against the Government in this Court, and it constitutes a separate Congressional appropriation."); *Gibney*, 114 Ct. Cl. at 52 ("Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether . . . Congress appropriated an insufficient amount . . . or nothing at all, are questions . . . which do not enter into the consideration of case in the courts.").

B. In Any Event, Both GAO and *Moda* Agree That Appropriations *Were Available* for CMS to Incur RCP Obligations.

Although the Court's analysis can stop with the observation that Congress created a legal obligation to make full payments, this Court may observe, as Judge Wheeler did in *Moda*, that DOJ's proposition that CMS had no appropriated funds available to give rise to RCP obligations

is, in any event, incorrect. For FY 2014, the first year in which the exchanges were operational and the RCP was in effect, GAO opined that two sources of funding for RCP payments were available: (1) the 2014 CMS Program Management (PM) appropriation, and (2) "payments in" from profitable plans. *Moda*, 2017 WL 527588, at *16; The Hon. Jeff Sessions, the Hon. Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237, at *3 (Sept. 30, 2014). The CMS PM appropriation for FY 2014 included CMS's "other responsibilities" through September 30, 2014, includ[ing] the risk corridors program." B-325630, 2014 WL 4825237, at *3.

Any argument by the Government that payments were not *due* until the following fiscal year, and therefore CMS's FY 2014 PM appropriation is irrelevant to the formation of an obligation, is fundamentally untenable. The availability of funds "relates to [an Agency's] authority to ***obligate*** the appropriation"—which occurred in FY 2014 when QHP issuers submitted their rates and opted to participate in the exchanges in the forthcoming year—and does not relate to whether that obligation is *due or payable* in current or subsequent fiscal years. I GAO, *Principles of Fed. Appropriations Law* ["GAO Redbook"], at 5-3 - 5-4 (emphasis added) (3d ed. 2004), *available at* http://www.gao.gov/legal/redbook/overview; *see* II GAO Redbook at 7-4 - 7-5. It is black letter appropriations law that an "expired appropriation remains available for 5 years *for the purpose of paying obligations incurred* prior to the account's expiration and adjusting obligations that were previously unrecorded or under recorded." I GAO Redbook at 1-37 (emphasis added).[26] A legal "obligation arises when the definite commitment is made, *even though the actual payment may not take place until a future fiscal year*. . . . [T]he term

[26] An agency should record non-discretionary expenditures "*imposed by law*" as "obligations." II GAO Redbook at 7-43 (emphasis added). The fact that CMS *recorded* RCP payments as Government obligations in the fiscal years in which they were incurred (e.g., FY 2014) "evidences the obligation but does not create it." *Id.* at 7-8. CMS's actions are therefore highly *probative* that it formed an FY 2014 obligation.

'obligation' includes both matured and unmatured commitments . . . . An unmatured commitment is a liability which is *not yet payable* but for which a definite commitment nevertheless exists." II GAO Redbook at 7-4 - 7-5 (emphasis added). Thus, it is beyond dispute that there were in fact appropriations available for CMS to form obligations in FY 2014, notwithstanding that CMS would not *pay* its RCP obligations until the following fiscal year. *See id.*; *Moda*, 2017 WL 527588, at *17 n.13.

The same logic applies to FY 2015. As Judge Wheeler noted, appropriations were available for CMS to form 2015 RCP obligations (notwithstanding that payment would occur the following fiscal year) because Congress passed three continuing resolutions in the first several months of FY 2015 (by November 2014)—*before* Congress passed the 2015 Spending Law (in December 2014) that first restricted sources of RCP payments. These continuing resolutions allocated roughly $750 million in unrestricted funds to the CMS PM appropriation. *Moda*, 2017 WL 527588, at *17 n.13. Since unrestricted funds were available in November 2014, when HPIC's participation on the exchanges during benefit year 2015 was fixed and irrevocable, there can be no legitimate argument that CMS lacked funds to form RCP obligations for FY 2015.

For all the reasons discussed *supra* Section I, the text and purpose of Section 1342 unambiguously establish that Congress intended the Government to make full RCP payments, and statutorily required HHS to collect and remit payments under the RCP's formula, necessarily requiring HHS to incur obligations under the RCP's formula. When and how those obligations would later be paid is irrelevant to the question of the Government's liability.

C. The 2015 and 2016 Appropriations Acts Did Not Nullify or Modify the Government's RCP Obligations.

That Congress has curtailed HHS's ability to make RCP payments through appropriations legislation in the last two budget cycles, years after the ACA's passage and well after its

exchanges are under way, does *not* alter the Government's RCP *liability*. First, and as discussed above, the existence of a legal obligation is distinct from the means by which the Government fulfills that obligation. Second, the Government's temporary restrictions on specific sources for fulfilling those obligations have not modified the RCP; 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). *See Moda*, 2017 WL 527588, at *15, *17 (finding that Congress did not intend Section 1342 to be budget-neutral and that neither the 2015 nor 2016 Spending Laws abrogated or effectuated a substantive repeal or amendment of the RCP).

