No.

IN THE

Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,
Petitioner,

v.

UNITED STATES,
Respondent.

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Federal Circuit

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

1. Given the "cardinal rule" disfavoring implied repeals—which applies with "especial force" to appropriations acts and requires that repeal not be found unless the later enactment is "irreconcilable" with the former—can an appropriations rider whose text bars the agency's use of certain funds to pay a statutory obligation, but does not repeal or amend the statutory obligation, and is thus not inconsistent with it, nonetheless be held to impliedly repeal the obligation by elevating the perceived "intent" of the rider (drawn from unilluminating legislative history) above its text, and the text of the underlying statute?

2. Where the federal government has an unambiguous statutory payment obligation, under a program involving reciprocal commitments by the government and a private company participating in the program, does the presumption against retroactivity apply to the interpretation of an appropriations rider that is claimed to have impliedly repealed the government's obligation?

PARTIES TO THE PROCEEDING BELOW

Petitioner Maine Community Health Options was the appellant in the court of appeals.

Respondent United States was the appellee in the court of appeals.

RULE 29.6 STATEMENT

Petitioner Maine Community Health Options ("Health Options") is a non-profit corporation organized under the laws of Maine, with its principal place of business in Lewiston, Maine. Health Options has no parent corporation, and no publicly held corporation owns 10% or more shares of Health Options.

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PETITION FOR A WRIT OF CERTIORARI

Petitioner Maine Community Health Options ("Health Options") respectfully petitions for a writ of certiorari to review the judgment of the United States Court of Appeals for the Federal Circuit.

OPINIONS BELOW

The Federal Circuit's summary decision is unreported, but found at 729 F. App'x 939, reprinted at App.1a. That decision is controlled by *Moda Health Plan, Inc.* v. *United States*, 892 F.3d 1311 (Fed. Cir. 2018), reprinted at App.31a. The decision of the United States Court of Federal Claims is reported at 133 Fed. Cl. 1 and reprinted at App.89a.

JURISDICTION

The jurisdiction of the Court of Federal Claims was grounded on 28 U.S.C. §1491(a). The Federal Circuit had jurisdiction under 28 U.S.C. §1295(a)(3) and entered judgment on July 9, 2018. That court denied *en banc* review on November 6, 2018. This Court's jurisdiction is conferred by 28 U.S.C. §1254(1).

STATUTORY AND REGULATORY PROVISIONS INVOLVED

Section 1342(a) and (b)(1) of the Affordable Care Act, 42 U.S.C. §18062(a) and (b)(1), is reprinted verbatim at pages 3-4 below. Section 1342 (b)(2) and (c), 42 U.S.C. §18062(b)(2) and (c) are reprinted in the Appendix. The appropriation riders discussed below and cited at page 10, and cited provisions of Title 45 of the Code of Federal Regulations are set out in the Appendix.

STATEMENT

A. Statutory Framework.

The 2010 Affordable Care Act (ACA) sought to induce insurer participation in the health insurance exchanges by mitigating some of the uncertainty associated with insuring formerly uninsured customers. Specifically, to mitigate risk, lower premiums, and induce insurer participation, Section 1342 of the ACA, 42 U.S.C. §18062, established a three-year "risk corridors" program designed "to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government." Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,220 (Mar. 23, 2012). The program was explicitly modeled on a similar program under Medicare Part D, and was to be administered by the U.S. Department of Health and Human Services. It was mandatory for all participating insurers.

Section 1342 apportions to the federal government a specified share of insurer risk in prospectively setting premiums based on anticipated costs, a premium-setting process subject to state regulation. Section 1342 provides that if, at the end of the coverage year, the insurer experienced higher-than-expected allowable costs, the government "shall pay" the insurer part of its excess costs. Conversely, if an insurer experienced lower-than-expected allowable costs, it was required to pay the government a portion of the savings. See ACA §1342(b)(2), 42 U.S.C. §18062(b)(2). In fact, for benefit year 2014, the program's first year, Health Options paid the government $2,045,819.48 arising

from lower-than-expected allowable costs for policies it issued in the individual market.

Section 1342 specifies the terms of the required payments from the government to insurers as follows:

> (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 . . . under part D of title XVIII of the Social Security Act.
>
> (b) PAYMENT METHODOLOGY.—
>
> (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 of the target amount, the Secretary shall pay to the plan an amount equal to 50

percent of the target amount in excess of 103 percent of the target amount; and

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

42 U.S.C. §18062(a)&(b)(1).

B. Petitioner Health Options.

Health Options was founded in response to the ACA's invitation to sell insurance on the newly created exchanges. Given the uncertainty concerning this new market, Health Options relied on Section 1342 in setting premiums and selling coverage on the Maine and New Hampshire exchanges in 2014 and 2015, and Maine alone in 2016.

For 2014, Section 1342 required Health Options to pay the government more than $2 million based on its participation in the individual market, but the government still owes Health Options more

than $200,000 in connection with the small group market for that same benefit year. For benefit year 2015, the government owes Health Options more than $22 million under Section 1342, and for benefit year 2016, more than $35 million.[1]

C. Insurers Set Premiums and Offer Coverage on the ACA Exchanges Before Congress Turns to the Appropriation Process for the ACA.

In all states, premiums are approved by state regulators in the year preceding the year for which insurance is provided. For example, in Maine, premiums are typically approved by state regulators by August. In late fall, providers have "open enrollment" during which time customers sign up for coverage.

In the ordinary course, then, insurers' premium-setting and approval, the offer and sale of coverage on ACA exchanges, and the actual provision of coverage—payment of the enrollees' health care

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[1] HHS calculates the amounts due but unpaid. See CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RC-Issuer-level-Report.pdf; CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf; CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year" (Nov. 15, 2017), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

expenses—take place long before Congress turns to appropriations for any Section 1342 payments for a given year.[2] For example, coverage was sold in 2013 for benefit year 2014; the FY 2015 appropriation pertaining to Section 1342 amounts owed for 2014 was enacted in December 2014, at the end of the benefit year. Similarly, Section 1342 appropriations for 2015 performance (at rates approved in 2014) would be part of the appropriation process for FY 2016, enacted at the end of 2015.

Because a full accounting of costs for a given benefit year is not available immediately at the end of the calendar year, risk corridors payments (owed either to the insurer or to the government) were not calculated or paid until the following year. Thus, HHS did not make Section 1342 payments for 2014 until November 2015, after Health Options had (i) fully performed for 2014, (ii) largely performed for 2015, and (iii) locked in premiums and begun selling policies for 2016.

D. HHS Implementation of Section 1342

In its first regulatory notice setting forth policies and requirements for ACA participation, HHS observed that under Section 1342, payments out (to insurers) were not limited to collections in (from insurers):

> The risk corridors program is not statutorily required to be budget neu-

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[2] See *Moda,* 892 F.3d at 1317-18; *id.* at 1339 (Newman, J., dissenting). With limited exceptions, a provider cannot cancel a policy after it is sold. 45 C.F.R. §147.106(b). A provider offering coverage on an exchange can only cease offering coverage on 180 days' notice. See 45 C.F.R. §147.106(d).

> tral. 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). HHS's approach was consistent with the mandate to model the program after Medicare Part D's similar program, which is not budget-neutral.[3]

In March 2014, HHS explained that notwithstanding its overall responsibility to pay insurers according to the Section 1342 formula over the three-year life of the program, it would administer the program annually in a budget-neutral manner, limiting payments out to amounts collected in.[4] HHS stated that if collections did not reach the level required to fully meet its payment obligations each year, it would pay each insurer pro rata. It would then use the next year's collections to make up payments owed from the prior year. App.131a. Under this approach to annual payments, HHS would not need additional appropriated funds for Section 1342 payments (beyond amounts collected by HHS) during the three-year life of the program.

HHS anticipated that over the life of the program, total collections in would cover required

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[3] See 42 U.S.C. §1395w-115(e)(3)(A)); U.S. Gov't Accountability Off., GAO-15-447, Patient Protection and Affordable Care Act (Apr. 2015) at 14, *available at* http://www.gao.gov/assets/670/669942.pdf ("payments that CMS makes to [insurers] is not limited to [insurer] contributions.").

[4] CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), App.131a.

"payments out." HHS would establish later how to calculate payments "for the final year of the program" if "over the life of the three-year program" collections did not match payments owed. App.133a. Under HHS's approach—as the Government argued it below—HHS's obligations to insurers would not come due until the conclusion of the three-year program. See *Moda,* 892 F.3d at 1339 (Newman, J., dissenting).

The significant point is this: In (1) adopting "budget neutrality" for annual payments, (2) postponing the final accounting for each insurer to the end of the three-year program, and (3) acknowledging that its own ability to pay was subject to appropriations, HHS explicitly, formally, and consistently confirmed that the total amount due an insurer under the Section 1342 formula remained an "obligation[]" of the United States "for which full payment" is owed. See, *e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid . . . as [a] fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added); 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 obliga-

tion of the United States Government for which ***full payment*** is required") (emphases added). This is consistent with the text of Section 1342, which mandates that the government "shall pay."

HHS explicitly reaffirmed this point in testimony to Congress, with specific reference to the appropriation process. See Press Release, Energy and Commerce Committee, The Affordable Care Act on Shaky Ground: Outlook and Oversight (September 14, 2016) (Rep. Griffith: "Does CMS take the position that insurance plans are entitled to be made whole on risk corridor payments even though there's no appropriation to do so?" CMS Acting Administrator Andrew Slavitt: "Yes, it is an obligation of the federal government.").[5]

E. Congress's Failure to Appropriate Funds for Section 1342 Payments.

In December 2014, near the end of the first program year—during the lame-duck session after the 2014 election—Congress enacted its appropriations law for FY 2015, which would potentially allot money to HHS to cover any Section 1342 payments owed for the 2014 benefit year.

That law included a rider holding HHS to its stated intention to limit its annual payments out to collections in. It barred HHS from using its lump sum FY 2015 appropriation for Section 1342 payments:

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[5] *available at* https://archives-energycommerce.house.gov/news-center/press-releases/subhealth-and-suboversight-spotlight-obamacare-s-mounting-failures.

> None of the funds made available by this Act . . . or transferred from other accounts funded by this Act . . . may be used for payments under section 1342(b)(1) of [the ACA].

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227, 128 Stat. 2491 (2014).

As it turned out, Section 1342 amounts collected for 2014 (from insurers that realized excess savings) came nowhere close to what the government owed to insurers that incurred excess costs in 2014.[6] Paying out what it collected in, HHS paid out 12.6% of the total owed, paying each insurer pro rata on that basis.

Similar riders were included in the omnibus appropriation bills for FY 2016 and FY 2017, respectively.[7] HHS, for its part, used collections for benefit years 2015 and 2016 to further pay down what it still owed insurers for 2014, and paid out nothing for 2015 and 2016 amounts it owes.

With the three-year program now over, and with HHS having completed and published its final tallies on what is now due insurers under the Section 1342, Congress has still not appropriated any

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[6] Insurers' unanticipated costs largely resulted from the government's "transitional policy," announced after premiums were set. See *Moda*, 892 F.3d at 1316-17; *id.* at 1331 (Newman, J., dissenting).

[7] Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, §225, 129 Stat. 2624 (2015)); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, §223, 131 Stat. 543 (2017).

money designated to make Section 1342 payments and HHS has not made payment.

F. Proceedings Below.

Health Options and other insurers initially objected to HHS's decision not to make full risk corridors payments annually—and challenged that decision. Insurers' objections were greatly multiplied, however, when the three-year program concluded without Congress having funded the risk corridor obligations that remained unpaid: the "full payment" at the end of three years that HHS acknowledged to be an obligation of the United States.

Dozens of affected insurers pursued cases in the Court of Federal Claims to recover the unpaid amounts. The Tucker Act grants that court exclusive jurisdiction over large-dollar claims against the United States arising, *inter alia*, from statutory payment obligations. See 28 U.S.C. §1491. Judgments of that court are payable from the Judgment Fund, a standing appropriation created by Congress to pay judgments entered against the federal government.

Health Options filed this case in the Court of Federal Claims in August 2016. The Government moved to dismiss. First, it contended that because risk corridors payments were not due annually, the claim would not be ripe until a final accounting after the third year. Second, it argued that despite the "shall pay" text of the statute, Section 1342 was always supposed to be budget neutral and no obligation to pay arose without an appropriation. Finally, it argued that any Section 1342 payment obligation was abrogated by the riders barring HHS from using its annual appropriation for Section 1342 payments.

Court of Federal Claims Decision. The Court of Federal Claims concluded that the claim was ripe. It then held that whatever obligation Section 1342 created was irrelevant because the riders had negated it. See App.90a. Health Options timely appealed.

The Federal Circuit Decisions. After this case was fully briefed on appeal, it was stayed pending disposition of *Moda Health Plan, Inc.* v. *United States*, 17-1994, and *Land of Lincoln Mutual Health Insurance Co.* v. *United States*, 17-1224, cases brought by other insurers, involving the same issues (but decided differently by different judges on the Court of Federal Claims).

In *Moda*, 892 F.3d 1311, all three panel judges agreed that Section 1342, by its plain language ("shall pay"), obligated the government to make the full payments prescribed by the statutory formula. All three rejected the Government's contention that Section 1342, *as enacted*, was to be budget neutral and did not require payments out beyond collections in. *Moda,* 892 F.3d at 1320-21. They held that the absence of an appropriation did not affect the conclusion that Section 1342 created a payment obligation. Following this Court's and its own longstanding precedent, the panel acknowledged that whether a statute obligates the government to pay third parties is distinct from whether Congress appropriated funds to pay those obligations. *Id.* at 1321-22.

Nonetheless, two judges held that the appropriation riders "suspended" the payment obligation. They acknowledged that withholding appropriations from an agency merely limits the agency's ability to pay but does not eliminate the underlying

obligation. "Whether an appropriations bill impliedly suspends or repeals substantive law 'depends on the intention of [C]ongress expressed in the statutes.'" *Id.* at 1323 (quoting *United States* v. *Mitchell*, 109 U.S. 146, 150 (1883)). But the majority viewed this Court's statements—in *Mitchell* and *United States* v. *Langston*, 118 U.S. 389 (1886)—that the basis for repeal must be expressed in the statute, and not inferred from a failure to appropriate, as having been relaxed by later cases. It read this Court's later cases to compel a look beyond the statutory text to find Congress's *intent*, including by examining legislative history. *Id.* at 1323.

As evidence of "intent" here, the majority cited a GAO letter identifying appropriations potentially available to HHS for Section 1342 payments. The riders barred HHS's use of the funds—except, apparently, payments in—that GAO identified as available to HHS for that purpose. The cut-off of HHS access to such funds for annual Section 1342 payments was, of course, consistent with HHS's prior statement that it would administer the program annually in a budget neutral manner and thus required no appropriation beyond what it expected to take in that year.

The panel majority also cited a floor statement by House Appropriations Committee Chairman Rogers concerning the 2015 rider in which he said that HHS, by "regulation," had stated that the program would be budget neutral, and that the rider would prevent HHS from using its annual lump sum appropriation for Section 1342 payments. *Id.* at 1328 (quoting 160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014)).

As to whether this was an implied repeal, the panel majority reasoned:

> What else could Congress have intended? It clearly did not intend to consign risk corridors payments "to the fiscal limbo of an account due but not payable."

Id. at. 1325 (quoting *United States* v. *Will*, 449 U.S. 200, 224 (1980)). The panel majority declined to address the retroactive effect of its interpretation of the riders.

The panel majority held that the riders "suspended" the government's payment obligation. As seen below, "suspend" is a word that Congress has used in statutes to clarify that it intends, *prospectively*, to change the scheduled salary or bonus for an upcoming year. See *Will*, 449 U.S. at 222. As used by the Federal Circuit here, though, it referred to the indefinite cancellation of the obligation to pay insurers based on insurance they provided in the *previous* year. See *Moda,* 892 F.3d at 1329; *Id.* at 1333-34, 1334 n.2 (Newman, J., dissenting).

Judge Newman dissented. She agreed that "the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation." *Id.* at 1333 (Newman, J., dissenting) (quoting *Id.* at 1321). But in her view the majority's decision subverted that rule by holding that a rider that withheld funds from an agency abrogated the statutory payment obligation. Judge Newman went on to explain that the majority's decision was in conflict with *Langston* and other cases holding that failure to appropriate funds to meet

a statutory obligation does not repeal the obligation; the intention to repeal must be expressed in a statute, using "words that expressly or by clear implication modified or repealed the previous law." *Id.* at 1334.

Judge Newman then highlighted that the majority's interpretation of the legislative history could not surmount a second hurdle: the presumption against retroactivity. Insurers had been induced to offer, and had provided, coverage based on the government's statutory commitment to make full payments under Section 1342. Yet we "have received no advice of payments made at the end of 2017 or thereafter." *Id.* at 1339.

After entering judgment in *Moda*, the court entered judgment against Health Options. App.120a. The court later denied Health Options' (and other) petitions for rehearing *en banc*. *Moda Health Plan, Inc.* v. *United States*, 908 F.3d 738 (Fed. Cir. 2018). App.3a. Judge Wallach and Judge Newman dissented. App.11a.

REASONS TO GRANT THE PETITION

The Federal Circuit's Inversion And Rejection Of Two Historic Interpretive Canons Will Negatively Impact The Way The Government Does Business And The Way Law Is Made

The Federal Circuit inverted and rejected basic canons of statutory interpretation, encapsulating core principles, reflected in 150 years of settled law on how courts must address questions of implied repeal and retroactivity, particularly in cases involving appropriation laws. Because these precedent-setting errors are by the Federal Circuit, which has exclusive appellate jurisdiction over ma-

jor financial claims against the federal government, there will be no circuit split because this ruling has national effect. This Court's review is, therefore, necessary to restore the precedents on which both citizens and lawmakers themselves have relied for well more than a century.

The impact of the Federal Circuit's decision on Health Options and other insurers illustrates the importance of consistent adherence to the principles governing implied repeal. In each of the three years during which Section 1342 was in effect, insurers set premiums, offered and sold policies, and provided coverage, in reliance on the plain language of Section 1342, *i.e.*, the Secretary "shall pay to the plan." That language established a mandatory risk-sharing program involving clearly-specified, reciprocal commitments between the government and insurers. It required each insurer to pay the government if the insurer achieved cost savings, but required the government to pay the insurer if costs exceeded estimates. And insurers like Health Options did pay the government as Section 1342 required. But at the end of each program year, Congress failed (and, with the program now ended and the final accounting completed, *has since* failed) to hold up its side of the bargain. As computed by HHS, the total unpaid over three years exceeds $12 billion. See *Moda*, 892 F.3d at 1319. The sums at stake, number of insurers affected, and dozens of cases pending in the Court of Federal Claims directly impacted by this case, crystalizes the practical importance of the Federal Circuit's ruling not merely for this program, but for programs like it.

Yet nothing in the language of the supposed repealers would have alerted legislators that they were being asked to cancel the government's financial obligations to these insurers, let alone to do so after the insurers incurred major financial commitments in reliance on the reciprocal promises to pay.

In financial arrangements with the government, involving reciprocal commitments, companies must be able to rely on the actual words of the statutes under which they perform. They should not have to worry about those commitments being impliedly repealed *sub silentio* by subsequent Congresses in the course of failing to appropriate adequate funds to meet the obligation.

If there is to be a repeal, it should at least be identifiable to the legislators asked to vote on the repealer, and to their constituents who can call upon their representatives to vote "no." That is a fundamental safeguard built into the legislative process and has always been the rule. It is why implied repeals must be expressed in the text of the supposed repealer statute, and why this is especially true in connection with appropriations legislation, and more so still with appropriations legislation having retroactive effect. The decision below, by the appellate court that creates binding precedent for determining the financial obligations of the federal government, revises longstanding legal principles that govern how laws are made and interpreted, and how one does business with the government.

The government's tactic here evokes images of Lucy and the football, with the government as Lucy. And if the shoe were on the other foot, and an

insurer (like the Petitioner) had failed to pay the government what it owed under Section 1342, it is hard to imagine that the government would accept the explanation that no payment need be made simply because the insurer had internally decided not to allot funds to meet its obligation.

Two basic canons of statutory interpretation *should have* guided the Federal Circuit's interpretation of the riders here, but did not.

1. It is a "cardinal rule" that implied repeals are greatly disfavored; Congress's intention to repeal must be "expressed in the statutes,"[8] and when asserted to arise from "irreconcilable conflict" with prior law, that conflict must be "clear and manifest."[9] A subsequent Congress's inaction cannot erase statutes enacted by an earlier Congress. Moreover, the already strong presumption against implied repeal is of "especial force" in considering whether an implied repeal arises from an appropriations bill.[10] The cases have held for more than a century that a refusal to appropriate funds to pay a statutory obligation is not inconsistent with the continuing existence of the obligation.

Even for the federal government, the refusal to pay a debt does not cancel the debt. A refusal to provide funds to an agency prevents the agency from making payments, but leaves the underlying obligation intact. Under modern practice, the unpaid obligation is enforceable in the Court of Federal Claims under the Tucker Act, 28 U.S.C. §1491

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[8] *United States* v. *Mitchell*, 109 U.S. 146, 150 (1883).

[9] *Posadas* v. *Nat'l City Bank*, 296 U.S. 497, 503-04 (1936).

[10] *Will*, 449 U.S. at 221-22.

(and before that, in the United States Claims Court), with any resulting judgment payable from the standing appropriation in the Judgment Fund. See *Slattery* v. *United States*, 635 F.3d, 1298, 1317 (Fed. Cir. 2011) (en banc) (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments.").

The Federal Circuit misread this Court's precedents as having relaxed these rules. Instead of focusing on statutory text, the Federal Circuit read this Court's cases to require it to search for "congressional intent," which it here derived from legislative history that did not even address the point.

Indeed, the court inferred repeal here only by inverting the rule that a failure to appropriate funds to pay an obligation does not cancel the obligation. Rather than ask whether a rider cutting off agency access to funds cancelled the underlying "shall pay" obligation—to which the answer would have to be "No"—the Federal Circuit asked: "What else could Congress have intended?"

And instead of asking whether anything in the *text* of the rider was "irreconcilable" with the continued existence of the obligation, the panel majority set out in search of "intent" from a snippet of legislative history that actually states no intention at all to abrogate any existing statutory obligation. See Part B, *infra*.

This Court should grant certiorari to restore the basic rules that have long governed any inquiry into implied repeal.

2. Equally important, the Federal Circuit panel majority declined to apply, or even acknowledge, the strong presumption against construing statutes to have retroactive effect. That

presumption should have guided its interpretation of the riders here because it is not lightly assumed that Congress has enacted a law designed to extinguish the federal government's statutory obligations to businesses that have relied on those obligations. None of this Court's cases cited by the Federal Circuit addressed subsequent statutes that would apply retroactively if repealer were found.

