No. 18-1023

IN THE

Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,
Petitioner,

v.

UNITED STATES,
Respondent.

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

BRIEF FOR PETITIONER

STEPHEN J. MCBRADY
Counsel of Record
CLIFTON S. ELGARTEN
DANIEL W. WOLFF
A. XAVIER BAKER
CROWELL & MORING LLP
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004
(202) 624-2500
smcbrady@crowell.com
Counsel for Petitioner

QUESTIONS PRESENTED

1. Was the government's obligation to pay insurers pursuant to the direction and formula set forth in Section 1342 of the Affordable Care Act repealed or rendered unenforceable by appropriation riders that barred the agency from using certain funds for the required payments, but which did not repeal or amend, and were not irreconcilable with, the underlying Section 1342 payment obligation?

2. Given the "cardinal rule" disfavoring implied repeals, 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 itself, and is not irreconcilable with it, nonetheless be held to impliedly repeal the obligation based on a court's interpretation of unilluminating legislative history?

3. Where the federal government has a statutory payment obligation under a program involving reciprocal commitments by the government and a private company, and the company has performed its part of the bargain to its detriment, does the presumption against retroactivity apply to the interpretation of appropriation riders that are claimed to have impliedly repealed the government's obligation to pay?

PARTIES TO THE PROCEEDING

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 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.

TABLE OF CONTENTS

Page

QUESTIONS PRESENTED i

PARTIES TO THE PROCEEDING ii

RULE 29.6 STATEMENT iii

TABLE OF AUTHORITIES vii

PRELIMINARY STATEMENT 1

OPINIONS BELOW 3

JURISDICTION 3

STATUTORY AND REGULATORY PROVISIONS INVOLVED 3

STATEMENT 4

A. Statutory Framework. 4

B. Petitioner Health Options. 7

C. Insurers Set Premiums, Then Offered and Provided Coverage on the ACA Exchanges, Before Congress Began the Yearly Appropriation Process. 9

D. HHS's Implementation of Section 1342. 10

E. Congress's Failure to Appropriate Funds for Section 1342 Payments. 13

F. Proceedings Below; the Government's Position. 16

1. The Court of Federal Claims Decision. 18

2. The Federal Circuit Decisions. 18

SUMMARY OF ARGUMENT..... 21

ARGUMENT 23

I. SECTION 1342 REQUIRES FULL PAYMENT BY ITS TERMS. 24

II. THE APPROPRIATION RIDERS DO NOT ABROGATE THE GOVERNMENT'S PAYMENT OBLIGATION. 34

A. The Plain Language of the Riders Precludes the Conclusion That They Negated the Government's Obligations Under Section 1342. 34

B. The Federal Circuit Failed to Apply Controlling Principles of Statutory Interpretation, Misread This Court's Cases, and Misread the Legislative History. 39

1. Two Basic Principles of Statutory Interpretation Should Have Guided the Analysis Here. 40

a. Implied Repeal Is Disfavored and Not to Be Found Absent an Irreconcilable Conflict Between the Later and the Former Statute. 41

b. The Panel Majority Ignored the Presumption Against Retroactivity. 45

2. The Panel Majority Misunderstood This Court's Precedents. 48

3. The Panel Majority Misunderstood the Legislative Material Upon Which It Relied. 52

CONCLUSION 57

TABLE OF AUTHORITIES

Page(s)

Cases

Agwiak v. *United States*,
347 F.3d 1375 (Fed. Cir. 2003).....25

Alpine PCS, Inc. v. *United States*,
878 F.3d 1086 (Fed. Cir. 2018).....26

Bowen v. *Massachusetts*,
487 U.S. 879 (1988).....24, 25, 26

Branch v. *Smith*,
538 U.S. 254 (2003).....43

Collins v. *United States*,
15 Ct. Cl. 22 (1879).....31, 32

Fernandez-Vargas v. *Gonzales*,
548 U.S. 30 (2006).....45

Ferris v. *United States*,
27 Ct. Cl. 542 (1892).....33, 36, 54

Fisher v. *United States*,
402 F.3d 1167 (Fed. Cir. 2005).....26

Gibney v. *United States*,
114 Ct. Cl. 38 (1949).....31

Graham v. *United States*,
1 Ct. Cl. 380 (1865).....37

Greenlee Cty., Ariz. v. *United States*,
487 F.3d 871 (Fed. Cir. 2007).....25, 28

Highland Falls-Fort Montgomery Cent. Sch. Dist. v. *United States*,
48 F.3d 1166 (Fed. Cir. 2018).....28

J.E.M. Ag Supply, Inc. v. *Pioneer Hi-Bred Int'l, Inc.*,
534 U.S. 124 (2001).....43

Landgraf. v. *USI Film Prods.*,
511 U.S. 244 (1994).....41, 45, 47

Miller v. *United States*,
86 Ct. Cl. 609 (1938).....37

Moda Health Plan, Inc. v. *United States*,
892 F.3d 1311 (Fed. Cir. 2018).....*passim*

Moda Health Plan, Inc. v. *United States*,
908 F.3d 738 (Fed. Cir. 2018).....*passim*

Molina Healthcare of Cal. Inc. v. *United States*,
133 Fed. Cl. 14 (2017).....46

Morton v. *Mancari*,
417 U.S. 535 (1974).....39, 43

N.Y. Airways, Inc. v. *United States*,
369 F.2d 743 (Ct. Cl. 1966).....36

Parsons v. *United States*,
15 Ct. Cl. 246 (1879).....37

Posadas v. *Nat'l City Bank of N.Y.*,
296 U.S. 497 (1936).....38, 41, 43

Prairie Cty., Mont. v. *United States*,
113 Fed. Cl. 194 (2013).....28

Salazar v. *Ramah Navajo Chapter*,
567 U.S. 182 (2012).....*passim*

Slattery v. *United States*,
635 F.3d 1298 (Fed. Cir. 2011) (en banc).....30

Strong v. *United States*,
60 Ct. Cl. 627 (1925) 37

Tenn. Valley Auth. v. *Hill*,
437 U.S. 153 (1978).....42

United States Fid. & Guar. Co. v. *United States*,
209 U.S. 306 (1908).....45

United States v. *Bormes*,
568 U.S. 6 (2012).....26

United States v. *Dickerson*,
310 U.S. 554 (1940).....50, 51

United States v. *Hansen*,
772 F.2d 940 (D.C. Cir. 1985).....42

United States v. *Langston*,
118 U.S. 389 (1886).....30, 39, 40, 49

United States v. *Mitchell*,
109 U.S. 146 (1883).....*passim*

United States v. *Mitchell*,
463 U.S. 206 (1983).....24, 26

United States v. *St. Louis, S.F. & T.Ry. Co.*,
270 U.S. 1 (1926).....45

United States v. *Testan*,
424 U.S. 392 (1976).....24

United States v. *Vulte*,
233 U.S. 509 (1914).....49

United States v. *Will*,
449 U.S. 200 (1980).....*passim*

Statutes

28 U.S.C. §1254(1).....3

28 U.S.C. §1295(a)(3) 3

28 U.S.C. §1491(a).....3, 16, 21, 25

28 U.S.C. §2517(b).....32

31 U.S.C. §1304(a).....16, 32

31 U.S.C. §1341(a)(1)(A) 33

42 U.S.C. §280k(a) 28

42 U.S.C. §293k-2(e).....28

42 U.S.C. §1395w-115(e)(3)(A).....26

42 U.S.C. §1397m-1(b)(2)(A).....28

42 U.S.C. §18042.....8

42 U.S.C. §18062.....*passim*

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227, 128 Stat. 2491 (2014).....14, 35, 51

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, §225, 129 Stat. 2624 (2015).....14, 51

Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, §223, 131 Stat. 543 (2017).....14

Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, §222, 132 Stat. 740 (2018).....15

Regulations

45 C.F.R. §147.106(b).....9

45 C.F.R. §147.106(d).....9

Rules

House Rule XXI(2)(a)(2)(b) 42

Senate Rule XVI(4) 42

Federal Register

77 Fed. Reg. 17,220 (Mar. 23, 2012).....5

78 Fed. Reg. 15,410 (Mar. 11, 2013).....11

79 Fed. Reg. 13,744 (Mar. 11, 2014).....11

79 Fed. Reg. 30,240 (May 27, 2014).....12

80 Fed. Reg. 10,750 (Feb. 27, 2015).....12

Miscellaneous

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014).....20, 53

CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014).....11

CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016).....8

CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year" (Nov. 15, 2017).....9

CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015).....8

H.R. 221, 114th Cong. (2015).....55

H.R. 724, 114th Cong. (2015).....55

H.R. 4406, 113th Cong. (2014).....55

H.R. 5175, 113th Cong. (2014).....55

II GAO, *Principles of Fed. Appropriations Law* (3d ed. 2004).....46

Office of Mgmt. & Budget, Exec. Office of the President, Appendix, Budget of the United States Government, Fiscal Year 2017 (2016).....13

Press Release, Energy and Commerce Committee, The Affordable Care Act on Shaky Ground: Outlook and Oversight (September 14, 2016) 13

S.123, 114th Cong. (2015) 55

S.359, 114th Cong. (2015) 55

U.S. Gov't Accountability Off., GAO-15-447, Patient Protection and Affordable Care Act (Apr. 2015) 26

PRELIMINARY STATEMENT

For the federal government, as for any other debtor, a failure or refusal to allocate money to pay a debt does not cancel the debt. Indeed, Congress has provided that if a required federal government payment is not forthcoming, the government's monetary obligation can be confirmed and rendered as a judgment under the Tucker Act, and then paid from the permanent indefinite appropriation known as the Judgment Fund. To the extent Congress might have the power to cancel an obligation, doing so requires, at a minimum, a clear statement in the text of an enacted statute. Legislative inaction, and legislative history not reflected in statutory text, cannot retroactively repeal a statutory obligation of the United States.

In this case, the unambiguous language of the relevant statutes should have compelled judgment for insurers. Insurers relied on the unequivocal statutory direction in Section 1342 of the Affordable Care Act that the government "shall pay" insurers the full amount due under the statutory formula. The Federal Circuit panel unanimously concluded that, as enacted, Section 1342 required those payments. But the panel majority cited three subsequent appropriation riders barring agency access to certain appropriations to make those payments, ruling that the riders "suspended" the government's duty to pay. The panel majority reached that conclusion without identifying anything in the text of those riders repealing or superseding the payment obligations that Section 1342 imposed on the government.

For two related reasons, those riders were fully consistent with the continuing vitality of the underlying Section 1342 payment obligation:

First, under longstanding precedent, a failure to appropriate funds to satisfy a statutory obligation is not inconsistent with the continued existence of the obligation. Failure to appropriate money to an agency necessarily limits the *agency*'s ability to make payments, but it does not eliminate the *government*'s obligations to third parties. In order to change or eliminate the underlying statutory obligation, Congress must enact a new law, either expressly superseding prior law, or doing so by clear implication—where the new law is irreconcilable with the prior law.

Second, the riders were also consistent with the continued vitality of the underlying Section 1342 obligation because they were consistent with the Department of Health and Human Services' stated position on how it intended to administer the program over the course of its three-year life. HHS did not need yearly access to additional funds for Section 1342 payments because its stated intention was to limit *annual* payments out to the amount of *annual* payments in. At the same time, it acknowledged that the full amount owed insurers under the Section 1342 formula would remain an obligation of the United States payable upon a final accounting at the end of the three-year program.

The plain language of the relevant statutes is enough to require reversal in this case. But if more were needed, it is readily found in the panel majority's failure to properly apply two core principles of statutory interpretation that dispel

any doubt about the proper result. The first establishes the high standards for finding implied repeal. The second cautions against interpreting statutes to have retroactive effect. While these rules of construction give way in the face of evidence of clear congressional intent to the contrary, there was no such evidence here—certainly not in the unilluminating legislative history cited by the panel majority.

OPINIONS BELOW

The Federal Circuit's summary decision is unreported but found at 729 F. App'x 939, reprinted at Pet.App.1a. That decision is controlled by *Moda Health Plan, Inc.* v. *United States*, 892 F.3d 1311 (Fed. Cir. 2018), reprinted at Pet.App.31a. The United States Court of Federal Claims' decision is reported at 133 Fed. Cl. 1 and reprinted at Pet.App.89a. The order denying rehearing *en banc* (Pet.App.3a-8a) and accompanying dissenting opinions (Pet.App.11a-30a) are reported at 908 F.3d 738 (Fed. Cir. 2018).

JURISDICTION

The Court of Federal Claims' jurisdiction was grounded on the Tucker Act, 28 U.S.C. §1491(a). The Federal Circuit had jurisdiction under 28 U.S.C. §1295(a)(3), entered judgment on July 9, 2018, and 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), are

reprinted verbatim at pages 5-6 below. Section 1342 (b)(2) and (c), 42 U.S.C. §18062(b)(2) and (c), are reprinted in the Appendix to the Petition, Pet.App.121a-122a. The appropriation riders discussed below and cited at page 10, and cited provisions of Title 45 of the Code of Federal Regulations, are also set out in the Appendix to the Petition.

STATEMENT

A. Statutory Framework.

The Affordable Care Act (ACA) sought to make health insurance more broadly available to previously underinsured and uninsured individuals. Among other things, it established health insurance exchanges through which health insurance plans meeting ACA requirements could be purchased. And it required insurers[1] to provide coverage to individuals on an all-comers basis, without medical underwriting that measures insurer risk. Section 1342 sought to entice insurers to participate in the exchanges by mitigating the considerable rate-setting uncertainty associated with predicting the costs of insuring an unfamiliar population of enrollees, without benefit of medical underwriting, without exclusions for pre-existing conditions, and without benefit of lifetime limits on coverage expenses. The government's promise to share that risk would result in lower premiums

---

[1] The ACA refers to "issuers," "Qualified Health Plan (QHP) providers," and providers of "plans" or "participating plans." For consistency, this Brief uses the word "insurer" to refer to insurers with plans subject to Section 1342.

because insurers would not have to price all of that risk in setting premiums.

In particular, Section 1342 established a three-year "risk corridors" program "to protect against uncertainty in rate setting by qualified health plans [by] 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, by its terms, modeled on a similar program under Medicare Part D, and was to be administered by the Department of Health and Human Services (HHS). It was mandatory for all participating insurers.

The obligations created by Section 1342 were definite and reciprocal, imposing payment duties on both insurers and the government. Those reciprocal payment obligations created a form of risk-sharing for the difficult task of predicting the cost of providing insurance to new enrollees.

On the one hand, an insurer that experienced lower-than-expected allowable costs by a defined percentage had to pay the government a specified portion of its savings. See 42 U.S.C. §18062(b)(2). In fact, for the program's first benefit year, 2014, Petitioner paid the government $2,045,819.48, on account of lower-than-expected allowable costs on policies it issued in the individual market.

On the other hand, Section 1342 assigned the federal government a defined share of insurer risk in prospectively setting premiums based on predicted costs. Thus, for the coverage year, if an insurer experienced higher-than-expected

allowable costs by a defined percentage, Section 1342 mandated that the government "shall pay" that insurer a specified portion of its excess costs.

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).

Insurers' obligation to pay in, and the government's obligation to pay out, were stated in identical terms. *Compare* 42 U.S.C. §18062(b)(1) ("Payments Out": if costs are within specified limits, "the Secretary shall pay to the plan …") *with* 42 U.S.C. §18062(b)(2) ("Payments In": if costs are within specified limits "the plan shall pay to the Secretary ….").

B. Petitioner Health Options.

Maine Community Health Options was established as a CO-OP ("Consumer Operated and

Oriented Plan") insurer under Section 1322 of the ACA, 42 U.S.C. §18042. CO-OPs were created for the sole purpose of providing coverage on the newly-created exchanges.[2] Health Options offered coverage on the Maine exchange beginning in 2014 and on the New Hampshire exchange as well in 2015 and 2016. Health Options continues to operate in Maine, and throughout the period at issue, it was the largest provider of coverage on the Maine exchange.

Applying the Section 1342 formula to the 2014 benefit year, Health Options paid the government more than $2 million, reflecting its lower-than-expected costs in the individual market. But the government still owes Health Options more than $200,000 for the small group market in that same year. For benefit year 2015, the government owes Health Options more than $22 million; for benefit year 2016, more than $35 million. All these amounts were calculated and published by HHS itself, which tracked the amounts it owed insurers (and insurers owed the government) over the three-year life of the Section 1342 program.[3]

---

[2] The ACA requires CO-OP insurers to derive substantially all of their business from individual and small group markets served by the exchanges. 42 U.S.C. §18042(c)(1)(B).

[3] See CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("2014 Payment Memo"), *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) ("2015 Payment Memo"), *available at*

(continued…)

C. Insurers Set Premiums, Then Offered and Provided Coverage on the ACA Exchanges, Before Congress Began the Yearly Appropriation Process.

