Nos. 18-1023, 18-1028, and 18-1038

In the Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS, PETITIONER

v.

UNITED STATES OF AMERICA

ON WRITS OF CERTIORARI
TO THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

BRIEF FOR THE RESPONDENT

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MODA HEALTH PLAN, INC., ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NONPROFIT MUTUAL INSURANCE CORPORATION, PETITIONER

v.

UNITED STATES OF AMERICA

QUESTIONS PRESENTED

In Section 1342 of the Patient Protection and Affordable Care Act (ACA), 42 U.S.C. 18001 *et seq.*, Congress directed the Department of Health and Human Services (HHS) to establish a temporary "risk corridors" program for the years 2014, 2015, and 2016. 42 U.S.C. 18062. Under that program, HHS would collect "payments in" from relatively profitable insurers and make "payments out" to relatively unprofitable insurers pursuant to statutory formulas. *Ibid.* (capitalization and emphasis omitted). The ACA did not appropriate any funding for the risk-corridors program. Instead, Congress deferred the issue of funding to the annual appropriations process. In the appropriations acts that covered the program years, Congress permitted HHS to use "payments in" to make "payments out," but it explicitly prohibited HHS from using the only other funds that were potentially available to make such payments. HHS accordingly made risk-corridors "payments out" using only the amounts it had collected from insurers as "payments in."

Petitioners brought these actions asserting statutory and implied-in-fact contract claims and seeking money damages for additional amounts that they claimed were due to them as "payments out" under the ACA's formulas beyond the sums that Congress appropriated. The court of appeals rejected both claims. The questions presented are as follows:

1. Whether HHS's compliance with Congress's funding limitations is a statutory violation that provides the basis for damages claims against the United States.

2. Whether insurers have implied-in-fact contracts with the government entitling them to "payments out."

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OPINIONS BELOW

The opinion of the court of appeals in No. 18-1023 (18-1023 Pet. App. 1a-2a) is not published in the Federal Reporter but is reprinted at 729 Fed. Appx. 939. The opinion of the Court of Federal Claims in that case (18-1023 Pet. App. 89a-119a) is reported at 133 Fed. Cl. 1.

The opinion of the court of appeals in No. 18-1028 in the appeal of petitioner Moda Health Plan, Inc. (Pet. App. 1-60)[1] is reported at 892 F.3d 1311. The opinion and order of the Court of Federal Claims in that case (Pet. App. 85-152) is reported at 130 Fed. Cl. 436.

The opinion of the court of appeals in No. 18-1028 in the appeal of petitioner Blue Cross and Blue Shield of North Carolina (Pet. App. 61-62) is not published in the Federal Reporter but is reprinted at 729 Fed. Appx. 939. The opinion and order of the Court of Federal Claims in that case (Pet. App. 153-206) is reported at 131 Fed. Cl. 457.

The opinion of the court of appeals in No. 18-1038 (18-1038 Pet. App. 1a-6a) is reported at 892 F.3d 1184. The opinion and order of the Court of Federal Claims in that case (18-1038 Pet. App. 70a-140a) is reported at 129 Fed. Cl. 81.

JURISDICTION

The judgments of the court of appeals in No. 18-1023, and in No. 18-1028 in the appeal of petitioner Blue Cross and Blue Shield of North Carolina, were entered on July 9, 2018. The judgments of the court of appeals in No. 18-1028 in the appeal of petitioner Moda Health Plan, Inc., and in No. 18-1038 were entered on June 14, 2018. Petitions for rehearing were denied in each case

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[1] Unless otherwise indicated, "Pet. App." refers to the appendix to the petition for a writ of certiorari in No. 18-1028.

on November 6, 2018 (18-1023 Pet. App. 3a-8a). The petitions for writs of certiorari were filed on February 4, 2019, and granted on June 24, 2019. The jurisdiction of this Court rests on 28 U.S.C. 1254(1).

STATUTORY PROVISIONS INVOLVED

Pertinent statutory provisions are reprinted in the appendix to this brief. App., *infra*, 1a-51a.

STATEMENT

The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (42 U.S.C. 18001 *et seq.*), established Health Benefit Exchanges in which insurance companies could compete for new customers, incurring individually calculated business risks. The ACA did not require insurers to participate in those new markets. And it did not require taxpayers to indemnify insurers for their losses if they chose to participate but proved to be unprofitable. Instead, the ACA established three premium-stabilization programs, under which transfers would be made among insurers to mitigate some risks.