This Court should grant certiorari to affirm that the presumption against interpreting an act to have retroactive effect applies fully to cases asserting implied repeal, particularly where the government is said to be cancelling its own obligations by failing to appropriate. Indeed, the presumption against retroactivity should apply with extra force when combined with the already strong presumption against implied repeal. See Part A, *infra*.

* * * * *

That the Federal Circuit's decision changes the operative presumptions for determining whether subsequent appropriation measures should be interpreted to abrogate existing government payment obligations retroactively is a compelling reason to grant review. But it bears emphasis that both interpretative canons disregarded by the Federal Circuit embody important understandings about how the government is to conduct business with private entities, and how law is made.

The high bar to implied repeal, and the insistence that repeal be reflected in statutory text, honors the basic right of the governed to look in the statute books to determine what the law is.

Equally important, the high bar to implied repeals protects the legislative process itself. "Steady adherence" to this rule "is important, primarily to

facilitate not the task of judging but the task of legislating. It is one of the fundamental ground rules under which laws are framed." *United States* v. *Hansen*, 772 F.2d 940, 944 (D.C. Cir. 1985) (Scalia, J).

The presumption against implied repeal encapsulates the principle that repeal requires the same process as enactment: a majority of votes in both Houses, and concurrence by (or override of the veto of) the President. If, as here, there is nothing in the text of the supposed repealer that even the most avid supporter of the prior statute would oppose, it should be impossible to find the kind of manifest inconsistency between the two enactments that would warrant a finding of repeal. Indeed, for a court to disregard statutory language in favor of its own intuitions about "intent," drawn from an ambiguous-at-best statement of one legislator, puts the practical power to override existing statutes in the hands of the courts.

Moreover, the foundational presumption against interpreting statutes to have a retroactive effect should apply with special strength in considering claims of implied repeal of government-payment obligations such as those at issue here. Here, those obligations arose from a program under which the government induced businesses to participate. The businesses were statutorily required to pay the government under one set of contingencies, and the government obligated to pay those businesses under another. In a case like this, the failure to apply that presumption allowed the federal government to induce costly action, and extract payments from insurers, but then, after performance, simply by denying funds to the agency, effectively rewrite the law and cancel the obliga-

tion. That is a classic bait-and-switch, and no way for the government, or anyone, to do business.

A. The Federal Circuit's Failure to Apply the Presumption Against Retroactivity Undermines Reliance on the Government's Credit and Credibility.

As demonstrated in Part B, *infra*, the Federal Circuit's decision conflicts with this Court's decisions on implied repeal. Those decisions state that a finding of implied repeal is strongly disfavored, must be expressed in the statute, manifestly so, especially when said to arise from an appropriations act. The Federal Circuit's holding that this Court's cases now focus on "intent," as gleaned from legislative history, rather than statutory language, misreads the Court's cases and, if allowed to stand, will transform the law of implied repeal in cases involving government payments.

But the Federal Circuit's decision sets controlling precedent that is inconsistent with this Court's decisions in a further respect, which bears noting. Each of the three spending riders that the Federal Circuit held to abrogate the government's payment obligation for the years in question were enacted *after* insurers set their premiums and offered, sold, and provided coverage on the ACA exchanges for that year. Indeed, on the Government's own theory, insurers performed for three years on the expectation that the obligation to pay them under Section 1342 would not even come due until the three-year program concluded.

Because Congress does not lightly enact retroactive statutes, a statute ought not be construed to have retroactive effect if "susceptible of any other"

construction. *United States Fid. & Guar. Co* v. *United States*, 209 U.S. 306, 314 (1908). See *Fernandez-Vargas* v. *Gonzales*, 548 U.S. 30, 37 (2006) (no "retroactive effect unless such construction is required by explicit language or by necessary implication") (quoting *United States* v. *St. Louis, S.F. & T.Ry. Co.*, 270 U.S. 1, 3 (1926)); *Landgraf* v. *USI Film Prods.*, 511 U.S. 244, 280 (1994)(no retroactive effect "absent clear congressional intent favoring such a result"). The Federal Circuit panel here instead worked hard to interpret the riders to have precisely the kind of retroactive effect this Court's cases warn against. And it did so on top of the already strong presumption against implied repeal.

Although the retroactivity of the Government's proposed interpretation was squarely raised by the parties, and was a focus of dissent, the panel majority declined to directly address, let alone apply, the presumption against retroactivity here. But ignoring the issue cannot make it disappear.

All the panel majority said on the subject was that the government *owed* no payment until after performance by the insurers. *Moda*, 892 F.3d 1326-27. This was a theory advanced by the Government for why the presumption against retroactivity should not apply.

Retroactivity does not turn on the date payment is due, but instead on when reliance is induced and the obligation incurred. See *id.* at 1339 (Newman, J., dissenting) (abrogating payment obligations after insurers sold insurance on the exchanges impairs rights they possessed by virtue of performance). It thus should have applied here where the insurers set their premiums, offered and sold coverage on the exchanges, committed to pay

the government under Section 1342, and provided coverage in each of the three years the program was in place, *before* Congress addressed appropriations to cover its debts for each of those years.

It is bedrock federal fiscal law that the government can be liable for an obligation prior to, and independent of, when the accountants finally tabulate what is owed for a given fiscal year. See *Molina Healthcare of Cal. Inc.* v. *United States*, 133 Fed. Cl. 14, 38 (2017)[11].

None of this Court's cases cited by the panel majority as the basis for applying a relaxed view of the presumption against implied repeal involved retroactive legislation. To the contrary, in each case, the later enactment put in place a payment scale or limitation, replacing a prior payment method, *before* the work for which the payment was to be made was performed. See Part B.4, *infra*.

This case provides a particularly well-suited vehicle to confirm the importance of retroactivity considerations in connection with claimed repealers. That is because the reliance interest here was not abstract; it rested on reciprocal commitments by the insurers to the government, and the government to insurers. Insurers were induced to provide coverage, and then specifically required to participate in a risk-sharing program under which

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[11] See II GAO, *Principles of Fed. Appropriations Law* (3d ed. 2004) at 7-4 – 7-5, *available at* http://www.gao.gov/legal/redbook/overview (An "obligation arises when the definite commitment is made, even though the actual payment may not take place until a future fiscal year . . . .").

they would have to pay the government under one set of contingencies and the government would have to pay them under another. Businesses in that type of reciprocal relationship with the government should be able to rely on the government's statutory commitment, even when the appropriation to support the government's commitment will be left to a later date. If Congress believes that it is entitled to renege, it should have to do so explicitly, with a statute that says so, not through backdoor appropriation riders, which do not say that at all, but which the courts might still interpret to provide the desired result.

As Judge Newman observed, "[t]he government's access to private sector products and services is undermined if non-payment is readily achieved after performance by the private sector." *Moda*, 908 F.3d. at 741 (Newman, J., dissenting from denial of *en banc* review). See *id.* at 748 (Wallach, J., dissenting from denial of *en banc* review) ("To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promises to pay, severely undermines the Government's credibility as a reliable business partner."). *Cf. Salazar* v. *Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012) ("would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment" if the federal government could not be trusted to honor its promises of payment).

B. The Federal Circuit Has Inverted the Basic Principles Governing Implied Repeal of Government Payment Obligations.

1. The Federal Circuit Has Reversed the Rule That a Subsequent Congress's Refusal to Appropriate Funds Is Not in Irreconcilable Conflict With an Earlier Congress's Decision to Create a Statutory Payment Obligation.

For more than a century and a half, the principles for determining when a subsequent Congress has overridden statutes enacted by a prior Congress have been consistently applied. Those principles establish "fundamental ground rules under which laws are framed." *Hansen*, 772 F.2d at 944. The consistency in their application has long provided clear instruction to the political branches about what is required to repeal the duly-enacted law of a prior Congress.

The "cardinal rule" is that Congress's intention to repeal must "be clear and manifest." *Posadas* v. *Nat'l City Bank*, 296 U.S. 497, 503-04 (1936). "The *whole question* depends on the intention of Congress as *expressed in the statutes*." *Mitchell*, 109 U.S. at 150 (emphases added).

A later law impliedly supersedes an earlier one only if "the later act covers the whole subject of the earlier one and is clearly intended as a substitute," or the two laws are in "irreconcilable conflict." *Posadas*, 296 U.S. at 503.

The presumption against implied repeal is always strong. See *Will*, 449 U.S. at 221-22. But it

"applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *Id.* at 221-22. See *Tenn. Valley Auth.* v. *Hill*, 437 U.S. 153, 190 (1978). "Especial force" is appropriate, *inter alia*, because the question whether funds have been appropriated to an agency to meet an obligation is distinct from whether the obligation exists. An agency's refusal to pay, and Congress's failure to provide funds to an agency to pay, do *not* abrogate a statutory obligation to pay.

With or without an appropriation, the underlying obligation remains. See *Gibney*, 114 Ct. Cl. 38.[12] That obligation may be enforced as the law now provides: by suit in the Court of Federal Claims, with judgments rendered against the government enforceable against the standing appropriation in the Judgment Fund. See *Salazar*, 567 U.S. at 193-95.

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[12] The Claims Court, since replaced (with respect to trial court functions) by the Court of Federal Claims, described its authority in *Gibney*:

> It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them. ... Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate[s] an insufficient amount, or a sufficient amount, or nothing at all, are questions which are vital for the accounting officers, but which do not enter into the consideration of a case in the courts.

114 Ct. Cl. at 52.

These principles are foundational. As the United States Claims Court put it more than a century and a half ago:

> This court, established for the sole purpose of investigating claims against the government, does not deal with questions of appropriations, but with the legal liabilities incurred by the United States under contracts, express or implied, the laws of Congress, or the regulations of the executive departments . . . . That such liabilities may be created where there is no appropriation of money to meet them is recognized in section 3732 of the Revised Statutes.

Collins v. *United States*, 15 Ct. Cl. 22, 35 (1879). When the Claims Court spoke in *Collins*, its duty was to render judgment on the government's obligation, and it remained for the successful claimant to petition Congress to pay the judgment. That last step is now unnecessary because of the Judgment Fund, which is a general appropriation "to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law when . . . payment is not otherwise provided for . . . ." 31 U.S.C. §1304(a).[13] Thus, there is always an appropriation available to pay government debts once it is determined by judgment that money is owed.

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[13] Section 2517 of Title 28 states that, "[E]very final judgment rendered by the United States Court of Federal Claims against the United States shall be paid out of any general appropriation therefor."

The seminal case applying these principles to appropriations laws is *Langston*, 118 U.S. 389, where the Court held that failure to appropriate funds will not negate a payment obligation where no statutory words negate the obligation itself. As concisely put in *Ferris* v. *United States*, 27 Ct. Cl. 542, 546 (1892): "[A]n appropriation *per se* merely imposes limitations upon the Government's own agents." Its "insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties." In *Salazar*, this Court, citing *Ferris,* relied on precisely that principle.

Simply put, the decision not to provide money to an agency to meet a statutory obligation, like an agency decision not to pay, is not in "irreconcilable conflict"[14] with the continued existence of that obligation. See *Salazar*, 567 U.S. at 197 (citing cases and applying the rule). The riders here did not tinker with the underlying obligation. And that fact should have been dispositive here. "[W]hen two statutes are capable of coexistence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective. *Morton* v. *Mancari*, 417 U.S. 535, 551 (1974). The Federal Circuit disregarded that duty. This Court should reestablish it.

In seeking out "intent" not revealed in statutory language or structure, the Federal Circuit undermined a basic aspect of the legislative process. Because the riders by their text addressed only HHS's use of funds, there was no reason for insur-

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[14] See *Posadas*, 296 U.S. at 503-04.

ers, or risk corridors supporters in Congress, or the President, to think that they were abrogating the underlying statutory formula governing Section 1342 payments.

Indeed, HHS had already stated that it would administer annual payments in a budget neutral manner. It would not determine the final tally for any insurer until the conclusion of the three-year program, *i.e.*, not until 2017. There was, therefore, no reason for Congress to appropriate anything more than what HHS sought, which was nothing. At the same time, HHS repeatedly confirmed—including to Congress—that it remained the government's obligation to make "full payments" based on the statutory formula.

To put it in simple terms: For even the most ardent and knowledgeable supporters of the risk corridors program in Congress, there was nothing in the text of spending riders to vote against, or for the President to veto.[15] Thus, it is impossible to see the riders as "irreconcilable" with the underlying Section 1342 statutory obligation.

Under the Federal Circuit's approach, members of a later Congress can slip a repeal past congressional opponents, or at least throw the issue open to the courts, by barring access to appropriations. And they can do so without ever stating an intention to change the underlying obligation.

It is of course true that when the risk corridors debt came due at the end of the three years, and

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[15] Indeed, bills that by their text amended Section 1342 were not enacted, evidencing the legislative hurdles a true repealer faces. See *Moda*, 908 F.3d. at 746 (Wallach, J., dissenting).

the final accounting completed, Congress declined to appropriate money to pay the final tab. But that is an even more unlikely basis for implied repeal. The *inaction* of a subsequent Congress in failing to appropriate funds cannot cancel the duly enacted statute of a prior Congress.

2. The Federal Circuit Has Inverted the Presumption that a Failure to Appropriate Funds to Pay an Obligation Does Not Repeal the Obligation.

Until now, it was settled that a refusal to appropriate funds to an agency restricts what the agency can do, but does not diminish the government's obligations to "other parties" *vis-a-vis* the government. See *Ferris*, 27 Ct. Cl. at 546. But here, facing a rider barring agency access to funds, the court asked:

> What else could Congress have intended? It clearly did not intend to consign risk corridors payment "to the fiscal limbo of an account due but not payable."

Moda, 892 F.3d at 1325 (citing *Will,* 449 U.S. at 224). The Federal Circuit's formulation—looking at a limitation on the agency's use of funds and asking what else could it mean *except* to abrogate the underlying obligation—turns the presumption against implied repeal on its head.

The Federal Circuit's citation to *Will* to support that inversion is misplaced. *Will* did not speak of "fiscal limbo" as a reason to *presume* that Congress must have repealed the substantive obligation when it withheld appropriations. It used the

phrase only *after* finding the intention to "rescind" evident from statutory text, confirmed by four years of unequivocal, authoritative legislative statements. 449 U.S. at 224. No such statutory text exists here. The relevant text here is that of Section 1342 (which established the payment obligation), and that of the rider (which did not even arguably amend or repeal that obligation).

3. The Federal Circuit Has Departed From This Court's Precedents by Misreading This Court's Cases to Demand a Search for Legislative Intent, Notwithstanding the Clear Statutory Text.

The court of appeals cited this Court's salary and bonus decisions as directing it to look past the statutory text and draw some separate conclusion about congressional intent from legislative history. In so doing, the Federal Circuit misread those decisions. This Court's cases on implied repeal always begin, and mostly end, with text. To be sure, those cases have cited legislative history. But in each instance, the text itself revealed the intention to pay salaries in the upcoming year in a manner different from what the earlier statute prescribed. Where cited, legislative history was directly on point, and offered to clear up a minor discrepancy—not to create repeal from unhelpful legislative history.

Mitchell states this Court's rule: Repeal must be "expressed in the statutes." 109 U.S. at 150. *Langston*, 118 U.S. 389, then held that failure to appropriate funds will not negate the government's statutory payment obligation where no statutory words stated such intent. See *Moda*, 892 F.3d at 1334-35 (Newman, J., dissenting).

The panel majority suggested that *Mitchell* and *Langston* have been relaxed by later cases, which—according to the panel majority—focus on "intent" and (as recounted by the Federal Circuit) reflect a willingness to rely on legislative history. *Moda*, 892 F.3d at 1322-25.

But there has been no relaxation, nor could there be. The disfavor associated with implied repeal reflects foundational principles. The salary and bonus cases cited by the Federal Circuit found repeal only when the later statute was facially irreconcilable with the prior statute and, where cited, definitive, on point, legislative history confirmed the repeal.

For example, in *Mitchell* and *Vulte*, the *prior* statute was itself an appropriation act—not a separate substantive statute. It is easy to see that a later appropriation act supersedes a prior one when it describes how payments are to be made in a manner manifestly different from the earlier one. Thus, in *Mitchell*, the basis for paying interpreters in the first statute was replaced with a different basis "plain upon the face of the statute." 109 U.S. at 150. In *United States* v. *Vulte*, 233 U.S. 509 (1914), the first appropriations measure described how bonuses were to be paid; the later stated exceptions.

United States v. *Dickerson*, 310 U.S. 554 (1940), involved an explicit suspension of payments for one of the years at issue. In the others, the statutory language was that "no part of any appropriation contained in this *or any other Act*" shall be used. That language, unlike the riders here, facially bars access to *all* government funds to pay the government's obligation, including (as would be

relevant here, and since its 1956 creation) the Judgment Fund. Moreover, on-point legislative history confirmed the intention to continue *the explicit statutory* suspension of the obligation.

Will was similar. The Court *began* by reinforcing that implied repeals through appropriation bills are especially disfavored. But in four successive years, Congress enacted riders barring automatic cost-of-living salary increases from taking effect. The rider in one year stated in terms that the increase "shall not take effect." 449 U.S. at 207. In the next two, riders barred use of appropriations "by this Act *or any other Act*" the comprehensive language for extending a suspension blessed in *Dickerson*. *Id.* The last year stated simply, funds "shall not be used." *Id.* at 208. So the Court looked to legislative history to see whether the differences in language signified a different intention. The legislative history squarely confirmed that the same intent prevailed throughout those four years: to "preven[t] the automatic cost-of-living pay increase." *Id.* at 223.

The Federal Circuit's effort to liken this case to *Will* was far-fetched. The explicit statutory language and unambiguous legislative history in *Will* looked nothing like what the panel cited here. *Will* is fully consistent with the rule that the intention to repeal must be clear and manifest, expressed in the statute—and the presumption against implied repeal has special force in connection with appropriations laws.

But here, the court of appeals identified nothing in the words or structure of the riders addressing, replacing, or being inconsistent with, the underlying obligations; so, too, the legislative history.

What it cited as the evidence of intent to repeal offered no support at all.

The Federal Circuit's process for discerning "intent" exemplifies why this Court should reaffirm that an unconstrained search for legislative intent, not tied to statutory text, cannot produce a defensible result.

The panel majority cited two things. First, it cited an inquiry to GAO asking what funds were available to HHS to make risk corridor payments. It then read the riders as barring the use of such funds to make Section 1342 payments beyond amounts taken in by HHS under the program. All well and good, but neither GAO's letter, nor the riders, stated that the absence of an appropriation would negate the underlying obligation, and HHS had already made clear that it did not seek to use the withheld funds for Section 1342 payments.

As the decisive evidence of "intent," the panel cited House Appropriations Chairman Rogers' statement on the FY 2015 Rider. He said:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over three year period risk corridors are in effect. The agreement includes new bill language to prevent CMS Program Management appropriation account from being used to support risk corridors payments.

892 F.3d at 1328 (quoting 160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014)).

On its face, this statement characterized an HHS regulatory action, not the effect of the rider on the ACA. As explained by Judge Wallach:

> Even if it is appropriate to look beyond the text of the statutes, the [cited] statement does not support the majority's position. Chairman Rogers did not say that the 2015 *appropriations rider* sought to make the risk corridors program budget neutral; instead, he said that such was the goal of *an HHS regulation* and that the 2015 appropriations rider sought to designate from which funds the payments out may not be made . . . . Chairman Rogers said nothing about the 2015 appropriations rider's effect on the Government's *obligation* to make payments out.

Moda, 908 F.3d at 746 (Wallach, J., dissenting) (emphases in original). Neither the rider, nor the statement, describes any intention to tamper with the underlying statute, or "defeat the rights of other parties." *Ferris*, 27 Ct. Cl. at 546.

Indeed, Chairman Rogers mischaracterized HHS's statements. First, the reference is apparently to a guidance document, not a regulation (See *Moda*, 892 F.3d at 1335). And HHS had not said that the government would never have to pay. It said that it would pay out with collections in, subject to a final accounting after three years. Indeed, HHS's later statements to Congress had squarely invoked the historic rule: Cutting off appropriations to HHS would not diminish the government's obligation to insurers. See Part B.2, *supra*.

In sum, the cited history here does not reflect any intention to tinker with existing statutory obligations to third parties like insurers here.

But even on its own terms, the panel's rhetorical question ("What else could Congress have intended?") only highlights why an inquiry into implied repeal must be based on the statutory language.

The most obvious answer to what "else" Congress could have intended is that it intended what the rider actually says. The rider held HHS to its stated intent pay out in that year only what it took in, with final reconciliation to take place after three years.

Or perhaps some in Congress mistakenly believed that HHS had, in fact, tried by regulation to impose budget neutrality over the program's life, or that Section 1342 required budget neutrality, as the Government unsuccessfully argued below in this case. Or perhaps Congress did not want to take any position on that at all: by refusing to allow HHS to make such payments, it put insurers to their proof, requiring them to demonstrate in court that Section 1342, as enacted, required these payments. Insurers have done so.

That such alternatives exist—and each of them is far more consistent with the text of the riders that the interpretation projected onto the rider by the Federal Circuit—demonstrates why an inquiry into congressional intent not rooted in statutory language cannot properly give rise to a finding of implied repeal.

When this Court has used "intent" to describe the inquiry into whether Congress repealed an ob-

ligation, it has emphasized an intent drawn primarily from the text of the statute itself. But the Federal Circuit has misinterpreted this Court's references to "intent" to mandate that even where the statute does not reveal an irreconcilable conflict with the prior statute, the court must disregard the text and draw some independent conclusion about intent to repeal, as here from the legislative history. This Court has not so held, but the Federal Circuit's rule will now control in cases seeking payment from the government. This Court should grant certiorari to reestablish that in considering implied repeals, statutory text is paramount, and that the presumptions against implied repeal, and against retroactive interpretations, apply with full force.

CONCLUSION

The petition should be granted.

Respectfully submitted.

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February 4, 2019

APPENDIX

APPENDIX A

NOTE: This disposition is nonprecedential.

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2017-2395

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellant,

v.

UNITED STATES,
Defendant-Appellee.

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

Decided: July 9, 2018

STEPHEN JOHN MCBRADY, Crowell & Moring, LLP, Washington, DC, for plaintiff-appellant.

ALISA BETH KLEIN, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC, for defendant-appellee. Also represented by MARK B. STERN, CARLEEN MARY ZUBRZYCKI, CHAD A. READLER.

Before PROST, *Chief Judge,* NEWMAN and
MOORE, *Circuit Judges.*

PROST, *Chief Judge*.

For the reasons stated in our decisions in *Moda Health Plan, Inc. v. United States*, 17-1994, and *Land of Lincoln Mutual Health Insurance Co. v. United States*, 17-1224, and consistent with the statement of appellant Maine Community Health Options, we affirm.

Appellant's motion to enter judgment is denied as moot.

AFFIRMED

APPENDIX B

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

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2017-1994

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MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

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Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

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2017-1224

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LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NON-PROFIT MUTUAL INSURANCE CORPORATION,

Plaintiff-Appellant,

v.