In all states, regulators approve premiums in the year preceding the benefit year for which insurance is provided. For example, in Maine, insurers develop proposed premiums and state regulators typically approve premiums by August. In late fall, insurers have "open enrollment," during which time customers may enroll for coverage.

This means that insurers' premium-setting and approval, their offer and sale of coverage on ACA exchanges, and then insurers' actual provision of coverage—*i.e.*, payment of enrollees' health care expenses—take place before Congress considers any needed appropriations to cover its obligations for that year.[4] For example, coverage was sold in

---

(continued)
https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf ("2015 Payment Memo"); CMS, "Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year" (Nov. 15, 2017) ("2016 Payment Memo"), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-Amounts-2016.pdf ("2016 Payment Memo").

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

2013 for benefit year 2014; the FY 2015 appropriation to HHS that would cover amounts owed for 2014 performance, was enacted in December 2014, at the very end of that benefit year. Similarly, appropriations for 2015 performance (based on premiums approved in 2014) were part of the appropriation process for FY 2016, enacted at the end of 2015.

Because a full accounting of allowable costs for a given benefit year is not available immediately at the end of the calendar year, risk corridor obligations (owed either to the insurer or by the insurer) were not calculated or paid until the following year. 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. HHS first provided the final accounting of payments due for the 2016 benefit year in November 2017. See n.3, *supra*.

D. HHS's Implementation of Section 1342.

In its first regulatory notice setting forth policies and requirements for ACA participation, HHS observed that Section 1342(b)(1) payments out (to insurers) were not to be limited to collections in (from insurers), *i.e.*, the program was not to be "budget neutral":

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

> section 1342 of the Affordable Care Act.

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013) (final rule).

In March and April 2014, first in a Federal Register Notice, and then in a lengthy guidance issued by the Centers for Medicare & Medicaid Services, "CMS" (part of HHS) explained that, notwithstanding its acknowledged duty to pay insurers the full amount owed under the Section 1342 formula over the three-year life of the program, it intended to administer the program *annually* in a budget-neutral manner, limiting annual payments out to collected payments.[5] If annual collections were insufficient to pay insurers according to the statutory formula, HHS would pay each insurer *pro rata*. It would then use the next year's collections to make up payments owed from the prior year. Pet.App.131a. Under this approach, HHS would not need funds for annual Section 1342 payments (beyond collections) during the three-year life of the program.

HHS anticipated that total collections would ultimately cover required "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. Pet.App.133a. As the Government presented it to the court below, under

---

[5] See 79 Fed. Reg. 13,744, 13,787; CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), Pet.App.131a.

HHS's approach to annual payments, the final accounting for HHS's obligations to insurers, and the payment obligation, would not come due until the conclusion of the three-year program. See *Moda,* 892 F.3d at 1339 (Newman, J., dissenting). At that point, HHS would find money from existing appropriations or seek an additional appropriation to cover the obligation.

Even while: (1) adopting "budget neutrality" for *annual* payments; (2) postponing the final tally and full payment for each insurer to the end of the three-year program; and (3) acknowledging that its own ability to pay would be (as an agent for the government, under the Anti-Deficiency Act) subject to appropriations, HHS consistently confirmed the central point at issue here: The total amount due each insurer under the statutory formula over the three-year period was an "obligation[]" of the United States "for which full payment" is owed. See 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 …."); 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 …."); 2014 Payment Memo ("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."); 2015 Payment Memo ("[T]he Affordable Care Act requires the Secretary to make full payments to issuers" and HHS will "record payments due as an obligation of

the United States Government for which full payment is required.").[6]

HHS confirmed the 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.").[7]

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

In December 2014, near the end of the first program year, Congress turned to HHS's Fiscal Year 2015 appropriation, providing HHS with access to funds covering the 2014 benefit year.

---

[6] Similarly, the Budget of the United States Government, Fiscal Year 2017 (Appendix at pp.470-71) listed Risk Corridors as a direct program obligation, but declined to offer cost estimates for 2016 and 2017. It noted that: "In the event of a shortfall over the life of the three-year Risk Corridors program, the Administration will work with Congress to provide necessary funds for outstanding payments." Office of Mgmt. & Budget, Exec. Office of the President, Appendix, Budget of the United States Government, Fiscal Year 2017 (2016) at 471.

[7] *available at* https://republicans-energycommerce.house.gov/news/press-release/subhealth-and-suboversight-spotlight-obamacare-s-mounting-failures/.

That appropriation law included a rider consistent with HHS's March 2014 stated intention to maintain annual budget neutrality and to postpone the final accounting and payment to the conclusion of the program. That rider barred HHS from using its lump sum FY 2015 program management appropriation for Section 1342 payments:

> None of the funds made available by this Act … 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].

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227, 128 Stat. 2491 (2014). Identical riders were included in the HHS appropriation acts for the 2015 and 2016 benefit years.[8] The riders thus left only insurers' "payments in" as a potential source of yearly "payments out."

As it turned out, however, Section 1342 collections for 2014 (from insurers realizing cost savings) did not come anywhere close to what the government owed insurers suffering excess costs. Much of the insurers' higher-than-anticipated costs resulted from HHS's "transitional policy," announced *after* premiums had been set. That

---

[8] 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).

policy allowed individuals and small businesses enrolled in non-ACA-compliant plans to retain that insurance. 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." *Moda*, 892 F.3d at 1317. HHS had noted that the government's payments to insurers under Section 1342 would help offset these unanticipated costs. See *id.*; *id.* at 1331 (Newman, J., dissenting).

Using only what it collected for 2014 benefit year payments, HHS paid each insurer *pro rata* 12.6 percent of the total 2014 payment it was owed under the Section 1342 formula. HHS later used collections for benefit years 2015 and 2016 to further pay down what it owed for 2014, leaving HHS with nothing for the 2015 and 2016 amounts it owed insurers. In November 2017, after the program ended, HHS published the final amounts owed insurers under the program. Since then, Congress has not appropriated funds to make those payments and has annually barred HHS from using its appropriated program management funds for that purpose, leaving HHS unable to make the payments. But Congress has not enacted any change to Section 1342, leaving the underlying payment obligation extant and unchanged.[9]

---

[9] See, *e.g.*, Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, §222, 132 Stat. 740 (2018).

F. Proceedings Below; the Government's Position.

Health Options and other insurers objected to HHS's decision not to make full risk corridors payments *annually* and instead provide full payment only after three years. Insurers' concerns multiplied when the three-year program concluded and HHS still did not pay, apparently because Congress had failed to appropriate funds to HHS for the "full payment" that HHS acknowledged as an obligation of the United States.

Affected insurers, including Health Options in August 2016, filed actions in the Court of Federal Claims to recover unpaid amounts. The Tucker Act, 28 U.S.C. §1491(a), grants that court jurisdiction over money claims against the United States. When debts are confirmed and rendered as judgments by that court, they are payable from the Judgment Fund, a permanent, indefinite appropriation created by Congress for that purpose. See 31 U.S.C. §1304(a).

The Government moved to dismiss, asserting that risk corridors payments (beyond amounts collected in) were not due annually, and would be payable only after three years, so Health Options' claim was not ripe, and the court would lack jurisdiction until after the third year. The Government explained:

> HHS, as administrator of the program, established a three-year payment framework under which it operates the program in a budget neutral manner by making payments for any particular benefit year from charges

> collected across all three years of the program's life span. Under this framework, HHS does not owe [Health Options], or any other issuer, final payment before the end of the program.

Gov't Mot. Dismiss at 2, *Maine Cmty. Health Options* v. *United States*, No. 16-cv-00967 (Fed. Cl. Jan. 13, 2017), ECF No. 22.

Indeed, the Government confirmed that HHS "interpreted Section 1342 to require full payments to issuers and that, if necessary, at the conclusion of the program, it would use sources of funding other than risk corridors collections, subject to the availability of appropriations." *Id*. at 9. It quoted HHS's September 9, 2016 guidance:

> 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 payment to issuers. HHS will record risk corridor payments due as an obligation of the United States Government for which full payment is required.

Id. at 10 n.6 (quoting CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016)).

1. The Court of Federal Claims Decision.

The Court of Federal Claims concluded that the claim was ripe, but that any insurer entitlement to payments was limited to what had been paid in. See Pet.App.90a. Health Options timely appealed to the United States Court of Appeals for the Federal Circuit.

2. The Federal Circuit Decisions.

After the appeal was fully briefed, the Federal Circuit stayed the appeal pending disposition of *Moda Health Plan* v. *United States*, and *Land of Lincoln Mutual Health Insurance Co.* v. *United States*.