1. 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 Laws, Congress has curtailed CMS's funding sources to make RCP payments, that fact is irrelevant to this lawsuit by HPIC.

"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.*, 487 F.3d at 877 (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 legislation. *See Greenlee Cty.*, 487 F.3d at 877. Nor does

it absolve the Government of its obligation to make payments mandated by law. *See id.*

The Spending Laws did not amend the RCP.[27] Relevant precedent illustrates this basic point. In *Langston*, the diplomatic representative to Haiti sued when Congress failed to appropriate sufficient funds to pay his statutorily set salary. 118 U.S. at 390. 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.

[27] Appropriations were available to make 2015 RCP payments because Congress passed three continuing resolutions in the first two-and-a-half months of FY 2015 (before enacting the 2015 Spending Law that first restricted sources of RCP payments). *See supra* Section I.C.

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 . . . .").

This Court should conclude that because the language in the 2015 and 2016 Spending Laws limited only the use of funds appropriated to *one specific account* and did not expand the limitation to other sources of funds using Congress's typical language to do so, those acts were comparable to the subsequent appropriations at issue in the line of cases finding that Congress did not intend to amend substantive law. *Moda*, 2017 WL 527588, at *18-*20 (citing *Langston*, 118 U.S. at 393; *Gibney*, 114 Ct. Cl. at 48; *N.Y. Airways*, 369 F.2d at 744; *District of Columbia*, 67 Fed. Cl. at 335). Because the Spending Laws do not "bar any appropriated funds from being used for a given purpose," the Court has found that the words did not "clearly manifest" an intent to repeal or amend.[28]

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 President's support or sufficient votes to override a veto, it cannot pass new legislation. The 113th Congress, which passed the 2015 Spending Law, directly considered proposed legislation to amend the ACA to limit or eliminate RCP payments. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014) (seeking to amend the RCP to "ensur[e] budget neutrality."); Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (seeking to eliminate the RCP). Neither bill passed. During the 2016 budget process, Congress considered an amendment expressly indicating that "Effective January 1, 2016, the Secretary shall not collect fees and shall not make payments under [the RCP]." 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) (statement of

[28] Indeed, the Court noted that precisely that language was used elsewhere in the 2015 Spending Law but was notably absent from the RCP provision. *See Moda*, 2017 WL 527588, at *21.

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. 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. No. 114-74, 12 (June 25, 2015); *see also id*. at 121, 126. These efforts, too, failed.

In other words, Congress tried—and *failed*—to actually repeal or modify the RCP. But its efforts to do so highlight 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*. To interpret appropriations bills to have accomplished what explicit legislation failed to effectuate would render our constitutional system of checks and balances a nullity. Congress could have repealed the ACA. It did not. Congress could have amended the RCP. It did not. It was only then that Congress settled for interfering 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. Conn. 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 to HPIC for 2014 and 2015 RCP payments.[29]

[29] If Congress *had* actually modified or repealed the RCP, its actions would face scrutiny under the Due Process Clause under the presumption against retroactivity. *Landgraf v. USI Film Prod.*, 511 U.S. 244, 265-66 (1994) ("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."). Courts' requirement that Congress must

2. 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, 221 (1980). This rule "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 221-22. "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 Laws merit no effect beyond their express words: a decision to foreclose certain sources of RCP funding.

In *N.Y. Airways*, Congress's 1965 appropriation deliberately underfunding subsidy payments under the Federal Aviation Act (pursuant to which helicopter companies had already rendered services) did not amend the original statute. 369 F.2d at 744-45. 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, in the absence of explicit amendment, this Court should not find that Congress impliedly repealed or amended the RCP. Congress has, at best, demonstrated an

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"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 repealed the ACA or the RCP, this Court need not confront this constitutional question and *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))).

effort by some members to "curtail and finally eliminate" RCP payments. *See id.* at 751. The Government still owes HPIC the money to which it is statutorily entitled.[30]

III. THIS COURT CAN GRANT HPIC THE RELIEF SOUGHT.

This Court can enter judgment for HPIC irrespective of how such a judgment will be effectuated by the political branches. As noted, "[t]he 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*, 114 Ct. Cl. at 52; *see Slattery*, 635 F.3d at 1317 ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims."); *N.Y. Airways*, 369 F.2d at 748 ("The failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in [this Court]."). If this Court determines that HPIC is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

HPIC respectfully requests that its motion for partial summary judgment be granted because, based on the undisputed facts, the Government owes HPIC timely annual and complete RCP payments as a matter of law. Specifically, HPIC 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.*, $1,033,744.52 (for benefit year 2014) and $18,084,109.23 (for benefit year 2015), totaling $19,117,853.55. Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

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

Dated: March 8, 2017

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CERTIFICATE OF SERVICE

I certify that on March 8, 2017, a copy of the forgoing "Plaintiff's Motion for Partial Summary Judgment and Memorandum of Law in Support," along with (1) Addendum A, and (2) 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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