UNITED STATES,

Defendant-Appellee.

———

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00744-CFL, Judge Charles F. Lettow.

2017-2154

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
Plaintiff-Appellant,

v.

UNITED STATES,
Defendant-Appellee.

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00651-LKG, Judge Lydia Kay Griggsby.

2017-2395

MAINE COMMUNITY HEALTH OPTIONS,
Plaintiff-Appellant,

v.

UNITED STATES,
Defendant-Appellee.

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

ON PETITIONS FOR REHEARING EN BANC

STEVEN ROSENBAUM, Covington & Burling LLP, Washington, DC, filed a petition for rehearing en banc for plaintiff-appellee in 2017-1994. Also represented by BRADLEY KEITH ERVIN; CAROLINE BROWN, PHILIP PEISCH, Brown & Peisch PLLC, Washington, DC.

DANIEL P. ALBERS, Barnes & Thornburg LLP, Chicago, IL, filed a petition for rehearing en banc for plaintiff-appellant in 2017-1224. Also represented by SCOTT E. PICKENS, Washington, DC; JONATHAN MASSEY, Massey & Gail LLP, Washington, DC.

LAWRENCE SHER, Reed Smith LLP, Washington, DC, filed a combined petition for panel rehearing and rehearing en banc for plaintiff-appellant in 2017-2154. Also represented by KYLE RICHARD BAHR, JAMES CHRISTOPHER MARTIN, CONOR MICHAEL SHAFFER, COLIN E. WRABLEY, Pittsburgh, PA.

STEPHEN JOHN MCBRADY, Crowell & Moring, LLP, Washington, DC, filed a petition for rehearing en banc for plaintiff-appellant in 2017-2395. Also represented by CLIFTON S. ELGARTEN, SKYE MATHIESON, DANIEL WILLIAM WOLFF.

ALISA BETH KLEIN, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC, filed a response to the petitions for defendant-appellee in 2017-1224, 2017-2154, 2017-2395 and defendant-appellant in 2017-1994. Also represented by JOSEPH H. HUNT, MARK B. STERN, CARLEEN MARY ZUBRZYCKI.

WILLIAM LEWIS ROBERTS, Faegre Baker Daniels LLP, Minneapolis, MN, for amici curiae Association for Community Affiliated Plans, Alliance of Community Health Plans in 2017-1994. Also represented by

JONATHAN WILLIAM DETTMANN, NICHOLAS JAMES NELSON.

STEVEN ALLEN NEELEY, JR., Husch Blackwell LLP, Washington, DC, for amicus curiae National Association of Insurance Commissioners in 2017-1994. Also represented by KIRSTEN A. BYRD, Kansas City, MO.

URSULA TAYLOR, Strategic Health Law, Chapel Hill, NC, for amicus curiae Blue Cross Blue Shield Association in 2017-1994. Also represented by SANDRA J. DURKIN, Butler Rubin Saltarelli & Boyd LLP, Chicago, IL.

BENJAMIN N. GUTMAN, Oregon Department of Justice, Salem, OR, for amici curiae State of Oregon, State of Alaska, State of California, State of Connecticut, State of Delaware, State of Hawaii, State of Kentucky, State of Maryland, State of Massachusetts, State of Minnesota, State of New Mexico, State of North Carolina, State of Pennsylvania, State of Rhode Island, State of Vermont, State of Washington, State of Wyoming, District of Columbia in 2017-1994. Also represented BY ELLEN F. ROSENBLUM. State of Oregon also represented by PEENESH SHAH.

LESLIE BERGER KIERNAN, Akin, Gump, Strauss, Hauer & Feld, LLP, Washington, DC, for amicus curiae America's Health Insurance Plans in 2017-1994, 2017-1224. Also represented by ROBERT K. HUFFMAN, PRATIK A. SHAH; RUTHANNE MARY DEUTSCH, HYLAND HUNT, Deutsch Hunt PLLC, Washington, DC; RALPH C. NASH, George Washington University Law School, Washington, DC.

STEPHEN A. SWEDLOW, Quinn Emanuel Urquhart & Sullivan, LLP, Chicago, IL, for amici curiae Health Republic Insurance Company, Common Ground Healthcare Cooperative, Kate Bundorf, Scott Harrington,

Mark Pauly, Michael Chernew, Thomas McGuire, Leemore Dafny, Kosali Simon in 2017-1224. Amicus curiae Health Republic Insurance Company also represented by J. D. HORTON, ADAM WOLFSON, Los Angeles, CA.

Before PROST, *Chief Judge*, NEWMAN, LOURIE, DYK, MOORE, REYNA, WALLACH, TARANTO, CHEN, HUGHES, and STOLL, *Circuit Judges*.[*]

NEWMAN, *Circuit Judge*, with whom WALLACH, *Circuit Judge*, joins, dissents from the denial of the petitions for rehearing en banc.

WALLACH, *Circuit Judge*, with whom NEWMAN, *Circuit Judge*, joins, dissents from the denial of the petitions for rehearing en banc.

PER CURIAM.

ORDER

Appellee Moda Health Plan, Inc. and appellants Land of Lincoln Mutual Health Insurance Company and Maine Community Health Options each filed petitions for rehearing en banc. Appellant Blue Cross and Blue Shield of North Carolina filed a petition for panel rehearing and rehearing en banc. A response to the petitions was invited by the court and filed by the United States. Several motions for leave to file amici curiae briefs were filed and granted by the court. The petitions for rehearing, response, and amici curiae briefs were first referred to the panel that heard the appeals, and thereafter to the circuit judges who are in regular active service. A poll was requested, taken, and failed.

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[*] Circuit Judge O'Malley did not participate.

Upon consideration thereof,

IT IS ORDERED THAT:

The petitions for panel rehearing are denied.

The petitions for rehearing en banc are denied.

The mandates of the court will issue on November 13, 2018.

FOR THE COURT

November 6, 2018
Date

/s/ Peter R. Marksteiner
Peter R. Marksteiner
Clerk of Court

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2017-1994

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Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

NEWMAN, *Circuit Judge*, with whom WALLACH, *Circuit Judge*, joins, dissenting from denial of the petition for rehearing en banc.

The judiciary's role is to assure fidelity to law and to the Constitution. The Federal Circuit has a special responsibility as a national court, for no other circuit court is in our jurisdictional loop. Thus when questions of national impact reach us, it devolves upon us to bring the full potential of the court to bear.

The national impact of these health insurance cases, coupled with the role of "appropriations riders" as a legislative tool, led to a split panel decision; and the ensuing requests for reconsideration have been accompanied by amicus curiae briefs on behalf of the insurance industry, state governments, economists and other scholars, and the public, advising us on the law, the Constitution, the legislative process, and the national interest. From the court's denial of rehearing en banc, I respectfully dissent.

The facts are simple; the principle large. The critical question concerns the methods by which the government deals with non-governmental entities that carry out legislated programs. Here, in order to persuade the nation's health insurance industry to provide insurance to previously uninsured or uninsurable persons, and thus to take insurance risks of unknown dimension, the Affordable Care Act[1] provided that insurance losses over a designated percentage would be reimbursed, and comparable profits would be turned over to the government—the "risk corridors" program.

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[1] Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010).

With this statutory commitment that the government "shall pay," 42 U.S.C. § 18062(b), the nation's insurance industry provided the designated health insurance. However, when large losses were experienced by some carriers, the government refused to appropriate the funds to pay the statutory shortfall, and required that existing funds not be used for this purpose. Thus the insurers, who had performed their part of the bargain, were denied the promised compensation. My colleagues now ratify that denial.

This is a question of the integrity of government. "It is very well to say that those who deal with the Government should turn square corners. But there is no reason why the square corners should constitute a one-way street." *Fed. Crop Ins. Corp. v. Merrill*, 332 U.S. 380, 387–88 (1947) (Jackson, J., dissenting); *see also* 48 C.F.R. § 1.102(b)(3) ("The Federal Acquisition System will . . . [c]onduct business with integrity, fairness, and openness."). Our system of public-private partnership depends on trust in the government as a fair partner. And when conflicting interests arise, assurance of fair dealing is a judicial responsibility.

I have previously elaborated on the violations of law and legislative process that apparently are ratified by the panel majority, *see Moda Health Plan, Inc. v. United States,* 892 F.3d 1311, 1331–40 (Fed. Cir. 2018) (Newman, J., dissenting). On these petitions for rehearing en banc, many amici curiae have provided advice. For example, America's Health Insurance Plans, a national association of the insurance industry, states:

> The panel majority's opinion, however, now makes it a risky business to rely upon the government's assurances. That deals a crippling blow to health insurance providers' business relationships with the government,

> which depend upon the providers' ability to trust that the government will act as a fair partner.

Br. of America's Health Ins. Plans, Inc. as Amicus Curiae in Supp. of Reh'g En Banc at 3, Aug. 20, 2018, ECF No. 111.

The amici report that this government action has caused significant harm to insurers who participated in the Affordable Care Act program. The National Association of Insurance Commissioners informs the court that "only six of the 24 CO-OPs operating at peak participation were still in business," and that the government's refusal to make the promised payments "transformed the Exchanges from promising to punitive for the insurance industry." Br. of Amicus Curiae The Nat'l Ass'n of Ins. Comm'rs in Supp. of Pl.-Appellee at 12, 14, Aug. 28, 2017, ECF No. 51. The Court of Federal Claims put it plainly, that the government's position that it can renege on its legislated and contractual commitments "is hardly worthy of our great government." *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 466 (2017).

In the national interest, there is even more at stake than these promises to the health insurance industry. The government's access to private sector products and services is undermined if non-payment is readily achieved after performance by the private sector. The Court has stated that "[i]f the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191–92 (2012).

Our national strength is our government ruled by law. The implementation of that rule has been reinforced in history: "It is as much the duty of Government to render prompt justice against itself in favor of citizens as it is to administer the same between private individuals." Abraham Lincoln, First Annual Message to Congress (Dec. 3, 1861), *reprinted in* James D. Richardson, A Compilation of the Messages and Papers of the Presidents 1789-1897, vol. VI 44, 51 (1897).

"It is emphatically the province and duty of the judicial department to say what the law is." *Marbury v. Madison*, 5 U.S. (1 Cranch) 137, 177 (1803). At a minimum, this court should review this matter en banc. From the denials of rehearing, I respectfully dissent.

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Appeal from the United States Court of Federal Claims in No. 1:16-cv-00967-EGB, Senior Judge Eric G. Bruggink.

WALLACH, *Circuit Judge*, with whom NEWMAN, *Circuit Judge*, joins, dissenting from the denial of the petition for rehearing en banc.

This case involves the obligation of Appellant United States ("the Government") to make so-called "risk corridors payments" to providers of certain health insurance plans, with the payments designed to help insurers mitigate risk when joining the new healthcare exchanges created by the Patient Protection and Affordable Care Act ("ACA"). *See* Pub. L. No. 111-148, 124 Stat. 119 (2010). The panel majority holds that, although it agrees with Appellee Moda Health Plan, Inc. ("Moda") that "the plain language of section 1342 [of the ACA, i.e., 42 U.S.C. § 18062 (2012)] created an obligation of the [G]overnment to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program," *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1322 (Fed. Cir. 2018), Congress repealed or suspended the Government's obligation to make the risk corridors payments by subsequently enacting *riders to appropriations bills*, *see id.* at 1322, 1331. However, the majority's holding regarding an implied repeal of the Government's obligation cannot be squared with Supreme Court precedent, which states that "[t]he doctrine disfavoring repeals by implication applies with full vigor when the subsequent legislation is an *appropriations* measure." *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978) (internal quotation marks, ellipsis, and citations omitted). Because I believe the appropriations riders did not impliedly repeal the Government's obligations to make risk corridors payments, I respectfully dissent from the denial of the petition for rehearing en banc.

DISCUSSION

I. The Government Is Legally Obligated to Make Risk Corridors Payments

Section 1342(a) of the ACA provides that the Secretary of the U.S. Department of Health and Human Services ("HHS")

> shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan [("QHP")] 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.

42 U.S.C. § 18062(a). The ACA provides a statutory formula whereby HHS receives "[p]ayments in" from QHP issuers that have excess profits and makes certain "[p]ayments out" to QHP issuers with excess losses. *Id.* § 18062(b)(1), (2). "Because insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new [ACA] exchanges, insurers faced significant risk if they elected to offer plans in these exchanges," and the risk corridors program was "designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk." *Moda*, 892 F.3d at 1314; *see id.* at 1315 ("The risk corridors program permitted issuers to lower premiums by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." (internal quotation marks, brackets, and citation omitted)). HHS explained "[t]he risk corridors program is not statutorily required to be budget neutral . . . . HHS will remit payments as required under [§] 1342." *Patient Protection and*

Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013).

Moda, for example, began participating in the health care exchanges as an issuer of QHPs in 2014. J.A. 61–62. As of March 2017, Moda was owed the following payments out under the risk corridors program: "$75,879,282.72 for benefit year 2014 and $133,951,163.07 for benefit year 2015, for a total of $209,830,445.79." J.A. 41 (Joint Status Report); *see* J.A. 44 (entering judgment, by Court of Federal Claims, for the total amount).

I agree with the majority that § 1342 obligates the Government to make risk corridors payments. I begin with the plain language of § 1342. *See BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (providing that statutory interpretation "begins with the statutory text"); *see also Sandifer v. U.S. Steel Corp.*, 571 U.S. 220, 227 (2014) ("It is a fundamental cannon of statutory construction that . . . words will be interpreted as taking their ordinary, contemporary, common meaning." (internal quotation marks and citation omitted)). Section 1342 uses the word shall to define HHS's risk corridors obligations. *See* 42 U.S.C. § 18062(a) (reciting that HHS "*shall* establish and administer a program of risk corridors" (emphasis added)), (b)(1) (dictating that HHS "*shall* provide under the program" certain payments out (emphasis added)), (b)(1)(A) (stating that when "a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, [HHS] *shall pay* to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount" (emphasis added)), (b)(1)(B) (stating that when "a participating plan's allowable

costs for any plan year are more than 108 percent of the target amount, [HHS] *shall pay* to the plan 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" (emphasis added)).

The word shall typically sets forth a command. *See* 1A N. Singer & J. Singer, Sutherland on Statutes and Statutory Construction § 32A:11 (7th ed. 2009) ("The use of the word [shall] as a command is now firmly fixed, both in common speech, in the second and third persons, and in legal phraseology."). "Dictionaries from the era of . . . enactment," *Sandifer*, 571 U.S. at 228, establish that shall generally imposes a mandatory duty, *see Shall*, *Black's Law Dictionary* (9th ed. 2009) (defining shall as "[h]as a duty to; more broadly, is required to" and explaining "[t]his is the mandatory sense that drafters typically intend and that courts typically uphold"); *Shall*, *Webster's New World College Dictionary* (4th ed. 2009) (explaining that shall is often "used . . . to express determination, compulsion, obligation, or necessity"). Although the "circumstances, or the context of an act" may indicate that the word shall is to be interpreted as "merely permissive, rather than imperative," Sutherland § 32A:11, nothing in § 1342 or the ACA indicates that the use of the word shall in relation to the Government's obligation to make risk corridors payments was intended to be interpreted in the permissive sense, rather than the imperative, *see* 42 U.S.C. § 18062. *See generally* Pub. L. No. 111-148, 124 Stat. 119. Indeed, the Supreme Court has routinely treated the word shall as an imperative. *See SAS Inst. Inc. v. Iancu*, 138 S. Ct. 1348, 1352 (2018) ("The word 'shall' generally imposes a nondiscretionary duty . . . ."); *Kingdomware Techs., Inc. v. United States*, 136 S. Ct. 1969, 1977 (2016) ("Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a

requirement."); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) ("[T]he mandatory 'shall[]' . . . normally creates an obligation impervious to judicial discretion." (citation omitted)). Therefore, the plain language of § 1342 requires HHS to make certain payments out in accordance with the statutory formula provided therein. *See* 42 U.S.C. § 18062(b)(1).

Section 1342 establishes this duty without respect to budgetary considerations, such as achieving budget neutrality or availability of appropriations. *See id.* § 18062; *see also Greenlee Cty. v. United States*, 487 F.3d 871, 878 (Fed. Cir. 2007) (providing a situation where a statute subjected Government liability for payments to the county to amounts appropriated by Congress). Therefore, as the panel majority found, the statutory text unambiguously obligates the Government to make the full risk corridors payments. *See Moda*, 892 F.3d at 1322 ("We conclude that the plain language of [§] 1342 *created an obligation* of the [G]overnment to pay participants in the health benefit exchanges *the full amount* indicated by the statutory formula for payments out under the risk corridors program." (emphases added)).

II. The Appropriations Riders Did Not Impliedly Repeal the Government's Obligation

"As a general rule, repeals by implication are not favored. This 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) (emphases added) (internal quotation marks and citations omitted). "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883). The Supreme Court

looks for "words that expressly, or by clear implication, modified or repealed the previous law." *United States v. Langston*, 118 U.S. 389, 394 (1886).

When Congress passed an appropriations bill to HHS in December 2014 for fiscal year 2015, it included an appropriations rider stating:

> *None of the funds* made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, *may be used for payments* under [§] 1342(b)(1) . . . (relating to risk corridors).

Consolidated and Further Continuing Appropriations Act, 2015 ("FY 2015 Appropriations"), Pub. L. No. 113-235, div. G, § 227, 128 Stat. 2130, 2491 (emphases added). Appropriations riders for fiscal years 2016 and 2017 included identical language. Consolidated Appropriations Act, 2017 ("FY 2017 Appropriations"), Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624.[1]

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[1] The majority's holding was limited to the appropriations riders for fiscal years 2015 and 2016 because the appropriations rider for fiscal year 2017 "had not yet been enacted before this case completed briefing." *Moda*, 892 F.3d at 1322 n.4. The majority explained that "[t]he [G]overnment's argument [for an implied repeal] applies equally" to the 2017 appropriations rider. *Id.* That appropriations rider became law in May 2017. *See generally* FY 2017 Appropriations. The majority's opinion, therefore, has the effect of repealing risk corridor payments for each of the years obligated by § 1342, i.e., 2014–2016. *See* 42 U.S.C. § 18062(a).

These appropriations riders do not clearly establish that Congress intended to repeal the Government's obligation to make risk corridors payments. The riders do not address *whether the obligation remains payable* and, at most, only address *from whence the funds to pay the obligation may come. See, e.g.*, FY 2015 Appropriations § 227. The present case is similar to *Langston*, in which the Supreme Court held that "a statute fixing the annual salary of a public officer at a named sum, without limitation as to time," was not "deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount . . . and which contained no words that expressly, or by clear implication, modified or repealed the previous law." 118 U.S. at 394. There, the claimant held a position, for which a statute indicated a person serving in that position "shall be entitled to a salary of $7,500 a year." *Id.* at 390 (internal quotation marks and citation omitted). While in some subsequent appropriations acts Congress appropriated the full $7,500, Congress appropriated only $5,000 for that particular position in appropriations acts for fiscal years 1883 and 1884. *See id.* at 391. The Supreme Court held the claimant was still due $7,500 for 1883 and 1884 because the salary "was originally fixed at the sum of $7,500," and "[n]either of the acts appropriating $5,000 . . . contains any language to the effect that such sum shall be 'in full compensation' for those years" nor did either contain "an appropriation of money 'for additional pay,' from which it might be inferred that [C]ongress intended to repeal the act fixing his annual salary at $7,500." *Id.* at 393. The Supreme Court found it "not probable that [C]ongress" would "make a permanent reduction of [claimant's] salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel the

courts to say that harmony between the old and the new statute was impossible." *Id.* at 394.

Similarly, the appropriations riders at issue, enacted after Congress imposed the risk corridors payment obligation in the ACA, appropriated a lower amount. The riders *do not state* that this lower amount serves as full satisfaction of the Government's obligation under § 1342. *See, e.g.*, FY 2015 Appropriations § 227. Nor do the appropriations riders cut off *all* sources of funding for the risk corridors program. *See, e.g.*, *id.* (specifying particular funds from which risk corridors payments may not be made). In *Gibney v. United States*, our predecessor court held that appropriations language similar to the riders here was "a mere limitation on the expenditure of a particular fund," and "d[id] not have the effect of either repealing or even suspending an existing statutory obligation any more than the failure to pay a note in the year in which it was due would cancel the obligation stipulated in the note." 114 Ct. Cl. 38, 50–51 (1949); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 752 (Ct. Cl. 1966) (explaining "the failure of Congress . . . to appropriate or make available sufficient funds does not repudiate the obligation").

Akin to the situation here, the appropriations bill in *Gibney* stated "*none of the funds* appropriated for the Immigration and Naturalization Service *shall be used to pay* compensation for overtime services." 114 Ct. Cl. at 48 (emphases added); *see* FY 2015 Appropriations § 227 ("*None of the funds* made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, *may be used*

for payments under [§] 1342(b)(1) . . . ." (emphases added)); *see also Beer v. United States*, 696 F.3d 1174, 1185 (Fed. Cir. 2012) (en banc) (holding that a 2001 amendment to an appropriations bill did not impliedly repeal a 1989 law that guaranteed judicial cost of living adjustments). Because I believe § 1342 is "reasonabl[y] constru[ed]" as setting forth the Government's obligation to make risk corridors payments out and the appropriations riders as simply designating from which funds the payments out may not be made, I believe we must "give effect to the provisions of each," rather than finding the statutory obligation impliedly repealed. *Langston*, 118 U.S. at 393.

Although the majority points to a single statement made during legislative debates for the 2015 appropriations rider to support its position that each appropriations rider intended to make the risk corridors program budget neutral, *see Moda*, 892 F.3d at 1325, this statement hardly provides the requisite clear legislative intent for an implied repeal. Then-Chairman of the House Committee on Appropriations Harold Rogers stated:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent the [Centers for Medicare and Medicaid Services] Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). However, the Supreme Court has indicated "[t]he whole question depends on the intention of [C]ongress

as expressed in the statutes." *Mitchell*, 109 U.S. at 150. It is not appropriate to rely on Chairman Rogers's statement to inject ambiguity into the appropriations riders' plain meaning. *See Gibney*, 114 Ct. Cl. at 53 ("We must take what the [appropriations bill] says and not what one member of [Congress] might have been under the impression it contained."). Even if it is appropriate to look beyond the text of the statutes, the above statement does not support the majority's position. Chairman Rogers did not say that the 2015 *appropriations rider* sought to make the risk corridors program budget neutral; instead, he said that such was the goal of *an HHS regulation* and that the 2015 appropriations rider sought to designate from which funds the payments out may not be made. *See* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). Chairman Rogers said nothing about the 2015 appropriations rider's effect on the Government's *obligation* to make payments out. *See id.*

If anything, I believe it is more probative of legislative intent that Congress, eight months before it passed the first appropriations rider, introduced legislation to repeal the Government's obligation to make full risk corridors payments by requiring budget neutrality, but failed to pass that legislation. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, § 2, 113th Cong. (2014) (proposing to add to § 1342 a subsection that states that HHS "shall ensure that payments out and payments in . . . are provided for in amounts that [HHS] determines are necessary to reduce to zero the cost"); *see also Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962) ("When the repeal of a highly significant law is urged upon [Congress] and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide

by that decision."), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union, Local 770*, 398 U.S. 235 (1970). Less than two months after enacting the first of the appropriations riders, Congress considered but did not pass legislation solely meant to make the risk corridors program budget neutral. *See* Taxpayer Bailout Protection Act, H.R. 724, § 2, 114th Cong. (2015) (providing that payments out should not exceed payments in); Taxpayer Bailout Protection Act, S. 359, § 2, 114th Cong. (2015) (same). While we are generally "reluctant to draw inferences from the failure of Congress to act," *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 220 (1983), I understand these facts to support a finding that Congress did not intend the appropriations riders either to repeal the Government's obligation to make risk corridors payments or to decrease the Government's exposure to liability by temporarily capping the amount of payments by making the program budget neutral, *see id.* (stating "it would . . . appear improper for us to give a reading to [an a]ct that Congress considered and rejected").