In *Moda*, 892 F.3d at 1311, all three panel judges agreed 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 under the risk corridors program." *Id.* at 1322. All three rejected the Government's contention that, as enacted, Section 1342 was to be budget neutral. *Id.* at 1320-21. Following longstanding precedent, they held that the question whether Section 1342 created a payment obligation was distinct from whether Congress appropriated funds to meet that obligation. It "has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt." And the "statutory obligation to pay persist[s] independent of the appropriation of funds to satisfy that obligation." While a federal agency cannot dispense funds not appropriated to it, Congress's

failure to appropriate funds to an agency does not abrogate the government's obligation to pay third parties. *Id.* at 1321-22.

Nonetheless, the panel majority held that "riders in the appropriations bills for FY 2015 and FY 2016" had "suspended" the payment obligation—leaving it unenforceable. *Id.* at 1322. The panel majority acknowledged that this Court has held that "[w]hether an appropriations bill impliedly suspends or repeals substantive law 'depends on the intention of [C]ongress as 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 focus on statutory text, and the high bar to implied repeal, as having been eroded by later decisions, which now requires a court to look beyond the statutory text and seek out the *intent* of a limitation on appropriations by examining legislative history. *Id.* at 1323-24.

The panel majority did not find implied repeal in the text of the riders. Instead, purporting to derive the "intent" of "Congress," it referenced a letter from two Members to GAO, asking what accounts were available to HHS for Section 1342 payments without additional appropriations. *Id.* at 1325; see also *id.* at 1318. GAO answered that (1) "payments in" could be regarded as user fees available for Section 1342 payments out, and (2) HHS could also tap its annual general lump sum program management appropriation for Section 1342 payments out. *Id.* at 1318. But GAO addressed only what funds would be available to the agency, not the existence of the underlying

obligation. The panel majority also cited a 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 program management funds for Section 1342 payments. *Id.* at 1319 (quoting 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014)).

The panel majority did not address the implications of the fact that the riders simply paralleled HHS's stated intention to administer the program annually in a budget neutral manner, while confirming that full payment remained an obligation of the United States, payable at the conclusion of the three-year program. The panel majority also declined to address the retroactive effect of its interpretation of the riders on insurers that performed for three years in reliance on Section 1342.

Judge Newman dissented. She agreed with the majority 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 she viewed the majority as then subverting that rule by holding that a subsequent rider that merely withheld funds from an agency abrogated the obligation. Judge Newman reminded the majority that 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 also noted that the majority's interpretation created an "after-the-fact repudiation of the government's obligations," and, therefore, could not surmount a second hurdle: the presumption against retroactivity. Insurers were induced to provide coverage based on the government's commitment to make the required payments. Yet "[w]e 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. Pet.App.120a. The court later denied Health Options' and others' petitions for rehearing *en banc*. *Moda Health Plan, Inc.* v. *United States*, 908 F.3d 738 (Fed. Cir. 2018). Pet.App.3a. Judge Wallach and Judge Newman dissented. Pet.App.11a-30a.

SUMMARY OF ARGUMENT

The plain language of the relevant statutory provisions controls the disposition of this case. Section 1342 of the ACA created a mandatory risk sharing program that obligated insurers to pay the government according to a statutory formula under one set of circumstances, and required the government to pay insurers under another. The payment obligations were subject to the statutory formula, but otherwise unequivocal, enforceable under the Tucker Act, 28 U.S.C. §1491(a), and, upon final determination and judgment, payable from the standing appropriation known as the Judgment Fund.

Nothing in the appropriation riders negated that obligation. The riders limited the funds

available to HHS to make Section 1342 payments. But the government may incur a debt independent of whether Congress has appropriated funds to satisfy that debt. And while a congressionally imposed limit on an agency's use of appropriated funds will, under the Anti-Deficiency Act, bar *an agency* from using funds for a particular purpose, it does not relieve the government of its obligations to third parties. Such absolution can only come from a change to the law creating the obligation. A failure to appropriate funds to support a payment obligation is, therefore, not "irreconcilable with" the continued existence of the underlying obligation—as the high bar to finding implied repeal would require. Even for the federal government, failure to fund a debt does not cancel the debt.

Moreover, at that stage, Congress's decision to deny HHS access to general program management funds for Section 1342 payments was fully consistent with HHS's stated intention to limit annual payments out to collections in during the life of the program, while confirming that full payment ultimately remained an obligation of the United States.

Two basic canons of statutory interpretation *should have* guided the Federal Circuit's interpretation of the riders, but did not. Each precludes the sort of speculative resort to legislative history engaged in by the Federal Circuit here.

First is the "cardinal rule" that implied repeals are greatly disfavored. The intention to repeal must be "expressed in the statutes," and when

asserted to arise from "irreconcilable conflict" with prior law, that conflict must be "clear and manifest." The resistance to implied repeal is of "especial force" in considering whether repeal arises from an appropriations bill. If, as here, nothing in the text of the appropriation changed or superseded the underlying Section 1342 obligation, or would have alerted even the most avid and knowledgeable supporter of Section 1342 that repeal was afoot, it is impossible to find the kind of manifest inconsistency between the former and later enactment that might support implied repeal.

Second, the panel majority declined to apply the longstanding presumption against retroactivity. In reliance on Section 1342, each insurer set premiums, offered and sold insurance, made payments to cover their enrollees' health care expenses, and suffered the losses in which the government promised to share, *before* Congress enacted the riders, and ultimately failed to appropriate the funds, that the Federal Circuit held to cancel the government's payment obligation. The Federal Circuit's ruling that riders enacted after performance cancelled the statutory obligation to pay has the effect of transforming seemingly benign and, at most, ambiguous legislative action into precisely the kind of bait and switch that the presumption against retroactivity protects against.

ARGUMENT

Section 1342 of the ACA, 42 U.S.C. §18062, created an obligation to pay that was not negated by the subsequent appropriation riders limiting the

funds available to the agency to make the required payments.

I. SECTION 1342 REQUIRES FULL PAYMENT BY ITS TERMS.

When a statute mandates the payment of money by the federal government (*i.e.*, is "money-mandating"), and the money is not paid, the Tucker Act provides for jurisdiction in the Court of Federal Claims and the government's sovereign immunity is waived. *United States* v. *Mitchell*, 463 U.S. 206, 212-19 (1983). Moreover, when a statute directs the federal government to pay compensation, claimants have a "substantive right enforceable against the United States for money damages." *Id.* at 217; see *United States* v. *Testan,* 424 U.S. 392, 400 (1976) (entitlement to money damages depends upon whether a federal statute "can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained"). Justice Scalia summed up these basic Tucker Act principles three decades ago: "[A] statute commanding the payment of a specified amount of money by the United States impliedly authorizes (absent other indication) a claim for damages in the defaulted amount." *Bowen* v. *Massachusetts*, 487 U.S. 879, 923-24 (1988) (Scalia, J., dissenting).

The Federal Circuit panel in this case unanimously and properly held that, as enacted, Section 1342 obligated the government to pay insurers the full amount due under Section 1342's detailed statutory formula. This holding was consistent with the view expressed by HHS itself from the beginning of the Section 1342 program to the end, namely, that Section 1342 obligated the

United States to make full payments to insurers in accordance with the statutory formula. As an obligation set forth in a money-mandating statute, Section 1342's payment obligation is enforceable under the Tucker Act, 28 U.S.C. §1491(a), with any resulting judgment confirming the government's debt payable from the permanent appropriation in the Judgment Fund.

The plain language of Section 1342 compels that conclusion. Section 1342 imposes payment duties on both insurers and the government, based on a statutory formula. Under the heading "Payments In," it states that if an insurer's costs fall within certain ranges of the target amount, the insurer "shall pay to the Secretary" the defined portion of the cost-savings. See 42 U.S.C. §18062(b)(2). The Government has never suggested that there is anything equivocal about *insurers'* obligations to pay as specified in Section 1342. Insurers' Section 1342 payment obligation is mandatory, not voluntary.

The "shall pay" directive to the government under 42 U.S.C. §18062(b)(1)(A)&(B) is correspondingly unequivocal. Unsurprisingly, the "use of the word 'shall' generally makes a statute money-mandating." See *Greenlee Cty., Ariz.* v. *United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (citing *Agwiak* v. *United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). Thus, Section 1342

mandated the payment of money, and there was no "other indication" of a contrary meaning.[10]

Specifically (as HHS explained early on, see *supra*, Statement D), nothing in Section 1342 supported the Government's belated assertion that Section 1342 was, at its inception, "budget neutral," with payments out limited to payments in. HHS's view that Section 1342 commands full payment, and that the duty to cover any shortfall between payments in and payments out is an obligation of the United States, is consistent with the statute's plain language.[11] The two sections,

---

[10] See *Bowen*, 487 U.S. at 923-24 (Scalia, J., dissenting). The Court of Federal Claims, and the Court of Claims before it, have long provided recourse against the government under money-mandating statutes. *Mitchell*, 463 U.S. at 215-18. And while the question of Tucker Act jurisdiction, and the existence of a cause of action, are conceptually distinct, the payment mandate provides the cause of action, absent some countervailing provision indicating a contrary conclusion. *Id.;* see *Fisher* v. *United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (en banc in relevant part).

