IN THE UNITED STATES COURT OF FEDERAL CLAIMS

SANFORD HEALTH PLAN Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	Case No. 17-357C Judge Eric G. Bruggink

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

Plaintiff Sanford Health Plan ("Plaintiff" or "SHP") 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") for the purchase of health insurance.[1] The exchanges, among other things, dramatically increased the number of entities 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 of the new market 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 year to *pay* a portion of the differential *to the Government* ("payments in"), and, conversely,

[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 (Mar. 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 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 . . . .").

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 SHP. The RCP does not discriminate between the Government and insurers: both have payment obligations under the statutory formula. When SHP experienced lower-than-expected costs on the North Dakota exchange, it made ***full*** "payment in" of $562,300.01 to HHS as required by the RCP. Although the Government has required, and accepted, full "payments in" from SHP, it has refused to make full "payments out" when SHP experienced "losses" triggering the Government's payment obligations. It has made only partial payment toward its 2014 RCP obligations (approximately 15.1 percent of what is owed) and conceded that the remaining balance is an "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 35).[3] CMS has made no payment at all to SHP for benefit year 2015 and has publicly stated none will be forthcoming anytime soon (if ever). *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016) ("2015 Payment Memo") (Add. A at 40). The Government's refusal to make full payments 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).

The Government's position is: If SHP's participation in the exchanges yielded gains

[3] Attached to this Memorandum is Addendum A ("Add. A") containing public HHS statements cited in this Memorandum, of which this court may take judicial notice. *See* Fed. R. Evid. 201.

within the specified RCP thresholds, the allowable costs would be viewed in retrospect as too low, and the Government would require full "payment in." But if SHP's allowable costs were retrospectively viewed as too high, SHP would be "out of luck," and left alone to shoulder the losses. This position disregards Section 1342's clear and money-mandating "shall pay" language and contradicts the fundamental risk-*sharing* purpose 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 SHP 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.

SHP brought high-quality, affordable health insurance to the people of South Dakota, North Dakota, and Iowa in 2014 and 2015, just as Congress envisioned when it crafted the ACA's system of requirements and incentives. Under the RCP, the Government owes SHP payments for those years based on overall higher-than-budgeted costs. There are three questions to answer in this case with three simple answers:

(1) How much does the Government owe SHP? Based on the undisputed facts, the Government owes SHP $8,979,924.04. *Infra* Section I.A.

(2) When does the Government owe it? The Government owes SHP now (*i.e.*, it is presently due). *Infra* Section I.B.

(3) Has the Government been relieved of its obligation to make payment? No action by HHS or Congress abrogated the Government's payment obligation under the RCP. *Infra* Section II.

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 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. The ACA prioritizes the consumer by promoting affordability and competitiveness in the marketplace. To this end, Congress implemented risk mitigation programs, including the RCP, to entice insurers to enter the individual and small group markets served by the exchanges, where consumers 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. CONGRESS CREATED THE RCP INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS SHP INTO THE MARKETPLACE.

Expanding healthcare coverage comes at a cost. For example, under the ACA, QHP issuers must cover a variety of essential health benefits at no additional cost to enrollees. The ACA's myriad mandates, 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 to insurers, while at the same time preventing unaffordable premiums for the millions of Americans that 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 ("Three Rs Overview"). 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 RCP]."). Medicare Part D's RCP is not budget neutral and payments (both in and out) are made annually. *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

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 parrot the statute. *See* 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). This makes good sense because the risk adjustment program is designed to share risk *among QHP issuers* while the RCP is designed to share risk *between QHP issuers and the Government*. *See* Three Rs Overview. Accordingly, 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 annual "Payment Rule" 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. SHP IS A QHP ISSUER THAT PARTICIPATED IN THE SOUTH DAKOTA, NORTH DAKOTA, AND IOWA EXCHANGES.