While the majority attempts to cast its opinion as holding "that Congress enacted *temporary* measures capping risk corridor payments out at the amount of payments in," *Moda*, 892 F.3d at 1327 (emphasis added), this characterization does not withstand scrutiny. Under the majority's holding, the appropriations riders have substantively altered the Government's § 1342 obligations for *every year* of the risk corridors program by no longer requiring the Government to make payments out subject to the statutory formula. *See id.* at 1322; *see also* 42 U.S.C. § 18062(b)(1) (providing the statutory formula for payments out). For instance, in the case of Moda, the Government has not made the full payments out in 2014, as calculated by the formula,

and has not made *a single* payment out in 2015. *See Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 448 (2017). Accordingly, I believe the majority erred in its consideration of the appropriations riders.

III. This Case Raises an Exceptionally Important Issue Regarding the Government's Reliability as an Honest Broker

The majority's holding casts doubt on the Government's continued reliability as a business partner in all sectors. The Government induced health insurance providers to enter the risky health exchanges through, inter alia, the risk corridors program. *See* Bundorf et al. Amicus Br. ("Economists & Professors Amicus Br.")[2] 3–7, *Land of Lincoln Health Ins. Co. v. United States*, No. 2017-1224, ECF No. 188. As the majority acknowledges, "[b]ecause insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new [ACA] exchanges, insurers faced significant risk if they elected to offer plans in these exchanges." *Moda*, 892 F.3d at 1314. The risk corridors program was "designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk" by "permit[ting] issuers to lower premiums by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." *Id.* at 1314, 1315 (internal quotation marks, brackets, and citation omitted). Therefore, "[b]y reducing the risk of participating in a newly created market, the Government encouraged firms to enter a new market[, i.e., the health care exchanges,] characterized by considerable uncertainty

[2] This amicus brief was submitted by "distinguished economists and professors of health policy, economics, and management." Economists & Professors Amicus Br. 1.

in the risk profile of potential enrollees (and, thus, profitability).” Economists & Professors Amicus Br. 6.

QHP issuers, like Moda, entered the health care exchanges and set premiums with the belief that they would receive risk corridors payments, *see* J.A. 61–62, and Congress, subsequently, passed the relevant appropriations riders, *see, e.g.*, FY 2015 Appropriations § 227. To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government’s credibility as a reliable business partner. For example, the ACA also “clearly and unambiguously imposes an obligation on . . . HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans,” *Montana Health Co-Op v. United States*, No. 18-143C, 2018 WL 4203938, at *5 (Fed. Cl. Sept. 4, 2018), but the Government refused to make those payments for reasons similar to those here, *see id.* at *1.

The Government’s refusal to honor its obligation has important consequences. “Based on the Government’s own official calculations, QHP [i]ssuers are owed about $12.3 billion dollars for the 2014–2016 plan years.” Health Republic Ins. Co. & Common Ground Healthcare Cooperative’s Amicus Br. (“Health Republic Amicus Br.”) 9, *Land of Lincoln Health Ins. Co. v. United States*, No. 2017-1224, ECF No. 189; *see Moda*, 892 F.3d at 1319 (acknowledging that the Government’s shortfall of payments out equaled “more than $12 billion”). These shortfalls have negatively affected not only health insurance providers but also health insurance recipients. For instance, by the end of 2016, eighteen of twenty-four health cooperatives that were participating in the exchanges were no longer in business because a lack of capital, in part, due to the lack of

risk corridors payments. Nat'l Ass'n of Ins. Comm'rs Amicus Br. 12–13, *Moda Health Plan, Inc. v. United States*, No. 2017-1994, ECF No. 51. Several health insurance companies "withdrew from the ACA exchanges entirely," and others still offering plans "had to compensate for this uncertainty in payment by offering health plans at *higher prices* than before." Health Republic Amicus Br. 11 (emphasis added). These consequences, which impact the cost of health care insurance for virtually all Americans, make this case fit for en banc consideration.

CONCLUSION

Rather than faithfully applying Supreme Court and our precedent disfavoring repeals by implication, *see, e.g.*, *Tenn. Valley Auth.*, 437 U.S. at 190, the majority holds that Congress *clearly* manifested its intent to repeal the Government's statutory obligation to make risk corridors payments pursuant to the ACA's formula, *see* 42 U.S.C. § 18062, through appropriations riders. I believe this conclusion is unsound. Thus, I respectfully dissent from the court's denial of the petition for rehearing en banc as to all of the above-captioned cases.

APPENDIX C

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2017-1994

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

Decided: June 14, 2018

STEVEN ROSENBAUM, Covington & Burling LLP, Washington, DC, argued for plaintiff-appellee. Also represented by SHRUTI CHAGANTI BARKER, CAROLINE BROWN, PHILIP PEISCH.

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THOMAS G. HUNGAR, Office of General Counsel, United States House of Representatives, Washington, DC, for amicus curiae United States House of

Representatives. Also represented by KIMBERLY HAMM, TODD B. TATELMAN.

WILLIAM LEWIS ROBERTS, Faegre Baker Daniels LLP, Minneapolis, MN, for amicus curiae Association for Community Affiliated Plans. Also represented by JONATHAN WILLIAM DETTMANN, KELLY J. FERMOYLE, NICHOLAS JAMES NELSON.

STEVEN ALLEN NEELEY, JR., Husch Blackwell LLP, Washington, DC, for amicus curiae National Association of Insurance Commissioners.

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URSULA TAYLOR, Butler Rubin Saltarelli & Boyd LLP, Chicago, IL, for amicus curiae Blue Cross Blue Shield Association. Also represented by SANDRA J. DURKIN.

BENJAMIN N. GUTMAN, Oregon Department of Justice, Salem, OR, for amici curiae State of Oregon, State of Alaska, State of Connecticut, State of Hawaii, State of Illinois, State of Iowa, State of Maryland, State of Massachusetts, State of Minnesota, State of New Mexico, State of North Carolina, State of Pennsylvania, State of Rhode Island, State of Vermont, State of Virginia, State of Washington, State of Wyoming, District of Columbia.

Before PROST, *Chief Judge,* NEWMAN and MOORE, *Circuit Judges.*

Opinion for the court filed by *Chief Judge* PROST.

Dissenting opinion filed by *Circuit Judge* NEWMAN.

PROST, *Chief Judge*.

A health insurer contends that the government failed to satisfy the full amount of its payment obligation under a program designed to alleviate the risk of offering coverage to an expanded pool of individuals. The Court of Federal Claims entered judgment for the insurer on both statutory and contract grounds. The government appeals. We reverse.

BACKGROUND

This case concerns a three-year "risk corridors" program described in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified at 42 U.S.C. §§ 18001 et seq.) ("ACA"), and implemented by regulations promulgated by the U.S. Department of Health and Human Services ("HHS"). The case also concerns the bills that appropriated funds to HHS and the Centers for Medicare & Medicaid Services ("CMS") within HHS for the fiscal years during which the program in question operated. We begin with the ACA.

I. The ACA

Among other reforms, the ACA established "health benefit exchanges"—virtual marketplaces in each state wherein individuals and small groups could purchase health coverage. 42 U.S.C. § 18031(b)(1). The new exchanges offered centralized opportunities for insurers to compete for new customers. The ACA required that all plans offered in the exchanges satisfy certain criteria, including providing certain "essential" benefits. *See* 42 U.S.C. §§ 18021, 18031(c).

Because insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new exchanges,

insurers faced significant risk if they elected to offer plans in these exchanges. The ACA established three programs designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk corridors. 42 U.S.C. §§ 18061–63. This case concerns the risk corridors program.

Section 1342 of the ACA directed the Secretary of HHS to establish a risk corridors program for calendar years 2014–2016. The full text of Section 1342 is reproduced below:

> (a) In general
>
> The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. §§ 1395w-101 et seq.].
>
> (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 percent 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 allowable costs in excess of 108 percent of the target amount.

(2) Payments in

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 less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall [be] reduced by any risk adjustment and reinsurance payments received under section[s] 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

42 U.S.C. § 18062.

Briefly, section 1342 directed the Secretary of HHS to establish a program whereby participating plans whose costs of providing coverage exceeded the premiums received (as determined by a statutory formula) would be paid a share of their excess costs by the Secretary— "payments out." Conversely, participating plans whose premiums exceeded their costs (according to the same formula) would pay a share of their profits to the Secretary—"payments in." The risk corridors program "permit[ted] issuers to lower [premiums] by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013).

On March 20, 2010, just three days before Congress passed the ACA, the Congressional Budget Office ("CBO") published an estimate of the ACA's cost. *See* Letter from Douglas Elmendorf, Director, CBO, to Nancy Pelosi, Speaker, House of Representatives tbl. 2 (Mar. 20, 2010) ("CBO Cost Estimate"), https://www.cbo.gov/sites/default/files/111th-congress-2009-2010/costestimate/amendreconprop.pdf. The CBO Cost Estimate made no mention of the risk corridors program, though it scored the reinsurance and risk adjustment programs. *Id*. Overall, CBO predicted the ACA would reduce the federal deficit by $143 billion over the 2010–2019 period it evaluated. *Id.* at p.2.

Preambulatory language in the ACA referred to CBO's overall scoring, noting that the "Act will reduce the Federal deficit between 2010 and 2019." ACA § 1563(a).

II. Implementing Regulations

In March 2012, HHS promulgated regulations establishing the risk corridors program as directed by section 1342. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,251–52 (Mar. 23, 2012) (codified at 45 C.F.R. Pt. 153, Subpart F). Those regulations defined terms such as "allowable costs," "administrative costs," "premiums earned," and "target amount," all of which would ultimately factor into the calculations of payments in and payments out required by the statutory formula. *E.g.*, *id*. at 17,236–39.

The regulations also provided that insurers offering qualified health plans in the exchanges "will receive payment from HHS in the following amounts, under the following circumstances" and it recited the same formula set forth in the statute for payments out. 45

C.F.R. § 153.510(b). The regulations similarly provided that insurers "must remit charges to HHS" according to the statutory formula for payments in. *Id.* § 153.510(c).

In March 2013, after an informal rulemaking proceeding, HHS published parameters for payments under various ACA programs for the first year of the exchanges, 2014, including the risk corridors program. The parameters revised certain definitions and added others, notably incorporating a certain level of profits as part of the allowable administrative costs. 78 Fed. Reg. at 15,530–31 (codified at 45 C.F.R. § 153.530). The parameters also provided that an issuer of a plan in an exchange must submit all information required for calculating risk corridors payments by July 31 of the year following the benefit year. *Id.* HHS also indicated that "the risk corridors program is not required to be budget neutral," so HHS would make full payments "as required under Section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. This constituted the final word from HHS on the risk corridors program before the exchanges opened and the program began.

III. Transitional Policy

The ACA established several reforms for insurance plans—such as requiring a minimum level of coverage—scheduled to take effect on January 1, 2014. ACA § 1255. Non-compliant plans in effect prior to the passage of the ACA in 2010, however, received a statutory exemption from certain requirements. 42 U.S.C. § 18011. This meant that insurers expected the pool of participants in the exchanges to include both previously uninsured individuals as well as individuals whose previous coverage terminated because

their respective plans did not comply with the ACA and did not qualify for the grandfathering exemption.

Individuals and small businesses enrolled in non-compliant plans not qualifying for the exemption received notice that their plans would be terminated. Many expressed concern that new coverage would be "more expensive than their current coverage, and thus they may be dissuaded from immediately transitioning to such coverage." J.A. 429. In November 2013, after appellee Moda Health Plan, Inc. and other insurers had already set premiums for the exchanges for 2014, HHS announced a one-year transitional policy that allowed insurers to continue to offer plans that did not comply with certain of the ACA's reforms even for non-grandfathered plans. J.A. 429–31. HHS directed state agencies to adopt the same policies. J.A. 431.

This dampened ACA enrollment in states implementing the policy, especially by healthier individuals who elected to maintain their lower level of coverage, leaving insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums. *See* Milliman, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 Individual Market 1 (July 2016) ("Our analysis indicates that issuers in states that implemented the transitional policy generally have higher medical loss ratios in the individual market."), http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf.

HHS acknowledged that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014" but noted "the risk corridor program should help ameliorate unanticipated changes in premium revenue." *Id.* HHS later extended the

transitional period to last the duration of the risk corridor program. J.A. 448–62.

After further informal rulemaking (begun soon after announcing the transitional policy), HHS informed insurers that it would adjust the operation of the risk corridors program for the 2014 benefit year to "offset losses that might occur under the transitional policy as a result of increased claims costs not accounted for when setting 2014 premiums." *HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13,744, 13,786–87 (Mar. 11, 2014). This included adjustments to HHS's formula for calculating the "allowable costs" and "target amount" involved in the statutory formula. *Id.*

HHS projected that these new changes (together with changes to the reinsurance program) would "result in net payments that are budget neutral in 2014" and that it "intend[ed] to implement this program in a budget neutral manner" with adjustments over time with that goal in mind. *Id.* at 13,787.

In April 2014, CMS, the division of HHS responsible for administering the risk corridors program, released guidance regarding "Risk Corridors and Budget Neutrality." J.A. 229–30. It explained a new budget neutrality policy as follows:

> We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions

> issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after the obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

J.A. 229.

As to any shortfall in the final year of payment, CMS stated it anticipated payments in would be sufficient, but that future guidance or rulemaking would address any persistent shortfalls. J.A. 230.

IV. Appropriations

In February 2014, after HHS had proposed its adjustments to account for the transitional policy (but before HHS had finalized the adjustments), Congress asked the Government Accountability Office ("GAO") to determine what sources of funds could be used to make any payments in execution of the risk corridors program. *See* Dep't of Health & Human Servs.—Risk Corridors Program ("GAO Report"), B-325630, 2014 WL 4825237, at *1 (Comp. Gen. Sept. 30, 2014) (noting request). GAO responded that it had identified two potential sources of funding in the appropriations for "Program Management" for CMS in FY 2014. That appropriation included a lump sum in excess of three

billion dollars for carrying out certain responsibilities, including "other responsibilities" of CMS as well as "such sums as may be collected from authorized user fees." *Id.* at *3 (citing Pub. L. No. 113-76, div. H, title II, 128 Stat. 5, 374 (Jan. 17, 2014)).

GAO concluded that the "other responsibilities" language in the CMS Program Management appropriation for FY 2014 could encompass payments to health plans under the risk corridors program, and so the lump-sum appropriation "would have been available for making payments pursuant to section 1342(b)(1)." *Id.* Further, GAO concluded that the payments in from the risk corridors program constituted "user fees," and so "any amounts collected in FY 2014 pursuant to section 1342(b)(2) would have been available . . . for making the payments pursuant to section 1342(b)(2)," though HHS had not planned to make any such collections or payments until FY 2015. *Id.* at *5 & n.7.

GAO clarified that appropriations acts "are considered nonpermanent legislation," so the language it analyzed regarding the lump-sum appropriation and user fees "would need to be included in the CMS PM appropriation for FY 2015" in order to be available to make any risk corridors payments in FY 2015. *Id.*

In December 2014, Congress passed its appropriations to HHS for FY 2015 (during which the first benefit year covered by the risk corridors program would conclude). That legislation reenacted the user fee language that GAO had analyzed and provided a lump sum for CMS's Program Management account; however, the lump-sum appropriation included a rider providing:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under Section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491.

Representative Harold Rogers, then-Chairman of the House Committee on Appropriations, explained his view of the appropriations rider upon its inclusion in the appropriations bill for FY 2015:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014).

Congress enacted identical riders in FY 2016 and FY 2017. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, § 225, 129 Stat. 2242, 2624; Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, title II, § 223, 131 Stat. 135, 543.[1]

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[1] Continuing resolutions in advance of the 2017 appropriations retained the same restrictions on funds. Continuing Appropria-

V. Subsequent Agency Action

In September 2015, CMS announced that the total amount of payments in fell short of the total amount requested in payments out. Specifically, it expected payments in of approximately $362 million but noted requests for payments out totaling $2.87 billion. J.A. 244. Accordingly, CMS planned to issue prorated payments at a rate of 12.6 percent, with any shortfall to be made up by the payments in received following the 2015 benefit year. *Id.*

A follow-up letter noted that HHS would "explore other sources of funding for risk corridors payments, subject to the availability of appropriations" in the event of a shortfall following the final year of the program. J.A. 245.

A report from CMS shows that the total amount of payments in collected for the 2014–2016 benefit years fell short of the total amount of payments out calculated according to the agency's formula by more than $12 billion. CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (November 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf.

VI. Procedural History

Moda commenced this action in the Court of Federal Claims under the Tucker Act in July 2016. It seeks the balance between the prorated payments it received and the full amount of payments out according to

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tions Act, 2017, Pub. L. No. 114 223, div. C, §§ 103–04, 130 Stat. 857, 908–09; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, § 101, 130 Stat. 1005, 1005–06.

section 1342. The Court of Federal Claims denied the government's motion to dismiss for lack of jurisdiction and for failure to state a claim and granted Moda's cross-motion for partial summary judgment as to liability.

Both sides stipulated that the government owed Moda $209,830,445.79 in accordance with the ruling on liability. J.A. 41. The trial court entered judgment for Moda accordingly. J.A. 45.

Dozens of other insurers filed actions alleging similar claims, with mixed results from the Court of Federal Claims. *See, e.g.*, *Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14 (2017) (ruling for the insurer); *Me. Cmty. Health Options v. United States*, 133 Fed. Cl. 1 (2017) (ruling for the government).

The Court of Federal Claims had jurisdiction under the Tucker Act, 28 U.S.C. § 1491(a)(1).[2] We have jurisdiction under 28 U.S.C. § 1295(a)(3).

DISCUSSION

Moda advances claims based on two theories. First, Moda contends that section 1342 itself obligates the

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[2] The government does not appeal the Court of Federal Claims' determination of Tucker Act jurisdiction, and it appears to concede that section 1342 is money-mandating for jurisdictional purposes (though not on the merits). Appellant's Reply Br. 11. As discussed below, we hold that section 1342 initially created an obligation to pay the full amount of payments out. We also agree with the Court of Federal Claims that the statute is money-mandating for jurisdictional purposes. *See Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (concluding a statute is money-mandating for jurisdictional purposes if it "can fairly be interpreted" to require payment of damages, or if it is "reasonably amenable" to such a reading, which does not require the plaintiff to have a successful claim on the merits).

government to pay insurers the full amount indicated by the statutory formula for payments out, notwithstanding the amount of payments in collected. Second, Moda contends that HHS made a contractual agreement to pay the full amount required by the statute in exchange for Moda's performance (by offering a compliant plan in an exchange), and the government breached that agreement by failing to pay the full amount according to the statutory formula for payments out.

We review the Court of Federal Claims' legal conclusion that the government was liable on both theories de novo. *See Starr Int'l Co. v. United States*, 856 F.3d 953, 963 (Fed. Cir. 2017).

I. Statutory Claim

Moda argues that section 1342 obligated the government to pay the full amount indicated by the statutory formula for payments out, not a pro rata sum of the payments in. The government responds that section 1342 itself contemplated operating the risk corridors program in a budget neutral manner (so the total amount of payments out due to insurers cannot exceed the amount of payments in). In the alternative, the government contends that appropriations riders on the fiscal years in which payments from the risk corridors program came due limited the government's obligation to the amount of payments in. Although we agree with Moda that section 1342 obligated the government to pay the full amount of risk corridors payments according to the formula it set forth, we hold that the riders on the relevant appropriations effected a suspension of that obligation for each of the relevant years.

We begin with the statute.

A. Statutory Interpretation

The government asserts that Congress designed section 1342 to be budget neutral, funded solely through payments in and that the statute carries no obligation to make payments at the full amount indicated by the statutory formula if payments in fell short.

Section 1342 is unambiguously mandatory. It provides that "[t]he Secretary *shall* establish and administer" a risk corridors program pursuant to which "[t]he Secretary *shall* provide" under the program that "the Secretary *shall* pay" an amount according to a statutory formula. 42 U.S.C. § 18062 (emphases added). Nothing in section 1342 indicates that the payment methodology is somehow limited by payments in. It simply sets forth a formula for calculating payment amounts based on a percentage of a "target amount" of allowable costs.

The government reasons that we must nevertheless interpret section 1342 to be budget neutral, because Congress relied on the CBO Cost Estimate that the ACA would decrease the federal deficit between 2010 and 2019, without evaluating the budgetary effect of the risk corridors program. Thus, according to the government, the ACA's passage rested on an understanding that the risk corridors program would be budget neutral.

Nothing in the CBO Cost Estimate indicates that it viewed the risk corridors program as budget neutral. Indeed, even if CBO had accurately predicted the $12.3 billion shortfall that now exists, CBO's overall estimate that the ACA would reduce the federal deficit would have remained true, since CBO had estimated a reduction of more than $100 billion. *See* CBO Cost Estimate at 2.

The government's amicus suggests it is "inconceivable" that CBO would have declined to analyze the budgetary impact of the risk corridors program, given its obligation to prepare "an estimate of the costs which would be incurred in carrying out such bill." Br. of Amicus Curiae U.S. House Rep. in Supp. of Appellant at 7 (quoting 2 U.S.C. § 653). Not so. It is entirely plausible that CBO expected payments in would roughly equal payments out over the three year program, especially since CBO could not have predicted the costly impact of HHS's transitional policy, which had not been contemplated at that time. Without more, CBO's omission of the risk corridors program from its report can be viewed as nothing more than a bare failure to speak. Moreover, even if CBO interpreted the statute to require budget neutrality, that interpretation warrants no deference, especially in light of HHS's subsequent interpretation to the contrary. CBO's silence simply cannot displace the plain meaning of the text of section 1342.

The government also argues that section 1342 created no obligation to make payments out in excess of payments in because it provided no budgetary authority to the Secretary of HHS and identified no source of funds for any payment obligations beyond payments in. But it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances.