This Court and the Federal Circuit are, of course, attentive to circumstances where contrary indications overcome those basic understandings. That is the case, for example, where Congress has established an alternative remedial framework, see *United States* v. *Bormes*, 568 U.S. 6, 13-14 (2012) (alternative remedy precludes Tucker Act suit); *Alpine PCS, Inc.* v. *United States*, 878 F.3d 1086, 1092-93 (Fed. Cir. 2018) (collecting cases), or where, in an action by a state, relief is more properly pursued through an equitable action in district court under the Administrative Procedure Act, see *Bowen,* 487 U.S. at 879.

[11] HHS's view that the program was not to be budget neutral was also consistent with the explicit requirement to base the program on Medicare Part D's program, under which (continued…)

"Payments In," and "Payments Out," operate independently. The government's payment obligation under the prescribed statutory payment formula is not made subject to a system of *pro rata* distribution depending on insurer payments in.[12]

The government's payment obligation here was readily recognizable for reasons beyond the explicit "shall pay" directive. The amount payable to insurers here was not obscure or subjective. The program had all of the indicia of a specific contractual exchange. This was not a gratuitous entitlement program indicating an intention to distribute funds for some broadly beneficent purpose. Nor does this case involve a claim for ill-defined damages for consequential harm allegedly caused by some asserted government malfeasance or misconduct.

To the contrary, Section 1342 promised specific payments, according to a well-defined formula. It promised those payments in exchange for insurers' provision of insurance meeting ACA specifications, and specific commitments from insurers. Insurers committed to perform, and then performed, their

---

(continued)
payments out are not limited to payments in. 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.").

[12] No one has suggested that if collections produced a surplus, the surplus was somehow to be re-distributed to insurers to maintain budget neutrality.

side of the bargain. There is nothing novel in the idea that an exchange of commitments and actual performance binds parties to a clearly stated commitment to pay. Indeed, the nature of the exchange was evident within Section 1342 itself, which imposed payment obligations on insurers as well as on the government.

The obligation was also *not* conditioned on, or made subject to, subsequent appropriations. When Congress wishes to condition obligations on subsequent appropriations, it says so. Thus, Congress often states that a particular program or payment is "subject to the availability of appropriations," or something similar. See, *e.g.*, *Salazar* v. *Ramah Navajo Chapter*, 567 U.S. 182, 188-89 (2012) (noting payments "subject to the availability of appropriations" under the statute at issue); *Prairie Cty., Mont.* v. *United States*, 113 Fed. Cl. 194, 199 (2013), aff'd, 782 F.3d 685 (Fed. Cir. 2015) ("the language 'subject to the availability of appropriations' is commonly used to restrict the government's liability to the amounts appropriated by Congress for the purpose") (citing *Greenlee Cty.*, 487 F.3d at 878-79); *Highland Falls-Fort Montgomery Cent. Sch. Dist.* v. *United States*, 48 F.3d 1166, 1168 (Fed. Cir. 2018) (involving a statute that explicitly recognized that "Congress may choose to appropriate less money … than is required to fund those entitlements fully," and specifying how appropriated money will be allocated in those circumstances). In fact, Congress repeatedly used "subject to appropriations" language elsewhere in the ACA itself. See, *e.g.*, 42 U.S.C. §280k(a) ("The Secretary … shall, subject to the availability of appropriations …."); *id.* §293k-

2(e), §1397m-1(b)(2)(A). All such language, commonly used by Congress in the ACA and elsewhere, would never be necessary—and the many times it was used, it would be rendered surplusage—if (as the Government intimated below) all statutory obligations were impliedly conditioned on whether Congress later appropriated money to meet the obligation.

Congress did not use language in Section 1342 conditioning the obligation on available appropriations. And there is no reason why Section 1342 should be read to say something it plainly does not say.

It is not surprising that Congress did not make its Section 1342 obligations conditional on subsequent appropriations. Congress was trying to entice insurers both to participate, and to keep premiums down, by promising to share in the substantial risk associated with providing ACA-compliant coverage to a group of potential enrollees for which there was little actuarial experience. Section 1342 would not have provided the assurances needed to achieve those objectives if insurers were told that the government's promise to pay according to the statutory formula was subject to the budgetary mood of a later Congress. Indeed, it is difficult to imagine that any insurer would see it as a fair exchange for it to have an absolute obligation to pay the government under Section 1342 if costs ended up low, but for the government to be left free to renege on its own Section 1342 obligations if costs ended up high after insurers had fully performed their part of the bargain and suffered the losses that Section 1342

was meant to mitigate.[13] There were, therefore, good reasons why the government's Section 1342 obligations were not created "subject to appropriations." It would have defeated the purpose of the Section.

The absence of an appropriation to support Section 1342 payments did not negate the Section 1342 obligation. Unless Congress expressly conditioned the government's obligations on an appropriation, the question whether a statute creates an obligation to pay is distinct from whether Congress has appropriated money to satisfy that obligation. See *United States* v. *Langston*, 118 U.S. 389, 394 (1886); *Slattery* v. *United States*, 635 F.3d 1298, 1303, 1321 (Fed. Cir. 2011) (en banc). There is nothing odd about Congress creating financial obligations without identifying a specific source of funding, particularly when Congress does not know how much money (if any) will be required to meet the obligation. As GAO later pointed out, Section 1342 payments

---

[13] 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); *accord 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."). See also *Salazar*, 567 U.S. at 191-92 ("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).

could, in the ordinary course, have simply been made by HHS, as needed, from HHS's general "lump sum" program management funds, or, of course, Congress could have made specific appropriations to meet Section 1342 payment obligations as and when they came due. In either case, the underlying obligation exists—and is enforceable under the Tucker Act—independent of the source of funds to meet the obligation.

Indeed, the basic distinction between whether the government has a payment obligation and whether Congress has appropriated funds to meet that obligation lies at the very heart of Tucker Act jurisdiction. As the Court of Claims (replaced with respect to trial court functions by the Court of Federal Claims) put it more than 150 years 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).[14]

---

[14] As restated 70 years later in *Gibney* v. *United States*, 114 Ct. Cl. 38, 52 (1949):

(continued…)

When the Court of Claims spoke in *Collins*, its duty was to report on the government's obligations. The successful claimant still had to ask Congress for funds to vindicate the findings. The Court of Claims was soon thereafter (in 1866) given the power to render judgments, and its jurisdiction was later expanded by the Tucker Act in 1887. But it was still frequently left to the prevailing party to seek an appropriation or source of funds to pay the judgment.

Since 1956, however, that last step has been unnecessary because Congress created the Judgment Fund, a permanent indefinite 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).[15] Thus, there is always an appropriation available to pay government

---

(continued)

> 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.

[15] 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 …." 28 U.S.C. §2517(b).

obligations, once proven and reduced to judgment, irrespective of whether Congress has separately appropriated money for the payments.

"An appropriation *per se* [or lack thereof] merely imposes limitations upon the Government's own agents," 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). In *Salazar*, 567 U.S. at 197, this Court quoted and relied on *Ferris* in support of precisely that point, holding that its rule applied under the current version of the Anti-Deficiency Act in the same way. The Anti-Deficiency Act (like its predecessors) merely places limits on the ability of government agents and agencies to create binding commitments for the United States; but it does not place limits on Congress itself.[16] In sum, the lack of an appropriation restrains the authority of the government's agents and agencies—here HHS. But it cannot affect or defeat the statutory rights of third parties.

---

[16] The Anti-Deficiency Act simply provides that "an 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).

II. THE APPROPRIATION RIDERS DO NOT ABROGATE THE GOVERNMENT'S PAYMENT OBLIGATION.

A. The Plain Language of the Riders Precludes the Conclusion That They Negated the Government's Obligations Under Section 1342.

In December 2014—near the end of the first program year in which insurers provided and paid the costs for the coverage that they sold in 2013—Congress enacted its appropriation law for FY 2015.

By that point, HHS had squarely confirmed that Section 1342 was not "budget neutral": *viz*, the government's obligation to make payments out was not restricted to payments in. The government was obligated to make the full payments mandated by the statutory formula.