Petitioners do not dispute that two of those three programs—risk adjustment and reinsurance—were properly funded solely with amounts collected from insurers or plans under those programs. Petitioners contend, however, that the third program—risk corridors—departed from that model and uniquely exposed the government to uncapped liability to insurers for subsidies in excess of the amounts Congress appropriated, based on criteria that depended largely on the insurers' own business judgments. On petitioners' theory, insurers collectively are owed approximately $12 billion, and petitioners are owed hundreds of millions of dollars. Petitioners maintain that they may recover such sums from the government as money damages and brought these actions to do so.

Congress did not expose the federal fisc to that massive liability for Congress's own funding determinations. The ACA reserved to future Congresses the determinations whether and to what extent to fund the risk-corridors program. Congress ultimately determined to appropriate only money collected by the Department of Health and Human Services (HHS) under the risk-corridors program itself. Federal law prohibited HHS from expending or committing funds beyond what Congress appropriated. HHS's compliance with Congress's express funding restrictions was not a statutory violation, and the ACA cannot fairly be construed to authorize damages actions against the United States for Congress's exercise of its appropriations prerogative. Nor did the risk-corridors provision create a contract with insurers that HHS breached by faithfully adhering to Congress's funding limitations. Under well-settled precedent, the provision is a regulation of actors in the marketplace, not an offer inviting acceptance that imposed contractual obligations on the United States.

A. Statutory Background

1. The ACA's expansion of coverage in the individual health-insurance market

The ACA contained numerous provisions designed to expand coverage in the individual health-insurance market. *King* v. *Burwell*, 135 S. Ct. 2480, 2485-2487 (2015). As particularly relevant here, it provided for billions of dollars of refundable annual tax credits to help individuals pay for insurance. *Id.* at 2489. The ACA also prohibited insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.* at 2486.

In addition, the ACA provided for the creation of Exchanges—online marketplaces in each State where individuals and small groups can purchase health insurance. *King*, 135 S. Ct. at 2487. All plans offered through an Exchange must be Qualified Health Plans, meaning that they provide "essential health benefits" and comply with other requirements. 42 U.S.C. 18021(a)(1)(B); see 45 C.F.R. Pts. 155, 156. Insurers had a strong business incentive to participate in the Exchanges—the only commercial channel to market plans to the millions of individuals eligible to receive tax credits. See 26 U.S.C. 36B (2012 & Supp. V 2017); *King*, 135 S. Ct. at 2493. Insurers likewise had business reasons to price their plans competitively.

2. The ACA's premium-stabilization programs

Like most business opportunities, participation in the Exchanges presented insurers with business risks. Among other risks, participating in an Exchange meant covering an expanded risk pool of persons whose health status was unknown, and insurers no longer could charge higher premiums or deny coverage based on a person's health. Pet. App. 2, 157. To mitigate pricing risks, the ACA provided for the establishment of three premium-stabilization programs, modeled on preexisting programs established under the Medicare program: reinsurance, risk corridors, and risk adjustment. ACA §§ 1341-1343, 124 Stat. 208-213 (42 U.S.C. 18061-18063). All three programs began operating in 2014. *Ibid.* The risk-adjustment program is permanent, but the reinsurance and risk-corridors programs operated only in 2014, 2015, and 2016. *Ibid.*

All three programs were designed to distribute some costs and risks among insurers, by using amounts col-

lected from plans with lower costs or risks to fund subsidies to plans with higher costs or risks. Under the reinsurance program, amounts collected from insurers and self-insured group health plans were used to fund payments to issuers of eligible plans that covered high-cost individuals in the individual market. ACA § 1341, 124 Stat. 208-211 (42 U.S.C. 18061). Under the risk-adjustment program, amounts collected from plans with healthier-than-average enrollee populations are used to fund payments to plans with unhealthier-than-average enrollee populations. § 1343, 124 Stat. 212-213 (42 U.S.C. 18063).[2]

These cases concern the third program—"risk corridors"—under which amounts collected from relatively profitable plans were used to fund payments to relatively unprofitable plans. ACA § 1342, 124 Stat. 211-212 (42 U.S.C. 18062); see Pet. App. 3. Section 1342 directed HHS to "establish and administer" a program under which insurers offering individual and small-group Qualified Health Plans in 2014, 2015, and 2016 "shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. 18062(a). Section 1342 directed that the "program shall be based" on an existing risk-corridors program "under [Medicare Part D]." *Ibid.*

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[2] Amounts collected under the reinsurance and risk-adjustment programs are distributed under the authority of the ACA itself. Sections 1341 and 1343 direct each State to collect amounts and make payments, and Section 1321, 42 U.S.C. 18041, directs HHS to act on behalf of a State that opted not to do so. In combination, the provisions establish an appropriation known as a special fund. See, *e.g.*, Office of Mgmt. & Budget, *Fiscal Year 2016 Appendix: Budget of the U.S. Government* 473, https://go.usa.gov/xmHCY.