In *United States v. Langston*, 118 U.S. 389 (1886), Congress appropriated only five thousand dollars for the salary of a foreign minister, though a statute provided that the official's salary would be seven thousand five hundred dollars. The Supreme Court held that the statute fixing the official's salary could

not be "abrogated or suspended by the subsequent enactments which merely appropriated a less amount" for the services rendered, absent "words that expressly, or by clear implication, modified or repealed the previous law." *Id.* at 393. That is, the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation.

Our predecessor court noted long ago that "[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties." *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) ("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.").

It is also of no moment that, as the government notes, HHS could not have made payments out to insurers in an amount totaling more than the amount of payments in without running afoul of the Anti-Deficiency Act. That Act provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure . . . exceeding an amount available in an appropriation . . . for the expenditure." 31 U.S.C. § 1341(a)(1)(A). But the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government. *See Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 197 (2012). The Anti-

Deficiency Act simply constrains government officials. *Id.*

For the same reason, it is immaterial that Congress provided that the risk corridors program established by section 1342 would be "based on the program" establishing risk corridors in Medicare Part D yet declined to provide "budget authority in advance of appropriations acts," as in the corresponding Medicare statute. *See* 42 U.S.C. § 1395w-115.[3] Budget authority is not *necessary* to create an obligation of the government; it is a means by which an officer is afforded that authority. *See* 2 U.S.C. § 622(2).

Here, the obligation is created by the statute itself, not by the agency. The government cites no authority for its contention that a statutory obligation cannot exist absent budget authority. Such a rule would be inconsistent with *Langston*, where the obligation existed independent of any budget authority and independent of a sufficient appropriation to meet the obligation.

We conclude that the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out

[3] The fact that the same provision also "represents the obligation of the Secretary to provide for the payment of amounts provided under this section" cuts both ways. 42 U.S.C. § 1395w-115. Although Congress never expressly stated that section 1342 represented an obligation of the Secretary, it used unambiguous mandatory language that in fact set forth such an obligation, especially in light of Congress's intent to make the risk corridors program in the ACA "based on" Medicare's obligatory program. The government offers no basis for concluding that stating the "obligation of the Secretary" outright is the sine qua non of finding an obligation here. The plain language of the statute controls.

under the risk corridors program. We next consider whether, notwithstanding that statutory requirement, Congress has suspended or repealed that obligation.

B. The Effect of the Appropriations Riders

The government next argues the riders in the appropriations bills for FY 2015 and FY 2016 repealed or suspended its obligation to make payments out in an aggregate amount exceeding payments in.[4] We agree.

Repeals by implication are generally disfavored, but "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" *United States v. Will*, 449 U.S. 200, 221–22 (1980) (quoting *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). Whether an appropriations bill impliedly suspends or repeals substantive law "depends on the intention of [C]ongress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883). The central issue on Moda's statutory claim, therefore, is whether the appropriations riders adequately expressed Congress's intent to suspend payments on the risk corridors program beyond the sum of payments in. We conclude the answer is yes.

Moda contends, however, this issue is also controlled by *Langston*. There, as discussed above, the Supreme Court held that a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation because it carried no implication of Congress's intent to amend or suspend the substantive law at issue. *Langston*, 118 U.S. at 394.

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[4] The government's argument applies equally to FY 2017, though that appropriations bill had not yet been enacted before this case completed briefing.

Just three years before *Langston*, however, the Supreme Court held that a statute that had set the salaries of certain interpreters at a fixed sum "in full of all emoluments whatsoever" had been impliedly amended, where Congress appropriated funds less than the fixed sum set by statute, with a separate sum set aside for additional compensation at the discretion of the Secretary of the Interior. *Mitchell*, 109 U.S. at 149. The Court held:

> This course of legislation . . . distinctly reveal[ed] a change in the policy of [C]ongress on the subject, namely that instead of establishing a salary for interpreters at a fixed amount, and cutting off all other emoluments and allowances, [C]ongress intended to reduce the salaries and place a fund at the disposal of the [S]ecretary of the [I]nterior, from which, at his discretion, additional emoluments and allowances might be given to the interpreters.

Id. at 149–50. Thus, "for the time covered by those" appropriations bills, the intent of Congress was "plain on the face of the statute." *Id.* at 150.

Langston expressly distinguished *Mitchell* because the appropriations bills in *Mitchell* implied "that [C]ongress intended to repeal the act" setting a fixed salary, with "additional pay" to be provided at the Secretary's discretion. *Langston*, 118 U.S. at 393. By contrast, Congress had "merely appropriated a less amount" for Langston's salary. *Id.* at 394.

The question before us, then, is whether the riders on the CMS Program Management appropriations supplied the clear implication of Congress's intent to impose a new payment methodology for the time

covered by the appropriations bills in question, as in *Mitchell*, or if Congress merely appropriated a less amount for the risk corridors program, as in *Langston*.

The Supreme Court has noted *Langston* "expresses the limit in that direction." *Belknap v. United States*, 150 U.S. 588, 595 (1893). The jurisprudence in the century and a half since *Langston* has cemented that decision's place as an extreme example of a mere failure to appropriate.[5] Our case falls clearly within the core of subsequent decisions wherein appropriations bills carried sufficient implication of repeal, amendment, or suspension of substantive law to effect that purpose, as in *Mitchell*.

In *United States v. Vulte*, 233 U.S. 509 (1914), the Supreme Court considered a series of enactments concerning bonuses for Marine Corps officers serving abroad. A 1902 act established a ten percent bonus for all such officers and appropriated funds accordingly. In 1906 and 1907, appropriations for the payment of that bonus carried a rider specifying that the funds could be used to pay officers serving "beyond the limits of the states comprising the Union of the territories of the United States contiguous thereto (*except P[ue]rto Rico and Hawaii*)." *Id.* at 512–13 (emphasis added) (citations omitted). The appropriations for 1908 contained no such rider and stated the increase of pay for officers serving abroad "shall be as now provided by law." *Id.* at 513 (citation omitted).

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[5] Contrary to the suggestion of the dissent, dissent at 8, we do not discard *Langston* due to its age, rather, we simply acknowledge the extensive body of decisions since it was decided that treat it as an outer bound, consistent with the Supreme Court's view in *Belknap*.

An officer serving in Puerto Rico in 1908 sought compensation accounting for the ten percent bonus enacted in 1902. The Supreme Court rejected the government's position that the exception in the appropriations bills of 1906 and 1907 impliedly repealed the 1902 act, noting that the appropriations riders lacked any "words of prospective extension" indicating a permanent change in the law. *Id.* at 514. Nevertheless, the Supreme Court acknowledged the appropriation riders *did* indicate Congress's intent to "temporarily suspend as to P[ue]rto Rico and Hawaii" the ten percent bonus in 1906 and 1907. *Id.*

In *Dickerson*, the Supreme Court considered the effect of various appropriations riders on a reenlistment bonus authorized by Congress in 1922. 310 U.S. at 555–56. After several years in force, an appropriations rider expressly suspended the bonus for the fiscal years ending in 1934–1937. *Id.* at 556. The text of the rider changed in the appropriations bill for the fiscal year ending in 1938. That bill omitted the express suspension, noting only that "no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1938, shall be available for the payment" of, inter alia, the reenlistment bonus. *Id.*

The appropriations bill for the fiscal year ending in 1939 repeated that language. *Id.* at 555. Floor debates showed that Congress intended the new language to carry the same restriction expressed in the earlier appropriations bills. *Id.* at 557–61. The Supreme Court held that the appropriations bill for the fiscal year ending in 1939 evinced Congress's intent to suspend the reenlistment bonus in light of persuasive evidence to that effect. *Id.* at 561.

Finally, in *Will*, the Supreme Court considered the effect of appropriations riders on a set of statutes

establishing annual pay raises for certain officials, including federal judges. 449 U.S at 204–05 (citing 5 U.S.C. § 5505). Over a span of four years, Congress passed appropriations acts with riders limiting the use of funds to pay the increases for federal judges, among others. *See id.* at 205–09. The first such rider provided that "no part of the funds appropriated in this Act or any other Act shall be used to pay the salary of an individual in a position or office referred to in" the act providing for the pay raises for federal judges. *Id.* at 206 (quoting Legislative Branch Appropriation Act, 1977, Pub. L. 94-440, 90 Stat. 1439, Title II).

The dispute in *Will* concerned whether the effect of the appropriations riders ran afoul of the Compensation Clause of the Constitution. Before reaching that issue, however, the Supreme Court first rejected the judges' contention that the appropriations bills did "no more than halt *funding* for the salary increases." *Id.* at 221. Acknowledging the general rule disfavoring repeals by implication and its "especial force" when the alleged repeal occurred in an appropriations bill, the Court held that in each of the four appropriations acts in question, "Congress intended to repeal or postpone previously authorized increases." *Id.* at 221–22. This was true although the riders in years 1, 3, and 4 were "phrased in terms of limiting funds." *Id.* at 223. The Court's conclusion was bolstered by floor debates occurring in year 3 of the appropriations riders as well as language expressly suspending the pay raises in year 2, but it concluded the rider in year 1 indicated that same clear intent:

> These passages indicate[d] clearly that Congress intended to rescind these rates entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear

> intent of Congress in each year was to stop for that year the application of the Adjustment Act.

Id. at 224.

Congress clearly indicated its intent here. It asked GAO what funding would be available to make risk corridors payments, and it cut off the *sole* source of funding identified beyond payments in. It did so in each of the three years of the program's existence. And the explanatory statement regarding the amendment containing the first rider of House Appropriations Chairman Rogers confirms that the appropriations language was added with the understanding that HHS's intent to operate the risk corridors program as a budget neutral program meant the government "will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). Plainly, Congress used language similar to the appropriations riders in *Vulte*, *Dickerson*, and *Will* (and quite clearer than the language in *Mitchell*) to temporarily cap the payments required by the statute at the amount of payments in for each of the applicable years just as those decisions altered statutory payment methodologies.[6]

What else could Congress have intended? It clearly did not intend to consign risk corridors payments "to the fiscal limbo of an account due but not payable." *See Will*, 449 U.S. at 224.

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[6] We do not "ratif[y] an 'indefinite suspension' of payment," dissent at 7, or a "permanent postponement," *id.* at 16. We hold only that Congress effected a suspension applicable to the fiscal years covered by each appropriations bill containing the rider, which corresponded to each fiscal year in which risk-corridor payments came due.

Moda contends that notwithstanding the similarities between our case and the foregoing authority, Congress simply intended to limit the use of a single source of funding while leaving others available. Moda points out that the appropriations riders in *Dickerson* and *Will* foreclosed the use of funding provided by that appropriations act "or any other act," while the riders here omit that global restriction. *Compare Dickerson*, 310 U.S. at 556, *and Will*, 449 U.S. at 206, *with* Consolidated and Further Continuing Appropriations Act, 2015, § 227, 128 Stat. at 2491. But the Supreme Court never considered the impact of that language in *Dickerson* or *Will*, and it found effective suspensions-by-appropriations in *Mitchell* and *Vulte* even absent that language.

Moda suggests that restricting access to funds from "any other act" was necessary to foreclose HHS from using funds that remained available. It points to the CMS Program Management appropriation for FY 2014 (before the risk corridors program began and before any appropriations riders had been enacted) as well as the Judgment Fund, a standing appropriation for the purpose of paying certain judgments against the government. We address each in turn.

In response to a request of Congress, GAO concluded that the FY 2014 CMS Program Management fund "would have been available for risk-corridors payments." *See* GAO Report at *3. According to Moda, this means HHS could have used funds from the FY 2014 appropriation to make risk corridors payments for the 2015 benefit year (which concluded in FY 2015). Not so. GAO's opinion only addressed what funds from FY 2014 would have been available for risk corridors payments had any such payments been among the "other responsibilities" of CMS *for that fiscal year*. That

appropriation expired in FY 2014. *See* 128 Stat. at 5 ("The following sums in this Act are appropriated . . . for the fiscal year ending September 30, 2014."). GAO specifically noted that "for funds to be available for this purpose in FY 2015, the CMS PM appropriation for FY 2015 must include language similar to the language included in the CMS PM appropriation for FY 2015." *Id.* at *5. Of course, Congress enacted the rider for FY 2015 instead.

GAO's opinion was correct. Under section 1342, HHS could not have collected or owed payments out or payments in during FY 2014 because the statute required calculations based on allowable costs for a *plan year* and the program was to run for calendar years 2014, 2015, and 2016. Thus, HHS could not have been responsible for payments out until, at the earliest, the end of calendar year 2014, which occurred during FY 2015.

Likewise, the CMS Program Management appropriations in the continuing resolutions enacted at the end of calendar year 2014 (during FY 2015) expired in December 2014, when Congress enacted the FY 2015 appropriations act (and the first rider in question)—still before HHS could have even calculated the payments in and payments out under the risk corridors program.

Moda's reliance on the Judgment Fund is also misplaced. The Judgment Fund is a general appropriation of "[n]ecessary amounts" in order "to pay final judgments" and other amounts owed via litigation against the government, subject to several conditions. 31 U.S.C. § 1304(a). The Judgment Fund "does not create an all-purpose fund for judicial disbursement." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 431 (1990). Rather, access to the Judgment Fund

presupposes liability. Moda's contention that the government's liability persists because it could pay what it owed under the statutory scheme from the Judgment Fund reverses the inquiry. The question is what Congress intended, not what funds might be used if Congress did *not* intend to suspend payments in exceeding payments out.

As discussed above, Congress's intent to temporarily cap payments out at the amount of payments in was clear from the appropriations riders and their legislative history. It did not need to use Moda's proposed magic words, "or any other act," to foreclose resort to the Judgment Fund. We simply cannot infer, as Moda's position would require, that upon enacting the appropriations riders, Congress intended to preserve insurers' statutory entitlement to full risk corridors payments but to require insurers to pursue litigation to collect what they were entitled to. That theory cannot displace the plain implication of the language and legislative history of the appropriations riders.

Moda points out that Congress's intent regarding the appropriations riders must be understood with the context of other legislative efforts surrounding the ACA and the risk corridors program in particular. For example, Moda points to Congress's failed attempt to enact legislation requiring budget neutrality for the risk corridors program. *See, e.g.*, Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). But we need not and do not conclude that Congress achieved through appropriations riders what it failed to do with permanent legislation. Rather, we only hold that Congress enacted temporary measures capping risk corridor payments out at the amount of payments in, and it did so for each year the program was in effect. (We need not address, for example, what would

have occurred if Congress had failed to include the rider in one of the acts appropriating funds for the fiscal years in which payments came due or if it had affirmatively appropriated funds through some other source.)

It is also irrelevant that the President signed the bills containing the appropriations riders, even as he threatened to veto any bill rolling back the ACA, as Moda points out. *See, e.g.*, Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA TODAY, Nov. 19, 2014 (noting that President Obama had threatened to veto twelve different bills that would have repealed or amended the ACA), http://www.usatoday.com/story/news/politics/2014/11/19/obama-veto-threats/19177413/. Again, we do not hold that the appropriations riders effected any permanent amendment. Moreover, Moda has offered no evidence that President Obama expressed any specific views of the implications of these appropriations riders before or after signing, much less evidence that could overcome the clear implication of the text of the riders and the surrounding legislative history.

Moda also contends that two decisions from our predecessor court, *New York Airways*, 369 F.2d at 743, and *Gibney v. United States*, 114 Ct. Cl. 38 (1949), demonstrate that the appropriations riders here do not carry such strong implications. In *New York Airways*, our predecessor court held that Congress's failure to appropriate sufficient funds to pay for services at a rate set by a government agency did not defeat the obligation to pay the full amount. 369 F.2d at 746. Floor debates indicated that "Congress was well-aware that the Government would be legally obligated to pay . . . even if the appropriations were deficient." *Id.* The court noted that Congress viewed the obligation

"as a contractual obligation enforceable in the courts which could be avoided only by changing the substantive law under which the Board set the rates, rather than by curtailing appropriations," and the agency made its similar view of the obligation clear to Congress. *Id.* at 747.

Here, the risk corridors program is an incentive program, not a quid pro quo exchange for services rendered like that in *New York Airways*. Moreover, it is much clearer here that Congress understood the appropriations riders to suspend substantive law, inasmuch as the appropriations riders directly responded to GAO's identification of only two sources of funding for the program.

In *Gibney*, a statute provided that certain employees of the Immigration and Naturalization Service would be paid overtime at a particular rate. Two subsequent statutes extended a more stringent overtime rate to other federal employees, while expressly leaving the prior rate for INS in place. A rider in an appropriations bill provided that "none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided in" the latter two acts. 114 Ct. Cl. at 48–49. INS agents who received overtime payments at the more stringent rate fixed in the latter acts sought payment at the earlier rate.

That rider, according to the *Gibney* court, constituted "a mere limitation on the expenditure of a particular fund and had no other effect," so it could not limit the overtime rate available to an INS agent. *Id.* at 51. But the court's holding ultimately rested on a different point—that limiting overtime payments "as provided in" the new acts had no effect on the rate for INS agents, since the new acts expressly preserved

their special overtime rate. The appropriations rider did "not even purport to affect the right of immigration inspectors to overtime pay as provided in the" earlier act. *Id.* at 55. The interpretation of the appropriations riders in *Gibney* cannot be viewed in isolation of its alternative holding, and there is no safety valve built into the ACA to preserve the government's obligation notwithstanding Congress's suspension of it. Accordingly, *Gibney* is inapposite.

After oral argument in this case had occurred, Moda filed a citation of supplemental authority as permitted by Rule 28(j) of the Federal Rules of Appellate Procedure, indicating that HHS had released a proposed budget for FY 2019, including a proposal indicating an $11.5 billion outlay for risk corridors payments in FY 2018 (reflective of the effect of sequestration on the total $12.3 billion outstanding) and noting a "legislative proposal to fully fund the Risk Corridors Program." *See* Appellee's Fed. R. App. P. 28(j) Notice Suppl. Auth. ("Moda 28(j) Letter") (Feb. 16, 2018), ECF No. 83, Exh. A (*Putting America's Health First, FY 2019 President's Budget for HHS* at 51 & n.5 & n.7, 54, 93 n.7 (2018)).[7]

According to Moda, this refutes the government's positions on its statutory claims. In particular, Moda states, "if the appropriation riders had substantively

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[7] A revised budget, released just days after Moda submitted the initial draft to the court, omitted the language Moda referred to. *See generally Putting America's Health First, FY 2019 President's Budget for HHS* (2018) (rev. Feb. 19, 2018), https://www.hhs.gov/sites/default/files/fy2019-budget-in-brief.pdf. The budget released by the White House, however, included remnants of HHS's initial draft. *An American Budget, Budget of the U.S. Government, Fiscal Year 2019* at 132, 141 (2018), OMB https://www.whitehouse.gov/wp-content/uploads/2018/02/budget-fy2019.pdf.

amended the ACA, the government would have no basis now to be proposing to appropriate funds to fulfill the entirety of its [risk corridor] obligations." Moda 28(j) Letter at 2.

Moda again misunderstands the inquiry. The question is what intent was communicated by Congress's enactments in the appropriations bills for FY 2015–2017. It is irrelevant that a subsequent Administration proposed a budget that set aside funds to make purported outstanding risk corridors payments. Of course, Congress could conceivably reinstate an obligation to make full payments, even now after the program has concluded. But the proposed budget does not place that question before us.

The intent of Congress remains clear. After GAO identified only two sources of funding for the risk corridors program—payments in and the CMS Program Management fund—Congress cut off access to the only fund drawn from taxpayers. A statement discussing that enactment acknowledged "that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. H9838. Congress could have meant nothing else but to cap the amount of payments out at the amount of payments in for each of the three years it enacted appropriations riders to that effect.

Moda contends that this result is inconsistent with the purpose of the risk corridors program. Perhaps. But it also seems that Congress expected the program to have minimal, if any, budget impact (even though we hold the text of section 1342 allowed for unbounded budget impact). Congress could not have predicted the shifting sands of the transitional policy implemented by HHS, which Moda blames for the higher costs it and other insurers bore through their participation in the

exchanges. In response to that turn of events, Congress made the policy choice to cap payments out, and it remade that decision for each year of the program. We do not sit in judgment of that decision. We simply hold that the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program.

Thus, Moda's statutory claim cannot stand.

II. Contract Claim

Moda also asserts an independent claim for breach of an implied-in-fact contract that purportedly promised payments of the full amount indicated by the statutory formula in exchange for participation in the exchanges.

The requirements for establishing a contract with the government are the same for express and implied contracts. *Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997). They are (1) "mutuality of intent to contract," (2) "consideration," (3) "lack of ambiguity in offer and acceptance," and (4) "actual authority" of the government representative whose conduct is relied upon to bind the government. *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

Absent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract. *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465–66 (1985). We apply a "presumption that 'a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *Id.* (quoting *Dodge v. Board of Educ.*, 302 U.S. 74, 79 (1937)). This is because the legislature's function is to

make laws establishing policy, not contracts, and policies "are inherently subject to revision and repeal." *Id.* at 466.

Moda does not contend that the government manifested intent via the text of section 1342 alone. Indeed, the statute contains no promissory language from which we could find such intent. Instead, Moda alleges a contract arising "from the combination of [the statutory] text, HHS's implementing regulations, HHS's preamble statements before the ACA became operational, and the conduct of the parties, including relating to the transitional policy." Appellee's Br. 55.

The centerpiece of Moda's contract theory (and the foundation for the trial court's decision in this case) is *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). There, the Atomic Energy Commission issued regulations titled "Ten Year Guaranteed Minimum Price," in order "[t]o stimulate domestic production of uranium." *Id.* at 404–05. The regulations established guaranteed minimum prices for uranium delivered to the commission, with specific conditions required for entitlement to the minimum price. *Id.*

The court observed that the title of the regulation indicated that the government would "guarantee" the prices recited and that the regulation's "purpose was to induce persons to find and mine uranium," when, due to restrictions on private transactions in uranium, "no one could have prudently engaged in its production unless he was assured of a Government market." *Id.* at 405–06.

The court rejected the government's position that the regulations constituted a mere invitation to make an offer, holding instead that the regulation itself constituted "an offer, which ripened into a contract

when it was accepted by the plaintiff's putting itself into a position to supply the ore or the refined uranium described in it." *Id.* at 405.

Moda contends that here, the statute, its implementing regulations, and HHS's conduct all evinced the government's intent to induce insurers to offer plans in the exchanges without an additional premium accounting for the risk of the dearth of data about the expanded market, in reliance on the presence of a fairly comprehensive safety net. But the overall scheme of the risk corridors program lacks the trappings of a contractual arrangement that drove the result in *Radium Mines*. There, the government made a "guarantee," it invited uranium dealers to make an "offer," and it promised to "offer a form of contract" setting forth "terms" of acceptance. *Id.* at 404–05; *see N.Y. Airways*, 369 F.2d at 752 (finding intent to form a contract where Congress specifically referred to "Liquidation of Contract Authorization"). Not so here.