However, by that point, HHS had also announced its intention to administer the three-year Section 1342 program annually in a budget neutral manner, using collections to cover annual payments out. Any annual shortfall would be allocated *pro rata* among insurers, subject to a final accounting, and "full payment" to each insurer—which it regarded as the statutory obligation of the United States—would be payable at the end of the program's three-year term. See *supra*, Statements D & F.

The FY 2015 omnibus appropriations act covering benefit year 2014 obligations included a rider that held HHS to its stated approach of administering the program annually in a budget

neutral manner by barring HHS from accessing its general program management fund for 2015's Section 1342 payments:

> 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 (Dec. 16, 2014). Congress enacted identical riders for FY 2016 and FY 2017, covering benefit years 2015 and 2016, in December 2015 and May 2017, respectively.

In November 2017, at the end of the three-year program period, HHS set forth the final year tally for each insurer.[17] Since then, Congress has continued to do nothing to change the underlying Section 1342 obligation, but has likewise declined to appropriate money or to allow HHS to use its general program management funds to meet its Section 1342 obligations. Consequently, HHS cannot pay, and insurers are left to their Tucker Act remedies.

The panel majority rejected insurers' claims for payment on the theory that Congress had nonetheless "suspended" the government's Section 1342 obligations. But the Federal Circuit's ruling was entirely atextual. The Federal Circuit identified nothing in the riders, let alone in

---

[17] See note 3, *supra*.

Congress's failure to appropriate funds, that amended or superseded Section 1342. The riders did not revise the underlying statute, nor set forth a payment formula supplanting the formula set forth in Section 1342. The panel majority's rationale rested entirely on its conception of congressional intent, derived from a bit of legislative history concerning the first of those riders.

By their actual terms, however, the riders addressed only the agency's use of funds from its yearly appropriation. And, as the panel acknowledged, it has long been understood that an appropriation or lack thereof "merely imposes limitations upon the Government's own agents"—here, HHS—but its "insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties." *Salazar*, 567 U.S. at 197 (quoting *Ferris*, 27 Ct. Cl. at 546); see *N.Y. Airways, Inc.* v. *United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) ("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"). In *New York Airways*, for example, Congress "deliberate[ly]" appropriated less than required, "well-aware that the Government would be legally obligated to pay" the total, which was a "contractual obligation enforceable in the courts which could be avoided only by changing the substantive law … rather than by curtailing appropriations." *Id.* at 747.

As cases cited throughout this brief demonstrate, it is not entirely uncommon for Congress to fail to appropriate money to meet statutory obligations, whether purposely or inadvertently. But the failure to do so does not negate the obligation to pay. Accord *Strong* v. *United States*, 60 Ct. Cl. 627, 630 (1925) (awarding statutorily-mandated pay despite inadequate appropriation). As the Court of Claims explained:

> The officers of the Treasury have no authority to pay the officer until an appropriation therefor[e] has been made. But the liability of the United States to pay exists independently of the appropriation, and may be enforced by proceedings in this court.

Id. See also *Miller* v. *United States*, 86 Ct. Cl. 609, 614 (1938) (judgment for difference where appropriation fell short of statutory amount); *Graham* v. *United States*, 1 Ct. Cl. 380, 382 (1865) (same); *Parsons* v. *United States*, 15 Ct. Cl. 246, 246-47 (1879) ("absence of an appropriation constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established").

The text of the ACA and riders should have been decisive. The panel majority thus erred in holding (based on its reading of legislative history) that the riders cancelled—or "suspended"—the underlying statutory obligation, not merely the agency's ability to use funds for payments to satisfy the obligation.

Indeed, the panel's use of "suspend" was itself suspect. "Suspend" is a word that Congress has sometimes used in statutes *prospectively* to eliminate a scheduled salary or bonus for an upcoming year. See, *e.g.*, *United States* v. *Will*, 449 U.S. 200, 222 (1980). There was no such enactment here. Here, it might be argued that the riders *prospectively* "suspended" *the agency*'s access to funds to make Section 1342 payments. But the riders, by their terms, referred only to the agency's use of funds and did not change or supersede the statutory obligation created by Section 1342 either prospectively or retrospectively. The Federal Circuit misused the word "suspend" to refer to a retroactive elimination of the government's obligations, based on a statute in effect for the *prior* year and insurance sold and provided in the *prior* year. See *Moda,* 892 F.3d at 1329; *id.* at 1333-34, 1334 n.2 (Newman, J., dissenting).

The Federal Circuit's ruling that the riders abrogated the underlying obligation, or rendered it unenforceable, was wrong. In the absence of an "irreconcilable" conflict between a prior and later statute, both must be given force. See *Posadas* v. *Nat'l City Bank of N.Y.*, 296 U.S. 497, 503-04 (1936). There was no conflict here. A limit on funds available to an agency to meet a statutory obligation is not in irreconcilable conflict with the continued existence of that obligation. See *Salazar*, 567 U.S. at 196-97 (citing cases and applying the rule). And that should have been dispositive. "[W]hen two statutes are capable of co-existence, 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).

This Court's cases have long applied that rule to appropriation statutes. A failure to appropriate money to pay an obligation leaves the unpaid obligation intact, enforceable, and outstanding. Thus, this Court held in *Langston* that "a statute fixing the annual salary of a public officer at a named sum" was not "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. "[A]ccording to the settled rules of interpretation," a subsequent enactment that appropriated a less amount for the government employee's salary did not abrogate or suspend the obligation to pay the salary in full. *Id.* at 393-94. If a statutory payment obligation is to be repealed by a subsequent appropriation act, the repeal must be "expressed in the statutes." *Mitchell*, 109 U.S. at 150. It was not expressed in the statutes in this case. And that should have been determinative.

B. The Federal Circuit Failed to Apply Controlling Principles of Statutory Interpretation, Misread This Court's Cases, and Misread the Legislative History.

The Federal Circuit cited nothing in the text of the riders repealing, suspending, or amending Section 1342, let alone converting its formula into one in which payments would be *pro rata* limited to amounts collected from insurers. But the Federal Circuit accepted the Government's argument that

the restrictive standards for judging implied repeal as set forth in *Langston* and *Mitchell*—focusing on statutory text and manifest inconsistency between the original statute and the subsequent appropriations act—had been eroded by this Court's later cases. It read this Court's cases now to *require* a court to look beyond the words of the rider, and the absence of any inconsistency, and instead attempt to tease out the unexpressed legislative intent from the legislative history. The Federal Circuit majority embarked on that task without identifying any ambiguity in the riders, ordinarily a precondition to consulting legislative history.

As shown below, the Federal Circuit erred in reading this Court's cases to require a search for intent beyond the plain language of the statutes in question. See section II.B.2, *infra*. The Federal Circuit also misread or misunderstood the materials it cited as legislative history (see section II.B.3, *infra*), and failed to properly apply two controlling principles of statutory interpretation that should have guided its analysis. We begin with those two principles.

1. Two Basic Principles of Statutory Interpretation Should Have Guided the Analysis Here.

Two basic principles of statutory interpretation should have guided the Federal Circuit's analysis, and (if applied properly) would have led to the correct result. Each principle rests on basic understandings about how legislatures in fact do, and should, operate. Requiring a showing of "clear intent"—whether to repeal, or to legislate

retroactively—provides the important assurance "that Congress itself has affirmatively considered the potential unfairness" of its actions "and determined that it is an acceptable price to pay for the countervailing benefits." See *Landgraf.* v. *USI Film Prods.,* 511 U.S. 244, 272-73 (1994). Strict and consistent adherence to those principles also provides the assurance that in interpreting and applying statutes, the courts are implementing the enacted will of Congress, not the considerations of an individual member or the courts' own intuitions. Those assurances were wholly absent here.

a. Implied Repeal Is Disfavored and Not to Be Found Absent an Irreconcilable Conflict Between the Later and the Former Statute.

For more than 150 years, the standards for determining when a subsequent Congress has overridden or supplanted a law enacted by a prior Congress have been well-understood and consistently applied. The "cardinal rule" is that implied repeal is greatly disfavored, and is rarely found. 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, more pertinent here, the two laws are in "irreconcilable conflict." The intention to repeal must "be clear and manifest." *Posadas*, 296 U.S. at 503-04. "The whole question depends on the intention of Congress as expressed in the statutes." *Mitchell*, 109 U.S. at 150.