SHP is a corporation organized under the laws of South Dakota, with its principal place of business in Sioux Falls, South Dakota. SHP is a nonprofit QHP issuer participating in the South Dakota, North Dakota, and Iowa exchanges. Overall, SHP has nearly 180,000 members through its fully insured and self-funded health care benefits offered to individuals, families, and businesses. SHP began providing affordable, high-quality health plans in South Dakota in 1998.

SHP is part of Sanford Health, a nonprofit, integrated health system headquartered in Sioux Falls, South Dakota. Sanford Health is one of the largest health systems in the nation with presence in nine states and four countries, and includes 43 hospitals and nearly 250 clinics. Sanford Health's 27,000 employees, including 1,400 physicians, make it the largest employer in the Dakotas. Sanford Health is a recognized leader in health care and strives to provide patients across its vast geography with convenient access to expert medical care, leading-edge technologies and world-class facilities. In addition to strong clinical care, Sanford Health is committed to education, community growth and research, with initiatives in genomic medicine and specialized centers researching cures for type 1 diabetes, breast cancer, and other diseases.

SHP 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 it offers. By any account, SHP 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. SHP OFFERED AFFORDABLE PREMIUMS RELYING ON THE RCP AS A HEDGE AGAINST MARKET INSTABILITY.

SHP, like many of its peers, 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 SHP from accurately setting premiums. Without a way to hedge the risk, SHP would have had to set premiums at dramatically higher rates to account for market uncertainty (if not decline to enter the market altogether, reducing competition and driving up premiums in its own right). That of course would have undermined the ACA's very purpose. The RCP was essential to SHP'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.[4] Long before the most recent push to repeal and replace the ACA, Congress introduced numerous bills to repeal the ACA in its entirety. Congress also considered at least half a dozen bills to impose budget neutrality on the RCP

[4] *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).

specifically and at least eight to repeal it altogether.[5]

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.[6] 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 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* Compl. ¶¶ 38, 65.

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.[7]

Other members of Congress shared Senator Rubio's sentiment and a historic budget impasse ensued that shut down the Government for over two weeks.[8] Only months later, in March 2014, HHS indicated *for the first time* in the preamble to its 2015 Payment Rule that it

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[5] *See* Addendum B (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).

[6] 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.

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

[8] *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.

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 SHP had already set premiums and enrolled members for the 2014 benefit year. And HHS never expressed this new point of view during its notice-and-comment rulemaking on its RCP implementing regulations, and did not even acknowledge that it was reversing course. In a follow-up guidance letter, HHS stated that it anticipated RCP "payments in" would 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.[9] Exactly *when* full payment would be remitted has never been clarified.

[9] *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. 10,750, 10,779 (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 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") (emphases added) (Add. A at 37); Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energy commerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (emphasis

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 appropriations bills, passed after QHP issuers like SHP had again set and submitted their premiums for benefit years 2015 and 2016 (in the fall of 2014 and 2015, respectively),[10] 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.[11] The Spending Laws did not nullify or modify the Government's RCP obligations.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. SHP is a corporation organized under the laws of South Dakota, with its principal place of business in Sioux Falls, South Dakota.

2. SHP is a nonprofit QHP issuer participating in the South Dakota, North Dakota, and Iowa exchanges.

3. In 2014 and 2015, SHP provided health insurance to its members on the federally-facilitated marketplaces in South Dakota and North Dakota as well as the Affordable Care Act-compliant Iowa state-federal partnership marketplace.

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added) (quoting Acting Administrator of CMS's testimony as part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight") (Add. A 45-46).

[10] 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 (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).

[11] 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").

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 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.
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> 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 (Add. A at 4).

6. HHS implemented the RCP at 45 C.F.R. § 153.510, stating in part (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 (Add. A at 10). 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 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 35). 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).

12. 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 37).

13. On September 14, 2016, in testimony before the House Energy and Commerce Committee, 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* Energy and Commerce Committee Press Release (emphasis added) (Add. A at 45-46).

14. SHP timely submitted its 2014 premiums to HHS by May 2013. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("2014 Payment Memo") (Add. A at 30-33); Compl. ¶ 38.