The risk corridors program is an incentive program designed to encourage the provision of affordable health care to third parties without a risk premium to account for the unreliability of data relating to participation of the exchanges—not the traditional quid pro quo contemplated in *Radium Mines*. Indeed, an insurer that included that risk premium, but nevertheless suffered losses for a benefit year as calculated by the statutory and regulatory formulas would still be entitled to seek risk corridors payments.

Additionally, the parties in *Radium Mines*, one of which was the government, never disputed that the government intended to form some contractual relationship at some time throughout the exchange. The only question there was whether the regulations themselves constituted an offer, or merely an invitation to

make offers. *Radium Mines* is only precedent for what it decided. *See Orenshteyn v. Citrix Sys., Inc.*, 691 F.3d 1356, 1360 (Fed. Cir. 2012) ("Generally, when an issue is not discussed in a decision, that decision is not binding precedent.").

Here, no statement by the government evinced an intention to form a contract. The statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program. These facts cannot overcome the "well-established presumption" that Congress and HHS never intended to form a contract by enacting the legislation and regulation at issue here.

Accordingly, Moda cannot state a contract claim.

* * *

Because we conclude that the government does not owe Moda anything in excess of its pro rata share of payments in, we need not address whether payments were due annually or only at the end of the three-year period covered by the risk corridors program.

CONCLUSION

Although section 1342 obligated the government to pay participants in the exchanges the full amount indicated by the formula for risk corridor payments, we hold that Congress suspended the government's obligation in each year of the program through clear intent manifested in appropriations riders. We also hold that the circumstances of this legislation and subsequent regulation did not create a contract promising the full amount of risk corridors payments. Accordingly, we hold that Moda has failed to state a viable claim for additional payments under the risk

corridors program under either a statutory or contract theory.

REVERSED

COSTS

The parties shall bear their own costs.

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2017-1994

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee

v.

UNITED STATES,

Defendant-Appellant

Appeal from the United States Court of Federal Claims in No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler.

NEWMAN, *Circuit Judge*, dissenting.

The United States and members of the health insurance industry, in connection with the program referred to as "Obamacare," agreed to a three-year plan that would mitigate the risk of providing low-cost insurance to previously uninsured and underinsured persons of unknown health risk. This risk-abatement plan is included in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA). As described by the

Court of Federal Claims,[1] the "risk corridors" provision accommodates the unpredictable risk of the

[1] *Moda Health Plan, Inc. v. United States,* 130 Fed. Cl. 436 (2017) ("Fed. Cl. Op.").

extended healthcare programs. By this provision, the government will "'share in profits or losses resulting from inaccurate rate setting from 2014 to 2016.'" Fed. Cl. Op., 130 Fed. Cl. at 444 (quoting *HHS Notice of Benefit and Payment Parameters for 2014*, 77 Fed. Reg. 73,118, 73,121 (Dec. 7, 2012)). The risk corridors program was enacted as Section 1342 of the Affordable Care Act, and is codified in Section 18062 of Title 42. Subsection (a) is as follows:

> The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of [the Medicare Act].

42 U.S.C. § 18062(a). The statute contains a detailed formula for this risk corridors sharing of profits and losses. Healthcare insurers throughout the nation, including Moda Health Plan, accepted and fulfilled the new healthcare procedures, in collaboration with administration of the ACA by the Centers for Medicare and Medicaid Services (CMS) in the Department of Health and Human Services (HHS).

Many health insurers soon experienced losses, attributed at least in part to a governmental action called the "transitional policy." Reassurance was presented, and Moda (and others) continued to perform their obligations. Although the government continued to collect "payments in" from insurers who more accurately predicted risk, the government has declined to

pay its required risk corridors amounts, by restricting the funds available for the "payments out."

The Court of Federal Claims held the government to its statutory and contractual obligations to Moda. My colleagues do not. I respectfully dissent.

The Court of Federal Claims interpreted the statute in accordance with its terms

The ACA provides the risk corridors formula, establishing that the insurer will make "payments in" to the government for the insurer's excess profits as calculated by the formula, and "payments out" from the government for the insurer's excess losses. The formula was enacted into statute:

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 percent 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 allowable costs in excess of 108 percent of the target amount.

42 U.S.C. § 18062(b). In March 2012, HHS issued regulations for the risk corridors program, stating that Qualified Health Plans (QHPs) "will receive payment" or "must remit charges" depending on their gains or

losses. 45 C.F.R. § 153.510(b), (c). In March 2013, HHS stated:

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

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15473 (Mar. 11, 2013) (JA565). Moda cites this reassurance, as Moda continued to offer and implement healthcare policies in accordance with the Affordable Care Act.

The "transitional policy" resulted in a change in the risk profile of participants in the Affordable Care Act. Moda states that "many individuals who had previously passed medical underwriting, and were considerably healthier than the uninsured population, maintained their existing insurance and did not enroll in QHPs," Moda Br. 7–8, thereby reducing the amount of premiums collected from healthier persons. HHS stated, in announcing the transitional policy, that "the risk corridor program should help ameliorate unanticipated changes in premium revenue." Letter from Gary Cohen, Dir., CMS Ctr. for Consumer Info. and Ins. Oversight ("CCIIO"), to State Ins. Comm'rs at 3 (Nov. 14, 2013) (JA431).

The transitional policy was initially announced as applying only until October 1, 2014. *Id.* at 1 (JA429). However, it was renewed throughout the period here at issue. Memorandum from Kevin Counihan, Dir., CMS CCIIO (Feb. 29, 2016) (JA457).

The risk corridors obligations were not cancelled by the appropriations riders

In April 2014, HHS-CMS issued an "informal bulletin" stating, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall." Memorandum from CMS CCIIO, Risk Corridors and Budget Neutrality (Apr. 11, 2014) (JA229). HHS also stated "that the Affordable Care Act requires the Secretary to make full payments to issuers," and that it was "recording those amounts that remain unpaid . . . [as an] obligation of the United States Government for which full payment is required." Memorandum from CMS CCIIO, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) (JA245).

The issue on this appeal is focused on the interpretation and application of the "rider" that was attached to the omnibus annual appropriations bills. This rider prohibits HHS from using its funds, including its bulk appropriation, to make risk corridors payments. My colleagues hold that this rider avoided or indefinitely postponed the government's risk corridors obligations. The Court of Federal Claims, receiving this argument from the United States, correctly discarded it.

Meanwhile, the risk corridors statute was not repealed or the payment regulations withdrawn, despite attempts in Congress. Moda continued to perform its obligations in accordance with its agreement with the CMS's administration of the Affordable Care Act.

A statute cannot be repealed or amended by inference

To change a statute, explicit legislative statement and action are required. Nor can governmental obligations be eliminated by simply restricting the funds that might be used to meet the obligation. The appropriation riders that prohibited the use of general HHS funds to pay the government's risk corridors obligations did not erase the obligations. The Court of Federal Claims correctly so held.

The mounting problems with the Affordable Care Act did not go unnoticed. In September 2014, the General Accountability Office (GAO) responded to an inquiry from Senator Jeff Sessions and Representative Fred Upton, and stated that "the CMS PM [Centers for Medicare Services-Program Management] appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1)." Letter from Susan A. Poling, GAO Gen. Counsel, to Sen. Jeff Sessions and Rep. Fred Upton 4 (Sept. 30, 2014) (JA237) ("Poling Letter"). The GAO also stated that "payments under the risk corridors program are properly characterized as user fees" and could be used to make payments out. *Id.* at 6 (JA239). This review also cited the available recourse to the general CMS assessment. However, in December 2014, the appropriations bill for that fiscal year contained a rider that prohibited HHS from using various funds, including the CMS PM funds, for risk corridors payments. The rider stated:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services-

> Program Management" account, may be used for payments under section 1342(b)(1) of [the ACA] (relating to risk corridors).

Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014). Similar riders were included in the omnibus appropriations bills for the ensuing years. As the Court of Federal Claims recited, by September 2016, after collecting all payments in for the 2015 year, it was clear that all payments in would be needed to cover 2014 losses, and that no payments out would be made for the 2015 plan year.

Moda states: "The Government owed Moda $89,426,430 for 2014 and $133,951,163 for 2015, but only paid $14,254,303 for 2014 and nothing for 2015, leaving a $209,123,290 shortfall." Moda Br. 10.

The panel majority ratifies an "indefinite suspension" of payment, stating that this was properly achieved by cutting off the funds for payment. The majority correctly states that "the government's statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation." Maj. Op. at 18. However, the majority then subverts its ruling, and holds that the government properly "indefinitely suspended" compliance with the statute.[2]

In *United States v. Will*, the Court explained that "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that . . . it could

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[2] The panel majority, responding to this dissent, states that it is not ratifying an indefinite suspension of payment. Maj. Op. at 25, n.6. However, payment has not been made, and the majority finds "the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." Maj. Op. at 32. Thus Moda, and the other participating insurers, have been forced into the courts.

accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" 449 U.S. 200, 222 (1980) (citing *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). However, this intent to suspend or repeal the statute must be expressed: "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883).

"The cardinal rule is that repeals by implication are not favored." *Posadas v. Nat'l City Bank*, 296 U.S. 497, 503 (1936). "The doctrine disfavoring repeals by implication 'applies with full vigor when . . . the subsequent legislation is an *appropriations* measure,'" as here. *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978) (citing *Comm. for Nuclear Responsibility, Inc. v. Seaborg*, 463 F.2d 783, 785 (D.C. Cir. 1971)). As the Court of Federal Claims observed:

> Repealing an obligation of the United States is a serious matter, and burying a repeal in a standard appropriations bill would provide clever legislators with an end-run around the substantive debates that a repeal might precipitate.

Fed. Cl. Op., 130 Fed. Cl. at 458.

The classic case of *United States v. Langston*, 118 U.S. 389 (1886), speaks clearly, that the intent to repeal or modify legislation must be clearly stated, in "words that expressly or by clear implication modified or repealed the previous law." *Id.* at 394. The Court explained that a statute should not be deemed abrogated or suspended unless a subsequent enactment contains words that "expressly, or by clear implication, modified or repealed the previous law." *Id.*

My colleagues dispose of *Langston* as an "extreme example," stating that subsequent decisions are more useful since *Langston* is a "century and a half" old. Maj. Op. at 21–22. Indeed it is, and has stood the test of a century and a half of logic, citation, and compliance. Nonetheless discarding *Langston*, the panel majority finds intent to change the government's obligations under the risk corridors statute. The majority concludes that "Congress clearly indicated its intent" to change the government's obligations, reciting two factors:

First, the majority concludes that the appropriations riders were a response to the GAO's guidance that there were two available sources of funding for the risk corridors program, and that Congress intended to remove the GAO-suggested source of funds from the HHS-CMS program management funds. My colleagues find that, by removing access to the HHS-CMS funds, Congress stated its clear intent to amend the statute and abrogate the payment obligation if the payments in were insufficient. *See* Poling Letter at 4-6 (JA237-39). Maj. Op. at 24. However, they point to no statement in the legislative history suggesting that the rider was enacted in response to the GAO's report.

Next, my colleagues look to the remarks of Chairman Harold Rogers to discern intent. He stated:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect. The agreement includes new bill language to prevent CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014) (explanatory statement submitted by Rep. Rogers, Chairman of the House Comm. on Appropriations, regarding the House Amendment to the Senate Amendment on H.R. 83, the Consolidated and Further Continuing Appropriations Act, 2015). Chairman Rogers is referring to the April 2014 "guidance," where HHS stated that they "anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments." Memorandum from CMS CCIIO, Risk Corridors and Budget Neutrality (Apr. 11, 2014) (JA229). In that guidance, HHS was stating its understanding that "risk corridors collections [might be] insufficient to make risk corridors payments for a year." *Id.*

In 2014, a bill to require budget neutrality in the operation of the risk corridors program was introduced. Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014). The proposed legislation sought to amend Section 1342(d) of the ACA to ensure budget neutrality of payments in and payments out. The bill stated:

> In implementing this section, the Secretary shall ensure that payments out and payments in under paragraphs (1) and (2) of subsection (b) are provided for in amounts that the Secretary determines are necessary to reduce to zero the cost . . . to the Federal Government of carrying out the program under this section.

Id. at § 2(d). The proposal, introduced by Senator Marco Rubio on April 7, 2014, was an effort to change the risk corridors program. The change was proposed,

but not enacted, providing an indication of legislative intent.[3]

We have been directed to no statement of abrogation or amendment of the statute, no disclaimer by the government of its statutory and contractual commitments. However, the government has not complied with these commitments—leading to this litigation.

The standard is high for intent to cancel or amend a statute. The standard is not met by the words of the riders. "[T]he intention of the legislature to repeal must be clear and manifest." *Posadas*, 296 U.S. at 503. "In the absence of some affirmative showing of an intention to repeal, the only permissible justification for a repeal by implication is when the earlier and later statutes are irreconcilable." *Morton v. Mancari*, 417 U.S. 535, 550 (1974) (citing *Georgia v. Pennsylvania R.R. Co*., 324 U.S. 439, 456–57 (1945)). Here, where there is no irreconcilable statute, repeal by implication is devoid of any support.

The panel majority does not suggest that intent to repeal can be found in the rider itself. Nor can intent be inferred from any evidence in the record. It is clear that Congress knew what intent would have looked like, because members of Congress tried, and failed, to

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[3] The panel majority argues that "we need not" consider Congress' refusal to enforce budget neutrality in the risk corridors program. Maj. Op. at 28. The Court has stated otherwise: "When the repeal of a highly significant law is urged upon that body and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide by that decision." *Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union, Loc. 770*, 398 U.S. 235 (1970).

achieve budget neutrality in the risk corridors program.

Instead, my colleagues hold that the statutory obligation was not repealed, but only "temporarily suspended." The unenacted text of the proposed "Bailout Act," reproduced *supra*, would have accomplished the result of budget neutrality that the majority finds was achieved by the riders. Congress' decision to forego this proposed repeal is highly probative of legislative intent.

Precedent does not deal favorably with repeal by implication—the other ground on which my colleagues rely. The panel majority relies heavily on *United States v. Vulte*, 233 U.S. 509 (1914). However, *Vulte* supports, rather than negates, the holding of the Court of Federal Claims. The facts are relevant: Lt. Vulte's pay as a lieutenant in the Marine Corps for service in Porto Rico was initially based on the Army's pay scale, and in 1902 Congress implemented a ten percent bonus for officers of his pay grade. In the appropriations acts for foreign service, for 1906 and 1907, Congress excluded officers serving in Porto Rico from receiving the bonus. In the act for 1908, the appropriations act continued the 10% bonus but did not mention an exclusion for service in Porto Rico. Lieutenant Vulte sought the bonus for 1908. The government argued that the 1906 and 1907 acts effectively repealed the 1902 bonus. The Court disagreed, and held that although the bonus was restricted for 1906 and 1907, the 1902 act was not repealed, and he was entitled to the 1908 bonus. *Id.* at 514.

The panel majority concludes that *Vulte* established a rule of "effective suspensions-by-appropriations." Maj. Op. at 26. That is not a valid conclusion. The Court held that, by altering the bonus for 1906 and

1907, Congress cannot have intended to effectuate a permanent repeal of the 1902 statute. *Vulte*, 233 U.S. at 514-15. And *Vulte* did not retroactively strip the officers of pay for duties they had performed while subject to the higher pay. On the question of whether an annual appropriations rider can permanently abrogate a statute, the *Vulte* Court stated:

> 'Nor ought such an intention on the part of the legislature to be presumed, unless it is expressed in the most clear and positive terms, and where the language admits of no other reasonable interpretation.' This follows naturally from the nature of appropriation bills, and the presumption hence arising is fortified by the rules of the Senate and House of Representatives.

Id. at 515 (quoting *Minis v. United States*, 40 U.S. 423, 445 (1841)). The panel majority's contrary position is not supported.

The panel majority also relies on *United States v. Mitchell*, 109 U.S. 146 (1883), to support the majority's ruling of "temporary suspension." Again, the case does not support the position taken by my colleagues. In *Mitchell* an appropriations act initially set the salaries of interpreters at $400 or $500. A subsequent appropriation, five years later, set "the appropriation for the annual pay of interpreters [at] $300 each, and a large sum was set apart for their additional compensation, to be distributed by the secretary of the interior at his discretion." *Id.* at 149. The Court stated, "[t]he whole question depends on the intention of congress as expressed in the statutes," *id.* at 150, and observed that the statute clearly stated the number of interpreters to be hired, the salary for those interpreters, and

the appropriation of an additional discretionary fund to cover additional compensation. *Id.* at 149.

The relevance of *Mitchell* is obscure, for the Court found the clear intent to change interpreters' pay for the subsequent years. There is no relation to the case at bar, where the majority holds that an appropriations rider can change the statutory obligation to compensate for past performance under an ongoing statute. However, *Mitchell* does reinforce the rule that repeal or suspension of a statute must be manifested by clearly stated intent to repeal or suspend. Also, like *Vulte*, the act that in *Mitchell* was "suspended" by a subsequent appropriation was itself an appropriation, not legislation incurring a statutory obligation. The appropriation rider in *Mitchell* simply modified an existing appropriation. In Moda's situation, however, the panel majority holds that the appropriation rider can suspend the authorizing legislation. No such intent can be found in the statute, as *Mitchell* requires and as the statute in that case provided.

The panel majority's theory is not supported by *Mitchell* and *Vulte*, for the statutes in both cases contain the clearly stated intent to modify existing appropriations. Moda's situation is more like that in *Langston*, where the Court stated:

> it is not probable that congress . . . should, at a subsequent date, make a permanent reduction of his salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel the courts to say that harmony between the old and the new statute was impossible.

Langston, 118 U.S. at 394. Similarly, it is not probable that Congress would abrogate its obligations under

the risk corridors program, undermining a foundation of the Affordable Care Act, without stating its intention to do so. The appropriations riders did not state that the government would not and need not meet its statutory commitment.

Precedent supports the decision of the Court of Federal Claims

In *New York Airways, Inc. v. United States*, the Court of Claims held 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." 369 F.2d 743, 748 (Ct. Cl. 1966) (citing *Vulte, supra*). The Civil Aeronautics Board had provided subsidies to helicopter carriers according to a statute whose appropriation provision stated:

> For payments to air carriers of so much of the compensation fixed and determined by the Civil Aeronautics Board under section 406 of the Federal Aviation Act of 1958 (49 U.S.C. § 1376), as is payable by the Board, including not to exceed $3,358,000 for subsidy for helicopter operations during the current fiscal year, $82,500,000, to remain available until expended.

Id. at 749 (citing 78 Stat. 640, 642 (1964)). However, the appropriation cap was not sufficient to cover the statutory obligation. The Court of Claims held that the insufficient appropriation did not abrogate the government's obligations to make payments. The court stated that "the failure of Congress or an agency to appropriate or make available sufficient funds does not repudiate the obligation; it merely bars the accounting agents of

the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims." *Id.* at 817.

Precedent also illustrates the circumstances in which intent to repeal or suspend may validly be found. In *Dickerson*, Congress had in 1922 enacted a reenlistment bonus for members of the armed forces who reenlisted within three months. For each year between 1934 and 1937 an appropriations rider stated that the reenlistment bonus "is hereby suspended." *Dickerson*, 310 U.S. at 556. For fiscal year 1938, the appropriations rider did not contain the same language, but stated that:

> no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1939, shall be available for the payment' of any enlistment allowance for 'reenlistments made during the fiscal year ending June 30, 1939 . . . .'

Id. at 555. The rider in *Dickerson* cut off funding from *all* sources, stating "no part of any appropriation contained in this or any other Act . . . shall be available." *Id.* The Court held that the new language continued to suspend the bonus statute, for the words, and the accompanying Congressional Record, display the clear intent to discontinue the bonus payment. The Record stated: "We have not paid [the enlistment bonus] for 5 years, and the latter part of this amendment now before the House is a Senate amendment which discontinues for another year the payment of the reenlistment allowances." 83 Cong. Rec. 9677 (1938) (statement of Rep. Woodrum). The Record and the statutory language left no doubt of congressional intent to continue the suspension of reenlistment bonuses. The panel majority recognizes that the Court in *Dickerson*

found "persuasive evidence" of "Congress's intent to suspend the reenlistment bonus." Maj. Op. at 23.

In *United States v. Will*, the Court considered statutes setting the salary of government officials including federal judges. 449 U.S. at 202. In four consecutive years, appropriations statutes had held that these officials would not be entitled to the cost-of-living adjustments otherwise paid to government employees. The annual blocking statutes were in various terms. In one year, the statute stated that the cost-of-living increase "shall not take effect" for these officials. *Id*. at 222. For two additional years, the appropriations statutes barred the use of funds appropriated "by this Act or any other Act," as in *Dickerson*. *See Will*, 449 U.S. at 205-06, 207. The fourth year's appropriation contained similar language, stating that "funds available for payments . . . shall not be used." *Id.* at 208. In each year, the language stated the clear intent that federal funds not be used for these cost-of-living adjustments.

The panel majority finds support in *Will*, and states that "the Supreme Court never considered the impact of that language in *Dickerson* or *Will*." Maj. Op. at 25. However, in *Dickerson* the Court twice repeated the "any other Act" language, *Dickerson*, 310 U.S. at 555, 556, in concluding that the language supported the intentional suspension. And in *Will*, the Court explicitly stated that the statutory language was "intended by Congress to block the increases the Adjustment Act otherwise would generate." *Will*, 449 U.S. at 223.

The Court found legislative intent clear in these cases. In contrast, the appropriations rider for risk corridors payments does not purport to change the government's statutory obligation, even as it withholds a source of funds for the statutory payment. My colleagues' ratification of some sort of permanent

postponement denies the legislative commitment of the government and the contractual understanding between the insurer and HHSCMS.

The riders cannot have retroactive effect after inducing participation

The creation of the risk corridors program as an inducement to the insurance industry to participate in the Affordable Care Act, and their responses and performance, negate any after-the-fact implication of repudiation of the government's obligations.

The government argued before the Court of Federal Claims that its obligations to insurers did not come due until the conclusion of the three year risk corridors program, and that "HHS has until the end of 2017 to pay Moda the full amount of its owed risk corridors payments, and Moda's claims are not yet ripe because payment is not yet due." Fed. Cl. Op., 130 Fed. Cl. at 451. We have received no advice of payments made at the end of 2017 or thereafter.

The appropriations rider cannot have retroactive effect on obligations already incurred and performance already achieved. Retroactive effect is not available to "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed. If the statute would operate retroactively, our traditional presumption teaches that it does not govern absent clear congressional intent favoring such a result." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994). Such clear intent is here absent.

Removal of Moda's right to risk corridors payments would "impair rights a party possessed when [it] acted," a "disfavored" application of statutes, for "a statute shall not be given retroactive effect unless such construction

is required by explicit language or by necessary implication." *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *United States v. St. Louis, S.F. & Tex. Ry. Co.*, 270 U.S. 1, 3 (1926)). Such premises are absent here.