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.*; see *Tenn. Valley Auth.* v. *Hill*, 437 U.S. 153, 190 (1978). Rules applicable in both Houses generally bar substantive legal changes in appropriations bills.[18] And the practicalities of the legislative appropriation process frequently preclude the kind of legislative scrutiny of appropriation measures that would warrant the courts drawing large, substantive inferences from obscure financing provisions.

In *Hill*, this Court squarely rejected reliance on the legislative history of an appropriations law—such as Committee Report language—as the basis for overriding a statutory mandate. 437 U.S. at 190-91. Otherwise, appropriation acts would become "pregnant with prospects of altering substantive legislation," requiring "Members to review exhaustively" all of their compatriots' commentary "before voting on an appropriation." *Id*.

The repeal of a law requires the same process as enactment: a majority of votes in both Houses, and concurrence by (or override of the veto of) the President. The high bar to implied repeal thus 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*

---

[18] House Rule XXI(2)(a)(2)(b); Senate Rule XVI(4).

v. *Hansen*, 772 F.2d 940, 944 (D.C. Cir. 1985) (Scalia, J.).

Under this system, laws enacted by one Congress stand on equal footing with those enacted by a later Congress, unless the later Congress has enacted a new law demonstrably supplanting the prior one. Therefore, "when 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." See *Morton*, 417 U.S. at 551; *Posadas*, 296 U.S. at 503.

This Court has, therefore, described repeal by implication as a "rarity." *J.E.M. Ag Supply, Inc.* v. *Pioneer Hi-Bred Int'l, Inc.*, 534 U.S. 124, 142 (2001); *see also Branch* v. *Smith*, 538 U.S. 254, 293 (2003) (O'Connor, J., concurring in part and dissenting in part) (describing how infrequent such findings are). Strict adherence to the high bar to implied repeal produces that rarity in two ways. The high bar guides the courts because it tells the courts specifically what to look for in considering questions of implied repeal. Clear rules help eliminate uncertainty and arbitrary decision-making.

But the high bar also guides Congress. The principles governing repeal have been around long enough that Congress knows that a clear statement is required to repeal or replace an existing law. While it is always conceivable that a subsequent statute will *unwittingly* repeal a prior one by virtue of patent inconsistency between the two, where (as here) the later Congress is aware of the prior law, it is reasonable to expect Congress to speak clearly

if intends to repeal it. Yet nothing in the riders at issue reflects even a feint at meeting that high bar.

Here, the Federal Circuit failed to heed this Court's longstanding caution against implied repeal. Indeed, it inverted the standard. Rather than ask whether a rider merely 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 the *text* of the rider was "irreconcilable" with the continued existence of the obligation, the panel majority derived "intent" from a snippet of legislative history (part of Chairman Rogers' lengthy floor statement) that actually states no intention at all to abrogate any existing statutory obligation. See *infra*, section II.B.3.

Because the riders addressed only HHS's use of annual funds, there was no reason for insurers, or Section 1342 supporters in Congress, or the President, to think that the riders were abrogating the underlying statutory formula or obligation governing Section 1342 payments. Indeed, HHS had already stated that it would annually administer Section 1342 without any additional funds (beyond payments in), while confirming that it remained the government's obligation to make "full payments" based on the statutory formula at the conclusion of the three years.

In simple terms: For even the most ardent and knowledgeable supporters of the ACA and Section 1342 in Congress, there was nothing in the text of spending riders to vote against. For the President, whose executive branch agency, HHS,

had already set forth the plan to limit *annual* payments out to collections, there was nothing in the text of the spending riders to veto.[19] If, as here, nothing in the text of the supposed repealer would alert even the most avid and astute supporter of the prior statute to repeal, it should be impossible to find the kind of manifest inconsistency between the two enactments that would warrant a finding of repeal.

b. The Panel Majority Ignored the Presumption Against Retroactivity.

The longstanding rule against interpreting statutes to have retroactive effect requires that if Congress believes that it is entitled to renege on a prior promise, it must do so explicitly, with statutory text reflecting the purposeful renege. *Landgraf,* 511 U.S. at 272 (presumption provides assurance of thoughtful consideration). Because legislatures do not lightly legislate retroactively, 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*, 511 U.S. at

---

[19] 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).

280 (no retroactive effect "absent clear congressional intent favoring such a result").

Instead of applying these principles, the panel majority ignored retroactivity and instead labored to interpret the riders to have precisely the kind of retroactive effect this Court's cases warn against. All that it said touching on the subject was that the government *owed* no payment until after performance by the insurers, when the insurers' losses were calculated. See *Moda*, 892 F.3d at 1326.

But retroactivity cannot plausibly turn on the date payments are due. It must instead revolve around when reliance is induced, action taken, losses suffered, and obligations 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 is also 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. II GAO, *Principles of Fed. Appropriations Law* (3d ed. 2004) at 7-4 – 7-5 (An "obligation arises when the definite commitment is made, even though the actual payment may not take place until a future fiscal year ….")[20]; *Molina Healthcare of Cal. Inc.* v. *United States*, 133 Fed. Cl. 14, 38 (2017). The triggering condition for applying the rule against retroactive construction of a statute centers on when actions are irrevocably

[20] *available at* https://www.gao.gov/special.pubs/d06382sp.pdf.

taken in reliance on existing conditions, particularly when that conduct triggers an obligation to pay.

The rule should have been applied here. This was no unilateral government benefits program. Here, insurers took actions, and were expected to take actions, in reliance on the statutory promise. They provided counter-promises and suffered actual, out-of-pocket losses of the kind that Section 1342 was intended to help cover. Insurers set premiums, offered and sold coverage on the exchanges, committed to pay the government under Section 1342, provided coverage in each of the three years the program was in place, and suffered the resulting injury in the form of out-of-pocket costs, all before Congress enacted the riders for each year that the Federal Circuit held to cancel the government's payment obligations. Indeed, on the basis of HHS's view and the Government's own theory earlier in this case (see Statement F, *supra*), insurers were required to fully perform, and suffer losses, for three years before the obligation to pay them in full under Section 1342 would come due.

If the presumption against interpreting statutes to have retroactive effect is to have any meaning, it must be that Congress cannot renege on an obligation through appropriation riders that do not address the issue, garnished with a dash of uninformative legislative history, leaving it to the courts to provide the result that Congress was itself unable to enact as law. *Landgraf,* 511 U.S. at 272-73.

None of this Court's cases cited by the panel majority as the basis for relaxing the rule against

implied repeal involved retroactive legislation. To the contrary, in each case, the later enactment put in place a salary or bonus limitation, inconsistent with a prior salary or bonus law, *before* the work for which the payment was to be made was performed. See *infra* section II.B.2.

2. The Panel Majority Misunderstood This Court's Precedents.

The Federal Circuit read this Court's salary and bonus appropriation decisions as directing it to look past statutory text to draw some separate conclusion about congressional intent from legislative background materials. The panel majority misread those decisions. This Court's cases on implied repeal in appropriation acts, as elsewhere, always begin with the text. Unless the *text* of the later appropriations act was found inconsistent with the prior law, the Court has not found implied repeal.

Indeed, while those cases reflect the custom of the times in readily citing legislative history, the Court's willingness to consult legislative history in those cases is best viewed as *supporting* the high bar on finding implied repeal, not *departing* from it: The Court has not relied on legislative history to find an intention to repeal not evident on the face of at least some of the subsequent statutes at issue. To the contrary, even where the subsequent appropriation act was, to all appearances, facially irreconcilable with the prior law, this Court's reluctance to find implied repeal has prompted the Court to look to legislative history to confirm, not independently justify, the repeal.

The rule is that when considering whether a subsequent appropriation act repeals a previously established statutory obligation, it is Congress's intent, as "expressed in the statutes," that controls. *Mitchell*, 109 U.S. at 150. The Court applied that rule in *Langston*. In *Langston*, Congress appropriated a "less amount" than required to satisfy the statutory payment obligation. The Court held that a limitation on the appropriation of funds, without "words that expressly, or by clear implication, modified or repealed the previous law," could not cancel the government's payment obligation. 118 U.S. at 394.

The Federal Circuit regarded *Langston* as a "bare failure to appropriate funds to meet a statutory obligation," *Moda*, 892 F.3d at 1323, which it contrasted with other salary and bonus cases that involved at least some text in the subsequent statute to construe. *Id*. at 1323-25. But the Federal Circuit missed the point. It is not the mere existence of appropriation act text that prompted inquiry into legislative intent. Rather, each case cited by the Federal Circuit involved a manifest inconsistency between the description of the salary or bonus obligation in the original statute, and in the text of the subsequent appropriation act, describing differently how the salary or bonus was to be paid in the appropriation year.