15. SHP's commitment to participate in the South Dakota, North Dakota, and Iowa exchanges was fixed and irrevocable by September 23, 2013, when QHP Issuer Agreements for SHP's participation in the exchanges were fully executed. *See* Compl. ¶ 65.

16. Pursuant to its obligations under the ACA and 45 C.F.R. § 153.500 *et seq.*, SHP 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); 2014 Payment Memo (Add. A at 30-33).

17. SHP's commitment to participate in the South Dakota, North Dakota, and Iowa exchanges was fixed and irrevocable on October 29, 2014, when QHP Issuer Agreements for SHP's participation in the exchanges were fully executed. *See* Compl. ¶ 75.

18. SHP submitted all data required for the RCP payment and charge calculations for the 2015 benefit year by the statutory deadline of July 31, 2016. *See* 45 C.F.R. § 153.530(d); 2015 Payment Memo (Add. A at 40-43).

19. CMS has conceded that, under the RCP, it owes SHP $3,665,695.66 for benefit year 2014 and $5,869,541.98 for benefit year 2015. 2014 Payment Memo (Add. A at 31-33); 2015 Payment Memo (Add. A at 41-43).

20. 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. *See* 2015 Payment Memo (Add. A at 40).

21. 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.*

22. To date, SHP has received only $555,313.60 of the $3,665,695.66 the Government owes under the RCP for the 2014 benefit year and owes $3,110,382.06. Compl. ¶¶ 61, 69, 81.

23. To date, SHP has not received any RCP payments for the 2015 benefit year.

24. 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 SHP 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). SHP 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). SHP 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. SHP has pled that the ACA is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that SHP fulfilled, and requires payment the Defendant has not made. *See, e.g.*, Compl. ¶¶ 11, 21, 58, 67, 69, 77, 80, 81, 99, 100. Accordingly, this Court's jurisdiction is beyond

dispute. *See* Order, *Maine Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF 30; *Moda Health Plan, Inc., v. United States*, No. CIV 16-649C, 2017 WL 527588, at *10 (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 SHP'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 above a certain amount, the Government owes the issuer money, and if there is a cost savings above a certain amount, the issuer owes money to the Government—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 SHP, 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 "s*hall*" 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. *See supra* note 9.

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."[12] *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 statute answers the question of whether the Government's obligation has changed (it has not) because it remains on the books in precisely the form in which it was enacted.

The Government posits that it can short-pay SHP and other plans for 2014 and not pay it 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 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[13] and Congress *intentionally* used the plural "corridors." *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)).

[12] 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).
[13] *See* 45 C.F.R. § 155.20.

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 appropriations 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. *See* Add. B at 3. The Government's liability to SHP 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.

SHP 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. *See, 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 SHP 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). *See, e.g.*, *Moda*, 2017 WL 527588, at *16-*17 (finding "the unambiguous language of Section 1342 dispositive" of the fact that Congress did not intend the RCP to be budget neutral).[14]

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 similar risk mitigation program in the healthcare industry, which is not budget neutral. ACA § 1342(a); *see* GAO 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

[14] In *Moda*, Judge Wheeler found, as SHP argues here, that the RCP is unambiguously *not* budget neutral under the plain meaning of Section 1342, as HHS/CMS contemporaneously and repeatedly recognized (as did everyone in the industry). *Moda*, 2017 WL 527588, at *15. HHS's multiple and consistent statements shortly after the ACA's passage buttress SHP's proposed interpretation that the statute is unambiguously not budget neutral.

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 offer essential health benefits affordably.[15] 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)).[16] Where Congress expressly modeled the ACA RCP on the Medicare Part D RCP, if it intended the ACA nonetheless not to track this defining characteristic of Part D, surely Congress would have said so explicitly. It did not.

Government counsel has elsewhere treated Congress's specific direction that Section 1342 be "based on" Medicare Part D as superfluous. *See, e.g.*, *Land of Lincoln*, 129 Fed. 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 think it does much other than to say there is supposed to be this program."). The Government ignores Section 1342's express directive and

[15] 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.").