Moda has recourse in the Judgment Fund

The Government does not argue that the Judgment Fund would not apply if judgment is entered against the United States, in accordance with Section 1491:

> The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States 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.

28 U.S.C. § 1491.

The Judgment Fund is established "to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law when . . . payment is not otherwise provided for . . . ." 31 U.S.C. § 1304(a); *see also* 28 U.S.C. §2517 ("Except as provided by chapter 71 of title 41, every final judgment rendered by the United States Court of Federal Claims against the United States shall be paid out of any general appropriation therefor.").

The contract claim is also supported

The Court of Federal Claims also found that the risk corridors statute is binding contractually, for the insurers and the Medicare administrator entered into

mutual commitments with respect to the conditions of performance of the Affordable Care Act. The Court of Federal Claims correctly concluded that an implied-in-fact contract existed between Moda and the government. I do not share my colleagues' conclusion that "Moda cannot state a contract claim." Maj. Op. at 35.

CONCLUSION

The government's ability to benefit from participation of private enterprise depends on the government's reputation as a fair partner. By holding that the government can avoid its obligations after they have been incurred, by declining to appropriate funds to pay the bill and by dismissing the availability of judicial recourse, this court undermines the reliability of dealings with the government.

I respectfully dissent from the panel majority's holding that the government need not meet its statutory and contractual obligations established in the risk corridors program.

APPENDIX D

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

[Filed: July 31, 2017]

No. 16-967C

MAINE COMMUNITY HEALTH OPTIONS,

Plaintiff,

v.

THE UNITED STATES,

Defendant.

Money mandating statute; Affordable Care Act; Risk Corridors Program; 42 U.S.C. § 18062; Appropriations riders; Limitation on use of funds.

Stephen McBrady, Washington, DC, for plaintiff. *Daniel Wolff* and *Xavier Baker*, of counsel.

Marc S. Sacks, United States Department of Justice, Commercial Litigation Branch, Civil Division, Washington, DC, for defendant. *Charles E. Canter*, *Terrance A. Mebane*, *Frances M. McLaughlin*, *L. Misha Preheim*, and *Phillip M. Seligman*, of counsel. Also on the briefs were *Chad A. Readler*, Acting Assistant Attorney General, *Ruth A. Harvey*, Director, *Kirk T. Manhardt*, Deputy Director.

OPINION

BRUGGINK, *Judge.*

This is a claim for statutory entitlement to payment under the "Risk Corridors Program" ("RCP") created by section 1342 of the Affordable Care Act ("ACA"), codified at 42 U.S.C. § 18062 (2012) ("section 1342"). The RCP is in essence a program in which insurers, and potentially the government, share both the risk and reward inherent in setting plan premiums. Plaintiff, Maine Community Health Options ("CHO") is a non-profit corporation with its principal place of business in Lewiston, Maine. It provides health insurance to its members under the federally-facilitated market place in Maine and New Hampshire. CHO is approved by the Centers for Medicare and Medicaid Services ("CMS") to offer qualified health care plans ("QHPs"). Plaintiff alleges that it is owed but has not been paid approximately $23 million under the RCP program for program years 2014 and 2015. CHO filed a motion for summary judgment on November 3, 2016. Defendant filed its opposition and moved for dismissal under Rules 12(b)(1) and 12(b)(6) on January 13, 2017. In an order dated March 9, 2017, we denied defendant's motion to dismiss for lack of jurisdiction and ripeness and preserved the remaining issues raised in plaintiff's motion for summary judgment and defendant's motion to dismiss for failure to state a claim. We also asked for additional targeted briefing. That briefing is complete. Supplemental oral argument was heard on July 24, 2017.

We conclude that Congress timely barred the use of appropriated funds to pay any amounts due under the RCP program beyond those collected from participating health care insurers. That conclusion makes it

unnecessary to pursue defendant's alternative argument that the statute cannot be construed to make the government a guarantor of deficiencies in collections under the risk corridors program.

BACKGROUND

The general way in which the program operates is that insurers whose costs for a calendar year exceed a target amount are entitled to a payment to partially recoup those expenses. Insurers whose costs are below the target amount pay a percentage of that delta into the program. The target amount is set with regard to the premiums established for each year. In this way, all participating insurers share in the risk and reward of setting premiums too high or too low. This lawsuit poses the question of whether the government has obligated itself to share in the risk by making up the difference when payments into the program fail to satisfy the amounts owed to insurers whose costs exceed the target.

There is only one count in the complaint: "Violation of Statutory and Regulatory Mandate to Make Payments." Plaintiff moved for summary judgment on that count, arguing that section 1342 mandates payment by the Department of Health and Human Services ("HHS") on a yearly basis if qualifying costs exceed a certain amount, and it is undisputed that plaintiff's costs did exceed that amount in the years 2014 and 2015.[1]

Defendant does not dispute that the amounts plaintiff calculated on a yearly basis are correct. Instead it moves for dismissal for failure to state a claim for two

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[1] Although the RCP applies to calendar years 2014, 2015, and 2016, any payment due for 2016 would not be calculated until July 2017, thus it could not have been included in the complaint.

legal reasons. First, defendant argues that Congress intended the RCP to be "budget neutral," meaning that section 1342 limits the government's payment obligations to the amounts collected from insurers whose costs are below the target amount and who therefore have paid into the RCP. If HHS collects less from insurers who must pay into the program than it owes to insurers who are due payment, then, according to defendant, the government is under no obligation to make up the difference with other funding sources. In sum, while section 1342 mandates the payment of money by HHS, that obligation is limited to the fees collected by the program. There is no underwriting by the government of deficits generated by the program.

Defendant's second and independent argument is that, even if the statutory language of the RCP provisions is construed to create an open-ended obligation on the part of the federal government to make up the deficits in the operation of the risk corridors, Congress timely barred the use of any appropriated funds other than fees collected in appropriations riders in 2014 and 2015 and that expression of congressional intent trumps any different obligation arguably created by section 1342.

In response, plaintiff asserts that Congress' failure to amend or repeal the RCP reflects that it was not intended to be budget neutral when it was originally passed and remains so today. Plaintiff also argues that the appropriations riders were not effective to limit the government's liability under the statute because section 1342 had already created an obligation before the riders were passed. Plaintiff urges that the riders should not be read to have retrospective effect.

Four other judges of this court have considered these and similar arguments. All found jurisdiction

and that the claims were not premature. *Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457 (2017); *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757 (2016); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81 (2016). Three of the judges went on to address the merits of insurers' claims and the government's defense of failure to state a claim. Two judges arrived at a different conclusion than the third. *Compare Land of Lincoln*, 129 Fed. Cl. at 108 (holding that the statute was ambiguous and deferring to the agency's interpretation that payments need neither be made yearly nor in any amount over what HHS collects under the program), *and Blue Cross*, 131 Fed. Cl. at 475 (holding that the plain language of the statute and regulation do not create an annual deadline to make RCP payments), *with Moda*, 130 Fed. Cl. at 455, 460-65 (holding, *inter alia*, that the statute is not budget-neutral and that the appropriations riders did not vitiate HHS' yearly payment obligation). Here, we have already held that section 1342 is money mandating, although we preserved defendant's contention that the mandate is capped by fees received. *See Maine Cmty. Health Options v. United States*, No. 16-967C (Fed. Cl. Mar. 9, 2017) (order denying Def.'s Mot. to Dismiss for lack of jurisdiction).

I. LEGISLATIVE HISTORY

We begin with some of the legislative history of the act, which is illustrative of the history of the particular provisions at issue. On September 17, 2009, the Senate Committee on Health, Education, Labor, and Pensions reported its version of the ACA to the floor. S. 1679, 111th Cong. § 142. This version included an express provision that authorized HHS to use money in the

Treasury for RCP payments to QHP issuers.[2] Over a month later, the Senate Committee on Finance subsequently reported its own version of the legislation. S. 1796, 111th Cong. § 1001 (2009). This version contained no reference to funding the RCP and modeled more closely the language eventually adopted in section 1342 of the ACA. *Id.*

Once the final draft of the ACA was prepared, the Congressional Budget Office ("CBO") released its budget scoring on March 20, 2010, notably omitting the RCP from the scoring and attributing no expenses to it. Letter from Douglas W. Elmendorf, Director, Cong. Budget Office, to Nancy Pelosi, Speaker, House of Representatives, Tbl. 2 (March 20, 2010). Congress relied on the CBO's report in passing the ACA, as stated in the legislation itself, "(1) [b]ased on . . . (CBO) estimates, this Act will reduce the Federal deficit between 2010 and 2019. (2) CBO projects this Act will continue to reduce budget deficits after 2019." Pub. L. No. 111-148, § 1563(a), 124 Stat. 270; *see also Land of Lincoln*, 129 Fed. Cl. at 104.

On March 23, 2010, the ACA became law, including section 1342, which 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

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[2] "(B) FUNDING.—There is hereby appropriated to the Start-Up Fund, out of any moneys in the Treasury not otherwise appropriated an amount requested by the Secretary of Health and Human Services as necessary to—. . . (iii) make payments under paragraph (3)." S.1679 § 3106(c)(1)(B). Paragraph 3 would have created a risk corridor program.

group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 USCS §§ 1395w-101 et seq.].

(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 percent 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 allowable costs in excess of 108 percent of the target amount.

(2) Payments in. 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 less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary

> an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062. The statute is silent here and elsewhere as to funding for the payments out other than the implication that the payments in could be used in that manner.

II. REGULATORY FRAMEWORK

The details of how the RCP would be administered and when payments were due or would be made were largely left to HHS. It published a final payment rule on March 23, 2012, stating in relevant part:

> (a) General requirement. A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.
>
> (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.

(c) Health insurance issuers' remittance of charges. QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:

(1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and

(2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

(d) Charge submission deadline. A QHP issuer must remit charges to HHS within 30 days after notification of such charges.

45 C.F.R. § 153.510 (2012); 78 Fed. Reg. 15,410, 15,531 (Mar. 11, 2013) (adding subsection (d)). At the same time, HHS also published an impact analysis of the new regulation. 77 Fed. Reg. 17,220, 17,243 (Mar. 23, 2012). It stated:

> CBO estimates that risk adjustment payments and collections are equal in the aggregate . . . . CBO did not score the impact of the risk corridors program, but assumed collections would equal payments to plans in the aggregate. The payments and receipts in risk adjustment and reinsurance are financial transfers between issuers and the entities running those programs.

Id. At 17,244.

III. AGENCY ACTION

The seemingly definitive statement notwithstanding, in the years following the adoption of its final rule, HHS took less-than-consistent positions with respect to whether the RCP would be implemented in a budget-neutral manner. During the comment and answer period for the 2013 final rule, HHS stated that "[t]he 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. Later, however, in its 2015 payment rule comment and answer, HHS stated it "intend[ed] to implement [RCP] in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, . . . [HHS] may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal." 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014). One

month later, HHS issued a bulletin outlining a pro rata approach for "payments out" if the "payments in" were not sufficient and promising that it would issue further guidance on risk corridor payments if the collections did not cover them entirely at the conclusion of the three-year program. Pl.'s Mot. Summ. J. Addendum A Doc. 5. HHS confirmed on two other separate occasions its intent for the RCP to be budget neutral over the course of the three-year program; yet it simultaneously recognized that, if there is a shortfall, "the Affordable Care Act requires the Secretary to make full payments to issuers," and "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations." 79 Fed. Reg. 30,240, 30,260 (May 27, 2014); 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

On October 1, 2015, HHS announced that it would only be able to pay 12.6% of amounts due for 2014 due to lower payments in than requested payments out. Approximately one month later, HHS communicated that it owed $241,717 to CHO, but would only be paying the pro-rated amount of $30,499.53. On the same day, however, HHS also informed QHP issuers that all unfulfilled payments out for the RCP were required to be paid in full and would be treated as fiscal year 2015 obligations for the government. The following year, HHS notified QHP issuers that it would allocate the full amount of collections for benefit year 2015 toward benefit year 2014 payments and use benefit year 2016 collections to satisfy everything that remained, although it concluded that any outstanding payments at the end of the three-year program would be "subject to the availability of appropriations." Pl.'s Mot. Summ. J. Addendum A Doc. 11.

In summary, HHS has attempted to maintain the general position that the RCP is not statutorily required to be budget neutral, but that HHS intended to implement it in a budget neutral manner. According to its interpretation, any additional payments owed but not covered by the RCP would be paid subject to the availability of appropriations.

IV. APPROPRIATIONS RIDERS

Both parties acknowledge that the chronology of events is especially critical, particularly pertaining to the appropriations riders. As CHO noted and the government agreed, the earliest possible HHS payments to QHP issuers could not occur before July 2015, when plaintiff submitted its cost information for benefit year 2014 to HHS. *See* Oral Arg. Tr. 54-55 (Feb. 15, 2017); Def.'s Suppl. Br. 8. HHS set a deadline of July 31, 2015 for insurers to submit premium and cost data for the preceding calendar year to HHS, and it set a deadline of August 1, 2016, for the 2015 calendar year. It began making payments for the proceeding years in December of 2015 and 2016.

In February 2014, prior to any plan data and payments, Congress asked the Government Accountability Office ("GAO") to determine what sources of funding would be available when RCP payments were due to QHP issuers. *U.S. Gov't Accountability Office, GAO Op. B-325630, Department of Health and Human Services–Risk Corridor Program* 1 (2014). GAO responded that the CMS Program Management ("PM") appropriation, essentially the operating budget, and "user fees" (RCP collections) could be used to make payments, but only if the appropriations from fiscal

year 2014 were re-enacted.[3] *Id.* at 4-5. The GAO report did not mention any other sources of funding as available to the program.

On December 16, 2014, Congress adopted an appropriation for fiscal year 2015. Beyond deciding not to adopt the same language as the previous year, Congress affirmatively prevented CMS Program Management funds from being used to satisfy an obligations under the RCP. The appropriation states:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services–Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Consolidated and Furthering Continuing Appropriations Act 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491 (2014). The Chairman of the House Committee on Appropriations explained the reasoning behind this measure:

> In 2014, HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk

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[3] Re-enactment was required because "[a]n appropriation in a regular, annual appropriation law may be construed to be permanent or available continuously only if the appropriation . . . expressly provides that it is available after the fiscal year covered by the law in which it exists." 31 U.S.C. § 1301(c) (2012). This appropriation did not expressly provide such an availability.

> corridors are in effect. The agreement includes new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments.

160 Cong. Rec. H9838 (daily ed. Dec.11, 2014). Congress thus expressly barred the use of appropriated funds for RCP payments and implicitly limited HHS to user fees funds to satisfy RCP payments.

Congress adopted an identical appropriation limitation the following year, which further included the following:

> In addition to the amounts otherwise available for "Centers for Medicare and Medicaid Services, Program Management", the Secretary of Health and Human Services may transfer up to $305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund to support program management activity related to the Medicare Program: *Provided*, that except for the foregoing purpose, such funds may not be used to support any provision of Public Law 111–148 or Public Law 111–152 (or any amendment made by either such Public Law) or to supplant any other amounts within such account.

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, title II, §§ 225-226, 129 Stat. 2242, 2624-25 (2015). The import is that extra funds appropriated to Medicare's operating budget could not be used to meet other obligations created by the ACA, such as the RCP. Similar to the year before, a Senate Committee Report detailed that this appropriation rider was aimed at protecting discretionary funds

(operating funds) from being used for RCP payments because that was never their intended purpose. S. Rep. No. 114-74, at 12 (2015).

DISCUSSION

Insofar as relevant here, the Tucker Act gives this court jurisdiction to hear claims for money against the United States founded upon any Act of Congress or any regulation. 28 U.S.C. §1491(a)(1) (2012). As the Supreme Court has made clear, however, the Tucker Act is merely jurisdictional; it is not a grant of substantive rights. *United States v. Testan*, 424 U.S. 392, 398 (1976). A successful plaintiff must point to a source in substantive law that creates liability. "[A] waiver of the traditional sovereign immunity 'cannot be implied but must be unequivocally expressed,'" *Id.* at 953-54 (citing *United States v. King*, 395 U.S. 1, 4 (1969)).

I. Statutory Interpretation

Plaintiff believes that this court's inquiry begins, and more importantly, ends with the text of section 1342's payment out provision, which states:

> (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 percent 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 allowable costs in excess of 108 percent of the target amount.

42 U.S.C. § 18062(b) (emphasis supplied). The use of "shall pay" creates an enforceable obligation, according to plaintiff.

As we held previously, there is no question that the statute commands payment of money by the Secretary. Thus the court has jurisdiction to decide whether plaintiff is entitled to payment, but whether the government's payment obligation is limited in some way by other provisions or by subsequent legislation remains unanswered by the language quoted above. The government urges that it is limited by both. The question generally stated then is whether the RCP contemplates merely a divvying up of fees received or if the Treasury is obligated to make up any difference. Defendant urges that Congress did not intend to obligate any payment of money beyond what is collected under the program and that, in any event, it expressly limited the funds available to make RCP payments in appropriation legislation. We do not reach the first issue because the answer to the second question is clear. Congress controls the purse. Within certain limitations, which we find not to be relevant here, it has the right to nullify what would otherwise appear to be binding commitments, and it did so here.

II. Statutory Amendment Via Appropriation

We hold that Congress clearly and timely expressed its intention that public funds not be used to pay deficiencies arising under section 1342, at least for fiscal years 2015 and 2016. While the application of

this fact is complicated in part by the lack of symmetry between the program years, which operate on a calendar basis, and fiscal years, which run from October 1 to September 30, it is undisputed that the appropriations riders at issue were adopted prior to what we view as the key dates: the end of benefit year 2014 and the end of benefit year 2015. We are thus not confronted with a situation in which the interdict comes after the entitlement is fixed.[4]

We begin with the proposition that Congress' power to spend, or not, is unimpeded by its earlier actions. This axiom of federal law has consequences as applied to the interplay between substantive legislation, such as the ACA, and the appropriations needed to fund it. The relevant principles are drawn from a few key decisions of the Supreme Court.

In *United States v. Mitchell*, 109 U.S. 146 (1883), an Indian interpreter for the Secretary of the Interior claimed he had not been paid his statutory salary. Congress had in 1834 dictated a salary of $400 per year. Yet Mr. Mitchell, who worked between 1878 and 1882, had been paid only $300 per year. Beginning in 1877, Congress had, in its annual appropriations for Indian affairs, specifically limited salaries for individuals like Mr. Mitchell to $300 per year. The Court observed the following:

> We find, therefore, this state of legislation: by the Revised Statutes, the salaries of interpreters were fixed . . . at $400 . . . . By the acts in force during the appellee's term of service, the appropriation for the annual pay of interpreters was $300 each, and a large sum

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[4] Thus plaintiff's concerns regarding retroactivity are not implicated.

> was set apart for their additional compensation, to be distributed by the Secretary of the Interior at his discretion.
>
> This course of legislation . . . distinctly reveals a change in the policy of Congress on this subject–namely that instead of establishing a salary for interpreters at a fixed amount and cutting off all other emoluments and allowances, Congress intended to reduce the salaries and place a fund at the disposal of the Secretary of the Interior.

Id. at 149.

The Court noted that it did not have before it a simple case of a failure to appropriate sufficient funds to cover an obligation: "On the contrary, in this case Congress has in other ways expressed its purpose to reduce for the time being the salaries of interpreters." *Id* at 150. The court found that his salary was fixed by the subsequent appropriation acts and not the earlier 1834 act.

A similar result obtained in *United States v. Dickerson*, 310 U.S. 554 (1940). Congress in 1922 had authorized the payment of an enlistment bonus to every soldier who re-enlisted within three months after the date of his discharge. The plaintiff had been honorably discharged at the termination of his enlistment in July 1938. He re-enlisted one day later. He was denied a bonus, however, because in June 1938 Congress, in a resolution appended to an appropriations bill, directed that no part of any appropriation for the fiscal year ending June 30, 1939, could be used to pay re-enlistment bonuses, "notwithstanding" the prior statute. *Id.* at 555. The Court of Claims ruled in favor of the soldier, on the grounds that the prior

legislation had not been repealed. The Supreme Court reversed. It held that "[t]here can be no doubt that Congress could suspend or repeal the authorization contained in Section 9, and it could accomplish its purpose by an amendment to an appropriation bill, or otherwise." *Id.* (citing *Mitchell*, 109 U.S. at 150). Because of sloppy legislative drafting, the Court was confronted with the argument that the resolution was not phrased in a clear enough manner to warrant setting aside the bonus. A review of the legislative history of the provision persuaded the Court that Congress' intent was clear.

Although it involved application of the Compensation Clause of Article III, § 1, *United States v. Will*, 449 U.S. 200 (1980), also assists the government here. The primary question there was whether Congress had timely intercepted judicial pay raises before they took effect at the beginning of four different calendar years. While the protection afforded by the Compensation Clause is not relevant here, the Court's observations about how to implement subsequent appropriations limitations if they undercut substantive provisions offer us guidance. Although repeals by implication are disfavored, particularly if they arise in appropriations legislation, Congress can suspend or repeal a statute in force by an amendment to appropriations bill. *Id.* at 222 (citing *Mitchell*, 109 U.S. at 150). The "whole question depends on the intention of Congress as expressed in the statutes." *Id.* Because Congress' intent in *Will* was unmistakable, the only limitation on its power to reverse the pay increases was the Compensation Clause, which only applied in two of the years at issue; "[t]o say that Congress could not alter a method of calculating salaries before it was executed would mean the Judicial Branch could command Congress to carry out an announced future intent as

to a decision the Constitution vest exclusively in the Congress." *Id.* at 228.

These three cases establish that Congress can effect a change to a substantive obligation that was earlier created through language in subsequent appropriations legislation. Thus the "shall pay" language of section 1342 is not dispositive in the face of two appropriations riders that limit the sources of funding for that obligation. We must therefore parse those appropriations to answer the question.

III. The Effect Of The Appropriations Legislation

Given that section 1342's payments in and payments out are accounted for on a yearly basis, the amount owed by or owed to an insurer in the RCP cannot be known until the end of the plan year after all of the expenses for that year are accounted for. The plan years correspond to calendar years. Thus the government's liability to any particular insurer for a particular year cannot be known until the last day of that calendar year.[5]

Congress passed the two relevant appropriations provisions in December of 2014 and 2015. The 2014 bill applies by its terms to fiscal year 2015, and the 2015 bill applies to fiscal year 2016. The government's fiscal year begins in October of the preceding calendar year. Thus, for the 2014 plan year (calendar year), even assuming that payment could be made as soon as costs were completely fixed on the final day of the year, any federal funds necessary to make RCP payments would come from 2015 fiscal year funds. The same is

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[5] Or perhaps even beyond that date since, as defendant pointed out during oral argument, insurance claims are regularly submitted for a plan year during the first few months of a subsequent year.

true for the following year (2015 payments could only be made from fiscal year 2016 funds). Thus we find that Congress timely intercepted its RCP obligations in those years by passing the appropriations provisions in December of each year.