Section 1342 prescribed formulas for determining whether a plan would be required under the program established by HHS to make a payment into the program or receive a payment out from HHS and, if so, how much. If a plan's "allowable costs" (essentially, the cost of paying benefits) were less than its aggregate premiums minus authorized administrative costs (the "target amount") by more than three percent, the plan had to pay a specified percentage of the difference to HHS. 42 U.S.C. 18062(b)(2). These payments were referred to as "payments in." *Ibid.* (capitalization and emphasis omitted). Conversely, if a plan's allowable costs exceeded its target amount by more than three percent, Section 1342 stated that the program would provide that HHS "shall pay" the plan a specified percentage of the difference, called "payments out," thus offsetting a portion of the shortfall of the plan's target amount compared to its allowable costs. 42 U.S.C. 18062(b)(1) (capitalization and emphasis omitted). HHS adopted implementing regulations that incorporated this methodology and defined various terms. 45 C.F.R. 153.500, 153.510(b) and (c).

3. Congress's funding decisions for risk corridors

For certain ACA programs, the ACA itself provided funding—either by appropriating funds directly, see, *e.g.*, 42 U.S.C. 300gg-93(e), 18001(g)(1), 18031(a)(1), 18042(g), 18043(c), or by amending already-existing appropriations to encompass new programs, as the ACA did for the premium tax credits that were due to begin in 2014, see § 1401(d), 124 Stat. 220. For risk corridors, however, it did neither. Instead, Congress left the determination whether to provide funding for risk-corridors "payments out," and if so how much, to the ordinary appropriations process through which Congress generally funds government programs.

Risk-corridors collections and payments could not begin until 2015, based on a retrospective analysis of data from 2014. See 42 U.S.C. 18062(a). The issue of funding thus was first addressed in the appropriations process for fiscal year 2015. In February 2014, anticipating that process, several Members of Congress requested the opinion of the Government Accountability Office (GAO) "regarding the availability of appropriations to make" risk-corridors payments. *Department of Health & Human Servs.—Risk Corridors Program*, B-325630, at 1 (Sept. 30, 2014), http://www.gao.gov/assets/670/666299.pdf (GAO Op.). GAO, in turn, solicited the views of HHS.

In its May 2014 response to GAO, HHS identified only one source of funding: the amounts that HHS would collect from plans under the risk-corridors program (*i.e.*, "payments in"). 17-1994 C.A. App. (C.A. App.) 231-233. HHS explained that a provision in the annually recurring "Program Management" appropriation for HHS's Centers for Medicare & Medicaid Services (CMS) permitted the expenditure of "such sums as may be collected from authorized user fees," and that this language would permit HHS to use amounts collected under the risk-corridors program to fund risk-corridors payments to insurers. *Id.* at 232 (quoting Consolidated Appropriations Act, 2014 (2014 Appropriations Act), Pub. L. No. 113-76, Div. H, Tit. II, 128 Stat. 374). HHS's response echoed a March 2014 preamble to risk-corridors regulations stating that HHS would implement the program "in a budget neutral manner." 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014).

In September 2014, GAO issued its opinion, explaining that "Section 1342, by its terms, did not enact an appropriation to make the payments specified in" that

provision. GAO Op. 3. GAO thus examined HHS's appropriations act for fiscal year 2014 and identified two provisions within the CMS Program Management appropriation that—if reenacted without change—would (in GAO's view) allow funds to be used to make risk-corridors payments. *Id.* at 3-7. First, GAO agreed with HHS that the user-fee provision would permit HHS to use "payments in" to fund "payments out." *Id.* at 3-6. Second, GAO additionally concluded that a separate provision in the Program Management appropriation—which appropriated a $3.6 billion lump sum from certain CMS trust funds for the management of particular programs (such as Medicaid and Medicare)—was broad enough to encompass risk-corridors "payments out." *Id.* at 3-4 (quoting 2014 Appropriations Act, 128 Stat. 374). GAO emphasized, however, that because appropriations acts "are considered nonpermanent legislation," the two provisions it had analyzed "would need to be included in the CMS [Program Management] appropriation for FY 2015" in order to make either source of funds available for risk-corridors payments in fiscal year 2015. *Id.* at 6.