In *Mitchell*, the first statute stated the salary for paying interpreters; the second stated that the salary for that year would be something else. 109 U.S. at 148. 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 for that period.

United States v. *Dickerson*, 310 U.S. 554 (1940) and *Will* each involved a series of appropriation riders over several years. In one or more years, the intention to suspend the obligation for the upcoming period was unequivocally expressed in the rider. The Court considered legislative history in order to confirm that the variation in language in the series of riders did not reflect a variation in intention.

Specifically, in *Dickerson*, Congress *explicitly* suspended reenlistment allowances for four years, stating that the allowance "is hereby suspended." 310 U.S. at 556. In the fifth year, a different "form of words" was used, directing that "no part of any appropriation contained in this *or any other Act*" shall be used to pay the allowances. *Id.* at 556-57 (emphasis added). The "this or any other Act" language was itself arguably sufficient to communicate that no money could be made available from anywhere in the government to pay the obligation. And classic legislative history—explanatory statements and floor colloquy squarely on point—confirmed the intention to "discontinue[ ] for another year the payment of the reenlistment allowances." *Id.* at 561.

Will was similar. It too dealt with a series of appropriation acts. The rider in one year directly stated that the statutorily-scheduled cost-of-living salary increase "shall not take effect." 449 U.S. at 207. In two others, riders barred use of appropriations in "this Act *or any other Act*," the same language blessed in *Dickerson* as sufficient to

suspend a payment obligation. *Id.* at 205-07 (emphasis added). Another rider specifically referenced the scheduled pay increase of "approximately 12.9 percent" "under existing law" and stated that funds "shall not be used" to pay "in excess of 5.5 percent." *Id.* at 208. Appellees argued that *none* of these riders did more than limit access to funds without affecting the underlying obligation. The Court found that all of them did, highlighting the explicit "shall not take effect" language used in one of the years, and explicit legislative history that confirmed Congress's consistent intent. *Id.* at 222-23.

In contrast, none of the riders at issue in this case contained language suspending the underlying statutory obligation, nor barring "payment" from appropriations in "this or any other act" as in *Dickerson*.[21] Thus, the predicate statutory

---

[21] Congress used this same broad "this or any other Act" language elsewhere in the appropriation acts that contained the riders at issue here. See, *e.g.*, Consolidated and Further Continuing Appropriations Act, 2015 (Pub. L. No. 113-235), §716 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay …."), §717 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay …."), §718 ("None of the funds appropriated by this or any other Act shall be used to pay …."); §731 ("None of the funds made available by this or any other Act may be used to …."), §735 ("None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay …."), §736 ("None of the funds made available by this Act may be used to procure …."); Consolidated Appropriations Act, 2016 (Pub. L. No. 114-113), §714 ("None of the funds appropriated or otherwise made available by this or any other Act shall be (continued…)

language manifesting repeal, and triggering resort to legislative history to confirm repeal, is absent here. The appropriation riders here were readily reconciled with the Section 1342 obligation.

Moreover, the salary cases cannot support the decision below for a second reason. None of them involved a retroactive repeal—except for brief periods in *Will* (when the cost-of-living adjustment was suspended shortly after being triggered, and held unconstitutional under the Compensation Clause). To the contrary, in each case, Congress enacted the law changing the remuneration before the employee or agent performed substantial work.

3. The Panel Majority Misunderstood the Legislative Material Upon Which It Relied.

Setting aside whether it was appropriate to draw upon legislative history at all, there was a notable absence of quality, quantity, and specificity in the legislative materials cited here. The panel majority cited two things:

First, it cited an inquiry to the GAO by two Members, asking what funds were generally available to HHS for Section 1342 payments. GAO responded that HHS could make Section 1342

(continued)
used to pay ….”), §715 (“None of the funds appropriated or otherwise made available by this or any other Act shall be used to pay ….”), §716 (“None of the funds appropriated by this or any other Act shall be used to pay ….”), §733 (“None of the funds appropriated or otherwise made available by this or any other Act shall be used ….”).

payments using usage fees—*i.e.*, payments in—and it could make Section 1342 payments from its general lump sum program management appropriation. The riders barred HHS from using the program management funds for Section 1342 payments, leaving only "payments in" available for that purpose. All well and good, but GAO's letter only addressed what funds were available to HHS, the government's agent, not the underlying obligation. And the limitation in the rider was fully consistent with HHS's own stated intention to maintain budget neutrality on a yearly basis—leaving the final tally, and "full payment" of the government's obligation, until the conclusion of the three-year program.

As the primary evidence of "intent," the panel cited one other Member, House Appropriations Chairman Rogers, and his comments on the FY 2015 rider inserted into the Congressional Record. His commentary included:

> 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 1319 (quoting 160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014)).

On its face, this statement simply characterized—actually, mischaracterized—HHS's regulatory actions, not any effect of the rider on the ACA. However accurately or inaccurately it characterized HHS's intentions, the statement cannot be read to suggest that anything in the rider itself changed the underlying statutory obligation. 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). The rider that was the focus of the panel majority's attention can fairly be read to hold HHS to its stated intention to administer the program yearly on a budget neutral basis, while acknowledging that full payment remained an obligation of the United States. But neither the rider, nor the statement, describes any intention to tamper with the underlying statute, or to "defeat the rights of other parties." *Ferris*, 27 Ct. Cl. at 546.

Again, assuming that it was even appropriate to look to such legislative materials at all, there is a notable dearth of both quantity and quality in the panel majority's sources. There was no demonstration, for example, that the letter exchange with GAO, involving two Members, reflects the knowledge of "Congress," as the panel implied. And the quoted statement of even the Chairman of the Appropriations Committee, buried in more than six hundred pages of material inserted in the Congressional Record, is still the statement of only a single member. Reliance on that statement is even more suspect since the majority in the House and Senate were of different political parties, with different declared positions on the virtues of the ACA. On any scale of credible insight into "intent," these sources are very different in quality and quantity from those cited in the salary cases discussed above.

Conversely, the Federal Circuit ignored classic indicators of congressional intent. Specific bills to impose budget neutrality on the Section 1342 program were proposed both before and after the riders began.[22] They were not enacted. And, of course, the Federal Circuit ignored HHS's clearly stated understanding that a lack of appropriation would not undermine the existence of the government's obligation to make full payment to insurers.

---

[22] See S.359, 114th Cong. (2015); H.R. 724, 114th Cong. (2015); S.123, 114th Cong. (2015); H.R. 221, 114th Cong. (2015); H.R. 5175, 113th Cong. (2014); H.R. 4406, 113th Cong. (2014).

But even crediting the Federal Circuit's source material, the inference of intent to repeal was unwarranted. It was the opposite of the natural inference.

The panel majority asked rhetorically, "What else could Congress have intended?"

But the obvious answer must be that Congress intended what the riders actually say. The riders held HHS to its stated intent to pay out yearly only what it took in, without abrogating the government's ultimate obligation to make the full payments required by the Section 1342 formula. Indeed, it was the Government's position in this case that insurers' claims to yearly Section 1342 payments were premature because HHS had made it clear, consistent with the riders, that it would pay out yearly only what it had taken in. Insurers' claim for full payment would ripen and come due only at the end of the three-year program.

There are other possible "intents." Perhaps some members did not want to be complicit in a statutory program they opposed and therefore did not want to vote to fund. Or perhaps some in Congress mistakenly believed that Section 1342 required budget neutrality (as the Government unsuccessfully argued below), in which case, it would make no sense to fund the program through HHS's program management appropriation. If that was the belief of some members of Congress, then it has been proven wrong. Or perhaps Congress did not want to take any position on that at all: By barring HHS from paying from yearly appropriations, it attempted to put insurers to their proof, requiring them to demonstrate in court

that Section 1342 required these payments. They have; it does. The panel majority's speculative approach to congressional intent does not come close to meeting the high bar required to demonstrate implied repeal, or to find that Congress has acted retroactively to extinguish an existing obligation.

The bottom line here is that through its appropriation enactments, Congress has constrained HHS in its ability to make the payments that Section 1342 requires. But Congress has done nothing to abrogate the obligation itself, leaving the payments that Section 1342 promises to eligible insurers owing and due.

CONCLUSION

The judgment of the court of appeals should be reversed.

Respectfully submitted,

STEPHEN J. MCBRADY
Counsel of Record
CLIFTON S. ELGARTEN
DANIEL W. WOLFF
A. XAVIER BAKER
CROWELL & MORING LLP
1001 Pennsylvania Ave., N.W.
Washington, D.C. 20004
(202) 624-2500
smcbrady@crowell.com

Counsel for Petitioner

August 30, 2019