Obligation necessarily precedes payment, and the obligation here matured at the end of benefit year 2014. This is because HHS was required to collect an entire year of data before compiling the information and determining RCP payment amounts. *See* 42 U.S.C. § 18062; 45 C.F.R. § 153.510. Once the benefit year concluded, the data was theoretically final, needing only to be reported and interpreted to ascertain what obligations existed within the RCP.

The effect of these riders was to prevent HHS from using its CMS operating fund to meet any government liability created by the RCP. This left HHS with only the user fees as available to make RCP payments. Plaintiff has not suggested an alternative source of funding for these payments, and we think for good reason. Other federal funds available to HHS are specifically set aside to pay benefits under Medicare and Medicaid. In order to touch those pools of money, Congress must expressly direct some other use for those funds. Plaintiff argues instead, citing several Court of Claims decisions, that the source of the funding is immaterial once the obligation is created. The Judgment Fund can be used to make up a shortfall, posits plaintiff. As we explained earlier, however, the law in this regard is not so simple. Congress can limit or forestall the payment of obligations it has earlier created through subsequent legislation, even by means of appropriations legislation.

The decisions of the Court of Claims and the Federal Circuit are largely consistent. Although the result in

Norcross v. United States, 142 Ct. Cl. 763 (1958), was favorable to the complainant, the court's reasoning does not dictate the result plaintiff wishes for here. A congressman had employed a clerk in his office, unaware that she was an Austrian citizen. Congress had adopted in 1952 an appropriations rider that placed limits, during that fiscal year, on hiring foreign nationals. Plaintiff had been employed in February 1952. The case was not heard until 1958, a year in which, as Judge Jones noted, the limitations no longer had effect because, "the restriction does not apply to funds appropriated by a subsequent Congress, unless the restriction were again attached," which it was not. He then helpfully suggested to his former colleagues in Congress that there was no reason "why a subsequent Congress may not pay the reasonable value of services actually rendered even though the funds of the 1952 appropriation act could not be used."[6] *Id.* at 766. Despite the creative result, the point remains that Congress' subsequent directions, expressed even in appropriations riders, can control prior promises.

Another opinion by Judge Jones, *Gibney v. United States*, 114 Ct. Cl. 38 (1949), dealt with an attempt to limit the government's liability for overtime pay. The legislative restriction provided that "none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided in the Federal Employees Pay Act of 1945." *Id.* at 48-49. In ruling for the employee, Judge Jones explained that

> The judgment of a court has nothing to do with the means–with the remedy for

[6] Judge Jones acknowledged "some difference of opinion" as to his reasoning, but noted, citing scripture, that the court agreed she should be paid. *Id.* at 767.

> satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them. Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate an insufficient amount, or a sufficient amount, or nothing at all, are questions which are vital for the accounting officers, but which do not enter into the consideration of a case in the courts.

Id. at 52. The court explained that "a pure limitation on an appropriation bill does not have the effect of either repealing or even suspending an existing statutory obligation any more than the failure to pay a note in the year in which it was due would cancel the obligation stipulated in the note." *Id.* at 50-51. Judge Jones distinguished *Dickerson* by explaining that, unlike the legislation in *Gibney,* which it viewed as strictly a limitation on the use of particular funds for a particular year, the history of the legislation in *Dickerson* demonstrated a clear intent to suspend the legislative authorization. In the case at bar, it is precisely the demonstrated clear Congressional intent that prevents the payment of federal funds to make RCP payments.

The Federal Circuit has had occasion twice to address Congress' dealings with "payments in lieu of taxes." The first was *Highland Falls-Fort Montgomery Central School District v. United States,* 48 F.3d 1166 (Fed. Cir. 1995). There the court noted that Congress had, beginning in 1950, continually re-authorized a program of compensating local school districts for the loss of property tax revenue due to the presence of

large federal military installations. The statute provided that, "the local educational agency shall be entitled to receive for such fiscal year such amount as, in the judgment of the Secretary [of Education], is equal to the [financial burden imposed.]" 20 U.S.C. § 237(a)(2) (1988 & Supp. V 1993) (repealed 1994). There were other provisions that provided subsidies under other, related circumstances. The statute recognized, however, the possibility that appropriations might be insufficient to fully fund all the eligible recipients under any of the applicable provisions. In that case, a recipient under section 237 was not only given priority, it was assured "100 percentum of the amount to which it is entitled as computed under that section." *Id.* § 240(c) (repealed 1994). Despite that provision, from 1989 to 1993, Congress did not appropriate sufficient funds to fully fund the program, and it further capped the amount payable to section 237 recipients at $15 million. The Department of Education followed those appropriation restrictions rather than the language of section 240.

The Federal Circuit endorsed DOE's approach:

> [W]e have great difficulty imagining a more direct statement of congressional intent than the instructions in the appropriations statutes at issue here. For example, the appropriation statue for fiscal year 1989 stated: "$15,000,000 shall be for entitlements under section 2 [Sec. 237] of said Act."

Highland Falls, 48 F.3d at 1170.

Moreover, the circuit court relied on two statutory provisions which it viewed as controlling. 31 U.S.C. § 1341(a)(1)(A) (2012) provides that "[a]n officer or employee of the United States Government . . . may

not . . . make or authorize an expenditure . . . exceeding an amount available in an appropriation . . . for the expenditure." Also, 31 U.S.C. § 1532 states that an "amount available under law may be withdrawn from one appropriation account and credited to another . . . only when authorized by law." In other words, an agency may not spend more money than Congress authorizes for it to use on a particular program, nor may it cannibalize one reticule to supplement another.

In *Prairie County v. United States,* 782 F.3d 685 (2015), the Federal Circuit had occasion to revisit the payment in lieu program. It recognized that "[i]t 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." *Id.* at 689 (quoting *N.Y. Airways v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966)).[7] Nevertheless, the court in *Prairie County* noted that Congress had spoken clearly when it wrote in 31 U.S.C. § 6906 that, "notwithstanding any other provision of this chapter no funds may be made available except to the extent provided in advance in appropriation Acts." 782 F.3d at 690.

In *Prairie County* the court distinguished several cases cited by plaintiff in this cases: *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182 (2012), and *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631 (2005). As the *Prairie County* court stated, where a government contract obligation exists, the government may be

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[7] We view it as telling, as well, that despite the statutory basis for the airlines' claims in *N.Y. Airways*, the court described Congress's own view that the obligations were more in the nature of contracts. *See* 369 F.2d at 747.

compelled to pay more than it originally appropriated. 782 F.3d at 687. This differs, however, from cases involving a benefits program because "there is greater room in benefits programs to find the government's liability limited to the amount appropriated." *Id.* at 689 (quoting *Greenlee County v. United States*, 487 F.3d 871, 879 (Fed. Cir. 2007)). Accordingly, *Ramah* and *Leavitt* are not controlling and the court's reasoning in *Prairie County* aligns with how we view similar precedent here.

Further, we agree with defendant that *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011), and *United States v. Langston*, 118 U.S. 389 (1886), do not lead to a different result. *Slattery* involved a contract claim against a non-appropriated fund instrumentality, and the court was presented with a question of jurisdiction. While it is true that the absence of general appropriations supporting the Federal Deposit Insurance Corporation did not deter the Federal Circuit from finding jurisdiction and potential liability, the court did not speak to the issue relevant here. In the present action, the remaining question is not the court's jurisdiction to hear money claims, the agency involved is not a non-appropriated fund instrumentality, and, most relevant for our purposes, the claim is not for breach of contract. As we discussed above, the Court has developed a different approach in judging Congress' ability to use appropriations limitations to bar recoveries in the case of statutory "benefits" as distinct from contract claims.[8]

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[8] The same would be true for breach of trust cases, and constitutional takings claims wherein government liability is either fixed by the constitution, and thus not subject to appropriations limitations, or by statutorily-created duties that create a fiduciary

Langston dealt with the salary of America's ambassador to Haiti. By statute the ambassador's salary had been pegged at $7,500, and that amount had been specifically appropriated for that purpose for several years. The annual appropriations included the statement that the appropriation "shall be in full for the annual salaries thereof from and after July 1, 1878." *Langston*, 118 U.S. at 390. Beginning in 1882, however, this language was omitted and the appropriation was for only $5,000. The Court sustained the ambassador's claim for the differential in pay, despite the absence of an appropriation for the full amount because of the earlier language indicating that the $7,500 salary should continue beyond 1878, and also because the later statute did not purport to cap his pay at $5,000:

> [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.

Langston, 118 U.S. at 394. The specificity of the earlier promise, in short, was not overcome by a later appropriation short of the promised amount.

The present facts offer a reverse scenario. The language of entitlement is not specific with respect to Congress's intent to appropriate, but its subsequent language disavowing any such obligation is clear.

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relationship between the government and some third party, such as Native American tribes.

Finally, also relevant is the Federal Circuit's decision in *Star-Glo Assocs., LP v. United States*, 414 F.3d 1349 (Fed. Cir. 2005). There, Congress had established a program to be administered by the Department of Agriculture to compensate Florida citrus growers for the compelled destruction of diseased trees. The program operated for two years before Congress, in October 2000, adopted an appropriations statute with respect to the fiscal year 2000, which provided that the Secretary of Agriculture "shall use $58,000,000 of the funds of the Commodity Credit Corporation to carry out this section, to remain available until expended." *Id.* at 1352. There is no question that the plaintiff growers complied with the applicable regulations and would have been compensated but for the appropriations cap. The Court of Federal Claims held, despite the fact that plaintiffs had applied for compensation prior to the exhaustion of the appropriated funds, they could not recover because the cap barred further payments. 59 Fed. Cl. 724, 733 (2004). The Federal Circuit affirmed, although on a somewhat different basis. Initially it agreed with the applicability of the cap. Relying on legislative history as well as the language of the appropriations statute, it concluded that there was "no room to doubt that Congress intended benefits available under section 810 to be capped at $58,000,000." *Id.* at 1355.

The plaintiffs in *Star-Glo* argued, however, that the fact that their applications were submitted prior to the exhaustion of funds made the cap irrelevant, and that it made the facts distinguishable from, for example, *Highland-Falls*, where the appropriation had been exhausted prior to the plaintiff seeking additional funds. The circuit court found it unnecessary to reach the question, however, because it ruled that plaintiff

did not qualify for any further payments under the terms of the statute. *Id.* at 1357-58.

Although it is difficult to harmonize the decisions in this lengthy history, we believe they lead to following controlling principles. Mere non-appropriation of sufficient funds to meet an existing obligation created by statute[9] will not thwart the courts' enforcement of the obligation. Whether Congress, in subsequent appropriations legislation, can block enforcement of a substantive obligation depends, ultimately, on how clearly it expresses its intent to do so.

These principles dictate the result here. Congress made clear its intention that no public funds be spent to reimburse risk corridor participants beyond their user fee contributions. It asked GAO what monies were available to HHS to make risk corridor payments. GAO answered that user fees and the CMS program management fund were the only sources available. Congress expressly blocked the use of the latter, leaving only the former. The government's obligation was thus capped to the amount brought in from user fees. We are not presented with possible exceptions to this outcome. There were no contract commitments and Congress did not merely fail to address the source of funding. It affirmatively barred the use of public funds in a timely manner, predating the maturation of any obligation to make statutory entitlement payments.

We recognize that Judge Wheeler arrived at a different conclusion in *Moda Health* after examining the same cases. We respectfully disagree with his

[9] We recognize that the case law dealing with contractual obligations, the takings clause, or those arising out of Indian trusts, is *sui generis*.

conclusion. He relied heavily on a distinction present in the legislation in *Dickerson* and *Will,* two cases in which appropriation bars were enforced to thwart the implementation of rights arising from substantive legislation. In both cases, Congress had used, in substance, the phrase, "the appropriation in this or any other Act." I.e., Congress was ensuring that the agencies would not subvert its intent by funding the programs at issue from other sources. Not finding that language in the appropriations riders in the present circumstances, he held that they did not limit the substantive obligation created by section 1432. *Moda*, 130 Fed. Cl. At 460-61. We disagree. These appropriations provisions were adopted after Congress inquired of GAO concerning available funding for the RCP payments. Congress was presented with two potential pools of money for RCP payments and clearly eliminated one of them, thus expressly limiting payments to the other pool—user fees. Once those funds were exhausted, the government's liability was capped.

Furthermore, we remain unconvinced by plaintiff's argument that Congress' failure to amend or repeal the RPC indicated that it did not intend the program to be budget neutral. We agree with defendant that it is imprudent to determine Congress' intent based merely upon what it was unable to do. The legislative history of the statute does not lend itself to plaintiff's interpretation. In fact, Congress opted to follow a committee design for section 1342 without an enumerated appropriation, declining to mimic a different committee's design which specifically included an appropriation. *Compare* S. 1796, 111th Cong., *with* S. 1679, 111th Cong. Congress had every opportunity to include an appropriation as it had in other sections of the ACA, *see, e.g.*, 42 U.S.C. §§ 18001(g)(1), 18031(a)(1), 18042(g), 18043(c), 18121(b), and remove

any doubt of budget neutrality, but declined to do so. While the CBO's decision to omit any reference to the RCP in the ACA scoring is not dispositive, it does suggest that plaintiff is incorrect. Plaintiff's position is further hampered in light of the subsequent appropriations riders that explicitly restrict where funding could be obtained after the GAO highlighted which sources may be available. As discussed previously, even if there were a mature obligation, Congress can amend it via appropriations legislation. *See Dickerson*, 310 U.S. at 555. Nonetheless, the actions or inactions of a previous Congress are not binding on a later Congress.

Although we raised the issue of the availability of the Judgment Fund for additional briefing, we conclude that the issue is immaterial. Retreat to the Judgment Fund assumes a liability in the first instance. *See Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990). We cannot order the payment of monies out of the Treasury beyond those arising from user fees.

CONCLUSION

Plaintiff's motion for summary judgment is denied. Defendant's motion to dismiss for failure to state a claim is granted. The Clerk is directed to dismiss the complaint and enter judgment accordingly. No costs.

s/ Eric G. Bruggink
ERIC G. BRUGGINK
Senior Judge

APPENDIX E

IN THE UNITED STATES COURT
OF FEDERAL CLAIMS

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Nos. 16-967 C

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MAINE COMMUNITY HEALTH OPTIONS,

Plaintiff,

v.

THE UNITED STATES,

Defendant.

———

JUDGMENT

Pursuant to the court's Opinion, filed July 31, 2017, denying plaintiff's motion for summary judgment and granting defendant's motion to dismiss,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiff's complaint is dismissed. No costs.

Lisa L. Reyes
Acting Clerk of Court

July 31, 2017

By: /s/ Anthony Curry
Deputy Clerk

NOTE: As to appeal, 60 days from this date, see RCFC 58.1, re number of copies and listing of all plaintiffs. Filing fee is $505.00.

APPENDIX F

Section 1342(b)(2) & (c) of the ACA, 42 U.S.C. § 18062(b)(2) & (c)

(b) Payment methodology

* * *

(2) Payments in

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 less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

(B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall reduced by any risk adjustment and reinsurance payments received under section 18061 and 18063 of this title.

(2) Target amount

The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

APPENDIX G

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2491 (2014)

SEC. 227. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2624 (2015)

SEC. 225. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 543 (2017)

SEC. 223. None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

APPENDIX H

28 U.S.C. §1491(a)(1)

Claims against United States generally; actions involving Tennessee Valley Authority

(a)(1) The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States 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. For the purpose of this paragraph, an express or implied contract with the Army and Air Force Exchange Service, Navy Exchanges, Marine Corps Exchanges, Coast Guard Exchanges, or Exchange Councils of the National Aeronautics and Space Administration shall be considered an express or implied contract with the United States.

APPENDIX I

31 U.S.C. §1304(a)

Judgments, awards, and compromise settlements

(a) Necessary amounts are appropriated to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law when—

(1) payment is not otherwise provided for;

(2) payment is certified by the Secretary of the Treasury; and

(3) the judgment, award, or settlement is payable—

(A) under section 2414, 2517, 2672, or 2677 of title 28;

(B) under section 3723 of this title;

(C) under a decision of a board of contract appeals; or

(D) in excess of an amount payable from the appropriations of an agency for a meritorious claim under section 2733 or 2734 of title 10, section 715 of title 32, or section 20113 of title 51.

APPENDIX J

45 C.F.R. §147.106(a)-(b), (d)(1)

Guaranteed renewability of coverage.

(a) ***General rule.*** Subject to paragraphs (b) through (d) of this section, a health insurance issuer offering health insurance coverage in the individual, small group, or large group market is required to renew or continue in force the coverage at the option of the plan sponsor or the individual, as applicable.

(b) ***Exceptions.*** An issuer may nonrenew or discontinue health insurance coverage offered in the group or individual market based only on one or more of the following:

(1) ***Nonpayment of premiums.*** The plan sponsor or individual, as applicable, has failed to pay premiums or contributions in accordance with the terms of the health insurance coverage, including any timeliness requirements.

(2) ***Fraud.*** The plan sponsor or individual, as applicable, has performed an act or practice that constitutes fraud or made an intentional misrepresentation of material fact in connection with the coverage.

(3) ***Violation of participation or contribution rules.*** In the case of group health insurance coverage, the plan sponsor has failed to comply with a material plan provision relating to employer contribution or group participation rules, pursuant to applicable state law. For purposes of this paragraph the following apply:

(i) The term "employer contribution rule" means a requirement relating to the minimum level or amount of employer contribution toward the premium for enrollment of participants and beneficiaries.

(ii) The term "group participation rule" means a requirement relating to the minimum number of participants or beneficiaries that must be enrolled in relation to a specified percentage or number of eligible individuals or employees of an employer.

(4) ***Termination of product.*** The issuer is ceasing to offer coverage in the market in accordance with paragraph (c) or (d) of this section and applicable State law.

(5) ***Enrollees' movement outside service area.*** For network plans, there is no longer any enrollee under the plan who lives, resides, or works in the service area of the issuer (or in the area for which the issuer is authorized to do business); and in the case of the small group market, the issuer applies the same criteria it would apply in denying enrollment in the plan under § 147.104(c)(1)(i); provided the issuer provides notice in accordance with the requirements of paragraph (c)(1) of this section.

(6) ***Association membership ceases.*** For coverage made available in the small or large group market only through one or more bona fide associations, if the employer's membership in the bona fide association ceases, but only if the coverage is terminated uniformly without regard to any health status-related factor relating to any covered individual.

* * *

(d) ***Discontinuing all coverage.***

(1) An issuer may elect to discontinue offering all health insurance coverage in the individual, small group, or large group market, or all markets, in a State in accordance with applicable State law only if -

(i) The issuer provides notice in writing to the applicable state authority and to each plan sponsor or individual, as applicable, (and all participants and beneficiaries covered under the coverage) of the discontinuation at least 180 calendar days prior to the date the coverage will be discontinued; and

(ii) All health insurance policies issued or delivered for issuance in the state in the applicable market (or markets) are discontinued and not renewed.

APPENDIX K

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

DEPARTMENT OF HEALTH &
HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and
Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: **April 11, 2014**

Subject: **Risk Corridors and Budget Neutrality**

Q1: In the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) and the Exchange and Insurance Market Standards for 2015 and Beyond NPRM (79 FR 15808), HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?

A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point

where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Example 1: For 2014, HHS collects $800 million in risk corridors charges, and QHP issuers seek $600 million risk corridors payments under the risk corridors formula. HHS would make the $600 million in risk corridors payments for 2014 and would retain the remaining $200 million for use in 2015 and potentially 2016 in case of a shortfall.

Example 2: For 2015, HHS collects $700 million in risk corridors charges, but QHP issuers seek $1 billion in risk corridors payments under the risk corridors formula. With the $200 million in excess charges collected for 2014, HHS would have a total of $900 million available to make risk corridors payments in 2015. Each QHP issuer would receive a risk corridors payment equal to 90 percent of the calculated amount of the risk corridors payment, leaving an aggregate risk corridors shortfall of $100 million for benefit year 2015. This $100 million shortfall would be paid for from risk corridors charges collected for 2016 before any risk corridors payments are made for the 2016 benefit year.

Q2: What happens if risk corridors collections do not match risk corridors payments in the final year of risk corridors?

A2: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rule-making how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program.

Q3: If HHS reduces risk corridors payments for a particular year because risk corridors collections are insufficient to make those payments, how should an issuer's medical loss ratio (MLR) calculation account for that reduction?

A3: Under 45 CFR 153.710(g)(1)(iv), an issuer should reflect in its MLR report the risk corridors payment to be made by HHS as reflected in the notification provided under §153.510(d). Because issuers will submit their risk corridors and MLR data simultaneously, issuers will not know the extent of any reduction in risk corridors payments when submitting their MLR calculations. As detailed in 45 CFR 153.710(g)(2), that reduction should be reflected in the next following MLR report. Although it is possible that not accounting for the reduction could affect an issuer's rebate obligations, that effect will be mitigated in the initial year because the MLR ratio is calculated based on three years of data, and will be eliminated by the second year because the reduction

will be reflected. We intend to provide more guidance on this reporting in the future.

Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?

A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

APPENDIX L

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

DEPARTMENT OF HEALTH &
HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information &
Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Subject: Risk Corridors Payments for the 2014 Benefit Year

On October 1, 2015, the Centers for Medicare & Medicaid Services (CMS) announced that for the first year of the three year risk corridors program, qualified health plan (QHP) issuers will pay charges of approximately $362 million, and QHP issuers have requested $2.87 billion of 2014 payments, based on current data for the 2014 benefit year.[1] Consistent with prior guidance, assuming full collections of risk corridors charges for the 2014 benefit year, insurers will be paid an amount that reflects a proration rate of 12.6% of their 2014 benefit year risk corridors payment

[1] "Risk Corridors Payment Proration Rate for 2014." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

requests.[2] The remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections.

In the event of a shortfall for the 2016 program year, the Department of Health and Human Services (HHS) will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required.

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[2] "Risk Corridors and Budget Neutrality." April 11, 2014. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. "Risk Corridors Payment Proration Rate." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

APPENDIX M

CMS CENTERS FOR MEDICARE & MEDICAID SERVICES CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

DEPARTMENT OF HEALTH &
HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and
Insurance Oversight
200 Independence Avenue SW

Washington, DC 20201

Date: September 9, 2016

Subject: Risk Corridors Payments for 2015

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS

issued a bulletin titled "Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing preliminary information about risk corridors for the 2015 benefit year. Risk corridors submissions are still undergoing review and complete information on payments and charges for the 2015 benefit year is not available at this time. However, based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments. HMS expects to begin collection of risk corridors charges and remittance of risk corridors payments on the same schedule as last year. Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments.

As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.

We know that a number of issuers have sued in federal court seeking to obtain the risk corridors amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time.