[16] 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).

instead reads out 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).[17] 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

[17] 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" (Budget Outlook) at 9 (Feb. 2014), *available at* https://www.cbo.gov/publication/45010.

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 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 or "subject to the availability of appropriations." *See United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("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." (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). The Government simply cannot add words to § 1342 that Congress excluded, particularly where those very words appear *elsewhere* in the law.[18]

Finally, RCP opponents have repeatedly introduced (and failed to pass) legislation intended to *make* the RCP budget neutral. *See infra* Section II.C.1. Obviously, if the RCP were budget neutral, such legislative efforts would have been unnecessary. *See, e.g.*, *ARRA Energy*

[18] Moreover, any Government argument that the RCP was intended to be budget neutral effectively converts the RCP into the risk adjustment program, which *is* budget neutral and was intended to share risk *among QHP issuers*. *See* Three Rs Overview. The RCP was designed to serve a distinct purpose by sharing risk *between QHP issuers and the Government.*

Co. I v. United States, 97 Fed. Cl. 12, 22 n.6 (2011) (noting that congressional attempts to amend a law provide support for the proposition that the law in its current form does not already do what the amendment proponents are seeking). 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 payments is demonstrated by HHS's acknowledgment of this fact on multiple occasions. *See supra* note 9.[19]

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 has argued that Congress believed it was far more likely that the RCP would generate more payments in than out based on Medicare Part D's RCP performance, as reflected in its guidance letter. *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).[20] The Government and insurers should be held to the same standard.

[19] 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 SHP, 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))).

[20] The CBO agreed. *See* Budget Outlook at 59 (predicting $8 billion in net revenue from RCP).

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

[21] 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.

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.[22]

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 SHP's expectation of annual payment, and it is the only interpretation that is consistent with the RCP's purpose. 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).

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

[22] *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.

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. *See, e.g.*, Order at 2, *Maine Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017), ECF 30 ("There is no indication that the statute means anything other than what it says, namely, that Congress adopted a risk-sharing program operated on a yearly basis.").

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.[23]

[23] *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 . . . .").

HHS's current position that, despite its acknowledgment that the RCP requires full payment to SHP and others, the Government can delay those payments until some indefinite time in the future, if at all, subverts Congress's intent. And to suggest, as HHS has, that QHP issuers of all sizes that sustain significant short-term losses, and 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.

II. THE GOVERNMENT'S LIABILITY DOES NOT DEPEND ON THERE ALSO BEING A DEDICATED SOURCE OF FUNDING FOR THAT LIABILITY.

The Government will likely contend that Section 1342's "shall pay" directive actually means "shall pay" *subject to appropriations*. The Government has posited that Congress never specified an appropriation to fund the RCP and prohibited payment from certain program funds in 2014 and 2015 appropriations riders. This, the Government argues, abrogated the Government's statutory mandate to pay. The Government is wrong.

A. The Government's Liability Does Not Turn on the Availability of a Specific Appropriation.

As discussed above (*supra* at Section I.A), Congress did not limit the Government's RCP liability with any typical words of limitation (*e.g.*, "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 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, SHP 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 statutory promise of payment in 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 argued that because a NAFI is not funded by appropriations, this Court lacks jurisdiction to adjudicate 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 abrogated its own contrary precedent[24] 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 . . .," 28 U.S.C. § 1491(a)(1), was not limited to the subset 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." *Slattery*, 635 F.3d 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 (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments").