Three months later, in December 2014, Congress enacted the appropriations act for HHS for fiscal year 2015. Consolidated and Further Continuing Appropriations Act, 2015 (2015 Appropriations Act), Pub. L. No. 113-235, Div. G, Tit. II, 128 Stat. 2477-2478. The 2015 Appropriations Act reenacted both the user-fee and lump-sum provisions of the Program Management appropriation. *Ibid.* But Congress also enacted a proviso that expressly prohibited the use of funds appropriated under the lump-sum provision for "payments out" under the risk-corridors program:

> None of the funds made available by this Act from [the CMS trust funds], or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services—Program Management' account, may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors).

§ 227, 128 Stat. 2491. Thus, the first time Congress enacted legislation to address funding for the risk-corridors program, Congress appropriated the amounts that would be collected from insurers as "payments in," but simultaneously barred HHS from using the only other funds that had been identified as potentially available.

In an "explanatory statement" on the bill, the Chairman of the House Committee on Appropriations explained that the legislation ensured that the program would be self-funded. 160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014) (statement of Rep. Rogers) (capitalization omitted). "In 2014," he noted, "HHS issued a regulation stating that the risk corridor program will be budget neutral, meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect," and the appropriations act "include[d] new bill language to prevent the CMS Program Management appropriation account from being used to support risk corridors payments." *Ibid.*; see 79 Fed. Reg. at 13,787. Congress reenacted the same restriction in appropriations acts covering the entire period of the program's operation.[3]

HHS accordingly used only the amounts collected from insurers to make risk-corridors "payments out."

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[3] Pet. App. 13 & n.1 (citing Pub. L. No. 114-113, Div. H, Tit. II, § 225, 129 Stat. 2624; Pub. L. No. 114-223, Div. C, §§ 103-104, 130 Stat. 909; Pub. L. No. 114-254, Div. A, § 101, 130 Stat. 1005-1006; and Pub. L. No. 115-31, Div. H, Tit. II, § 223, 131 Stat. 543).

Pet. App. 13-14. In October 2015, HHS announced that the total amount of "payments in" for 2014 (approximately $362 million) was well short of the claims it had received for "payments out" (approximately $2.87 billion) and that HHS thus would issue prorated payments. C.A. App. 244. HHS subsequently explained that "[t]he remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections." *Id.* at 245. HHS additionally observed that, if a shortfall remained after 2016, HHS would "explore other sources of funding for risk corridors payments, subject to the availability of appropriations." *Ibid.* In November 2017, HHS published statistics indicating that the total amount collected from insurers for the 2014-2016 period was approximately $12 billion less than the claims received. Pet. App. 14.

B. Proceedings Below

1. Petitioners' allegations and the trial court's rulings

Petitioners are four insurers that elected to participate in the Exchanges and thus sold plans subject to the risk-corridors program. Petitioners and other such insurers brought dozens of actions against the United States—including class actions—in the Court of Federal Claims under the Tucker Act, 28 U.S.C. 1491, alleging that they are entitled to the full amount calculated under the ACA's formulas for "payments out." Petitioners asserted statutory claims based on Section 1342 of the ACA, and three petitioners also asserted implied-in-fact contract claims. All petitioners sought money damages representing the difference between the amounts they received in "payments out" and the amounts they claim they were owed. Pet. App. 14-15,

85-86, 107-110, 153-156, 169-170; 18-1023 Pet. App. 90a-93a; 18-1038 Pet. App. 71a-74a, 87a-91a.

In the cases of three petitioners—Maine Community Health Options (Maine Community), Blue Cross and Blue Shield of North Carolina (Blue Cross), and Land of Lincoln Mutual Health Insurance Company (Land of Lincoln)—various Court of Federal Claims judges ruled for the government, dismissing the claims or granting judgment for the government. Pet. App. 153-206; 18-1023 Pet. App. 89a-119a; 18-1038 Pet. App. 70a-140a. In the case of petitioner Moda Health Plan, Inc. (Moda), a different judge granted summary judgment to Moda on its statutory and implied-contract claims. Pet. App. 85-152.[4]

2. The court of appeals' decisions

The court of appeals ruled for the government in all four cases. Pet. App. 1-39, 61-62; 18-1023 Pet. App. 1a-2a; 18-1038 Pet. App. 1a-4a.

a. The court of appeals first issued its decision in Moda's case, reversing the trial court's ruling in favor of Moda. Pet. App. 1-39. The court held that Moda had failed to state a claim for a statutory violation. *Id.* at 16-35. The court determined that 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," but it held that the appropriations provisos enacted for fiscal year 2015 and subsequent years had "repealed or suspended

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[4] Blue Cross and Land of Lincoln also asserted express-contract claims and claims under the Fifth Amendment's Takings Clause. Pet. App. 61, 196-198, 203-204; 18-1038 Pet. App. 4a, 123a-130a, 138a-140a. The lower courts rejected those claims, see *ibid.*, and those rulings were not challenged in the petitions.

[that] obligation." *Id.* at 20-21; see *id.* at 16-35. The court reasoned that, although "[r]epeals by implication are generally disfavored, * * * 'when Congress desires to suspend or repeal a statute in force, "there can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise."'" *Id.* at 21 (citations omitted). The court determined that the express restrictions in Congress's annual appropriations acts "adequately expressed Congress's intent to suspend payments on the risk corridors program beyond the sum of payments in." *Ibid.* The court found that those funding restrictions were "[p]lainly" intended to "cap the payments required by the statute at the amount of payments in for each of the applicable years." *Id.* at 26.

The court of appeals rejected Moda's argument that, in enacting those restrictions, Congress had "simply intended to limit the use of a single source of funding while leaving others available." Pet. App. 27. The court explained that no other funding sources were available to HHS from which it could make "payments out." *Id.* at 27-30. That was because, "[a]fter GAO identified only two sources of funding for the risk corridors program—payments in and the CMS Program Management fund—Congress cut off access to the only fund drawn from taxpayers," the lump-sum appropriation. *Id.* at 34. The court held that "Congress could have meant nothing else but to cap the amount of payments out at the amount of payments in for each of the three years it enacted appropriations riders to that effect," and "the appropriations riders carried the clear implication of Congress's intent to prevent the use of taxpayer funds to support the risk corridors program." *Id.* at 34-35.

The court of appeals also concluded that Moda failed to state a claim for breach of an implied-in-fact contract. Pet. App. 35-38. It observed that, under this Court's precedent, "[a]bsent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract." *Id.* at 35. Section 1342, the court of appeals explained, "contains no promissory language," and even Moda did not contend otherwise. *Id.* at 36. The court rejected the contention that an intent to bind the government contractually could be derived from the combination of Section 1342 and HHS's subsequent statements and regulations, concluding that "no statement by the government evinced an intention to form a contract." *Id.* at 38.

Judge Newman dissented. Pet. App. 40-60. In her view, Congress's intent in enacting the risk-corridors appropriations restrictions was unclear absent a "statement in the legislative history suggesting that the rider was enacted in response to the GAO's report," which she found lacking. *Id.* at 48. Judge Newman also opined that "the risk corridors statute is binding contractually, for the insurers and the Medicare administrator entered into mutual commitments with respect to the conditions of performance of the [ACA]." *Id.* at 59.

b. Based on its opinion in Moda's case, the court of appeals affirmed the rulings for the government in the other three petitioners' cases. Pet. App. 61-62; 18-1023 Pet. App. 1a-2a; 18-1038 Pet. App. 1a-4a.

c. Petitioners filed petitions for rehearing en banc, which were denied. 18-1023 Pet. App. 3a-8a. Judges Newman and Wallach each filed opinions dissenting from the denial of rehearing en banc. Pet. App. 66-84.

SUMMARY OF ARGUMENT

I. The court of appeals correctly concluded that petitioners cannot obtain damages in these suits under the Tucker Act for amounts of risk-corridors subsidies that Congress declined to appropriate.

A. To bring a damages action against the United States under the Tucker Act premised on an alleged violation of a federal statute, a plaintiff must surmount "two hurdles," by establishing: first, that the statute imposed a duty that the government failed to fulfill; and second, that the statute "'mandat[es] compensation for damages sustained as a result of a breach of th[ose] duties.'" *United States* v. *Navajo Nation*, 556 U.S. 287, 290-291 (2009) (citation omitted). Petitioners cannot make either showing.