Slattery's holding applies with equal force here, even though it specifically addressed jurisdiction over a claim for breach of a NAFI contract, because the Tucker Act 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 as a predicate condition to state a claim under Section 1342 amounts to a second "jurisdictional" test of the very sort rejected in *Slattery*. *See id*. at 1316 (reasoning that Tucker Act jurisdiction is determined by identification of a money-mandating statute and there is no need to identify a specific appropriation for what in essence would amount to a "second waiver" of sovereign immunity (citing *Mitchell v. United States*, 463 U.S. 206, 218 (1983))). The point is this: because Congress did not condition "payments out" on "payments in" (for the reasons explained above), the only limitation on SHP's right to payment on its statutory claim is its ability to

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

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 v. United States*, 114 Ct. Cl. 38, 52 (1949) ("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."). Outside of the Court of Federal Claims, the Government acknowledges this reality and recognizes that, if a plaintiff is successful:

> it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund, 31 U.S.C. § 1304(a). The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund.

Def.'s Mem. In Supp. of Mot. Summ. J. at 11, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (citing *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2191-92 (2012)).

B. In Any Event, Both GAO and the Court in *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 the Government's proposition that CMS had no appropriated funds available to pay 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 would misconstrue black letter fiscal law. 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).[25] 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 '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,

[25] 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.

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 (covering October 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 October 2014, when SHP's participation in 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.

The fact 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 the exchanges were 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 did not modify 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 to do so, 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 repeal or amendment of the RCP).

1. Congress Has Not Amended the RCP.

To date, Congress has neither repealed nor amended the RCP, despite dozens of attempts to do so. *See* Add. B at 3. Through the Spending Laws, Congress curtailed CMS's funding sources to make RCP payments. But that fact is irrelevant to this lawsuit by SHP.

The legal standard for finding that limiting language in appropriations laws vitiated a preexisting statutory right, and thus extinguished Tucker Act relief, is stringent—it is presumed not to happen. While Congress possesses the legal authority to prospectively amend preexisting substantive statutory obligations, it must do so "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted). Moreover, and of direct relevance here, "[t]his rule applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphasis added). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," the statutory instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "[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); *Greenlee Cty.*, 487 F.3d at 877 ("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." (citing *N.Y. Airways*, 369 F.2d at 748)). Restricting appropriations alone, without more, does not amend the underlying legislation. *See Greenlee Cty.*, 487 F.3d at 877; *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation."). 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.[26] Binding 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.*

[26] 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 II.B.

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*, 114 Ct. Cl. at 49-50 ("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 . . . .").

Because the language in the 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," they do not "clearly manifest" an intent to repeal or amend.[27]

Congress knows how to amend or repeal laws it does not like. The stringency of the legal standard ensures that when Congress's actions disturb the settled expectations of private parties induced by the words of a statute after the fact, its intent is clear and manifest. Moreover, 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

[27] 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.

passed the 2015 Spending Law, directly considered two pieces of 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 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 considered modifying or repealing the RCP—and *did not*. But the efforts to do so highlight what is patently clear about the RCP as enacted in 2010, which remains unmodified to date: *its obligation to make "payments out" was not constrained by budget neutrality*. To interpret appropriations bills to have accomplished what substantive 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. Congress interfered with CMS's funding authority to make RCP payments from certain accounts. 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 SHP.[28]

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. *Hill*, 437 U.S. at 190; *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 *New York 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

[28] If Congress *had* modified or repealed the RCP, its actions would be subject to the presumption against retroactivity. *Landgraf v. USI Film Prod.*, 511 U.S. 244, 265-66 (1994).

that Congress impliedly repealed or amended 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 SHP the money to which it is statutorily entitled.[29]

III. THIS COURT CAN GRANT SHP THE RELIEF SOUGHT.

This Court can enter judgment for SHP 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 SHP is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

SHP respectfully requests that its motion for partial summary judgment be granted because, based on the undisputed facts, the Government owes SHP timely annual and complete RCP payments as a matter of law. Specifically, SHP 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.*, $3,110,382.06 (for benefit year 2014) and $5,869,541.98 (for benefit year 2015), totaling $8,979,924.04. Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

[29] The law disfavoring repeal by implication echoes the same principles guiding the anti-retroactivity principle. *See supra* note 28.

Dated: March 22, 2017

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CERTIFICATE OF SERVICE

I certify that on March 22, 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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