Petitioners' claim is premised on Section 1342 of the ACA, which directed HHS to establish the risk-corridors program. That provision's text does not confer on insurers any entitlement to subsidies. Instead, it directed HHS to establish and administer a program through which it would collect "payments in" from relatively profitable insurers and make "payments out" to relatively unprofitable insurers according to statutory formulas. 42 U.S.C. 18062(a). That instruction to the agency was qualified by the Appropriations Clause, U.S. Const. Art. I, § 9, Cl. 7, which prohibits payment of federal funds absent an appropriation, see *OPM* v. *Richmond*, 496 U.S. 414, 424 (1990), and by statutes that implement the Clause. The Anti-Deficiency Act, 31 U.S.C. 1341(a)(1), prohibits expenditures in excess of appropriations, on pain of criminal penalties. And 31 U.S.C. 1301(d) makes clear that appropriations cannot be inferred but must be "specifically state[d]." *Ibid.* Read together with those statutes, Section 1342 did not

impose an unqualified obligation to make "payments out" pursuant to the statutory formula. Instead, HHS was required and empowered to make payments only to the extent Congress appropriated funds to do so—and Congress was free to decide whether and to what extent to fund those subsidies.

The ACA did not appropriate any funding for "payments out," instead deferring the issue of funding to the annual appropriations process. In the subsequent appropriations acts that governed the program's lifespan, Congress appropriated "payments in" as a funding source for "payments out" but explicitly barred HHS from using the only other potentially available funds—thus ensuring that the risk-corridors program would be self-funded. HHS distributed funds in accordance with Congress's instructions, making risk-corridors "payments out" using only "payments in."

HHS's compliance with Congress's funding limitations is not a breach of a statutory duty, and the ACA cannot fairly be read to mandate money damages for Congress's own funding choices. That would require imputing to Congress the illogical intention to deem its own exercise of its appropriations prerogatives a legal wrong warranting a remedy—and to swap damages suits under the Tucker Act for subsidies Congress itself declined to fund. To the extent Congress's funding decisions left statutory goals partially unfulfilled, petitioners' proper recourse was to seek further appropriations from Congress.

Petitioners' contrary position rests on mischaracterizing Section 1342 as a statutory promise to insurers that imposed obligations on the government equivalent to a contract. That argument elides the deeply rooted distinction between statutory provisions and contractual

obligations. A distinct, well-developed body of law governs claims premised on government contracts; indeed, petitioners unsuccessfully asserted contract claims here. Petitioners can neither rescue their failed contract claims by recasting them in statutory terms nor salvage their meritless statutory claims by invoking inapposite contract-law rhetoric and case law.

B. Even if Section 1342 alone could properly be read to impose an unqualified obligation on HHS to make full "payments out" according to the statutory formula, Congress's enactment of appropriations legislation barring HHS from using the only source of funds other than "payments in" eliminated that obligation. This Court has long recognized that Congress can modify or abrogate a statutory requirement through subsequent appropriations legislation. The import of the appropriations provisions here is unmistakable. As the court of appeals correctly determined, the clear intent of those provisions—by their terms and in their statutory context—was to limit risk-corridors "payments out" to amounts collected as "payments in." Petitioners have tendered no other persuasive explanation for those carefully calibrated provisions.

II. The court of appeals correctly rejected Moda's and Blue Cross's alternative theory that Section 1342 or HHS's actions gave rise to an implied-in-fact contract that entitled insurers to "payments out" irrespective of appropriations. This Court has long made clear that statutes are presumed not to create private contractual rights absent a "clear indication that the legislature intends to bind itself contractually." *National R.R. Passenger Corp.* v. *Atchison, Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-466 (1985). Section 1342 "contains no promissory language from which [courts] could find

such intent." Pet. App. 36. It is an exercise of Congress's authority to regulate actors in a marketplace, not a unilateral contract offer inviting acceptance by performance. Nor did HHS by its actions subject the government to contractual obligations. HHS recognized that its risk-corridors expenditures were constrained by available appropriations, and it lacked statutory authority to enter into contracts obligating the government to pay more than Congress appropriated.

ARGUMENT

I. THE AGENCY'S COMPLIANCE WITH THE FUNDING RESTRICTIONS CONGRESS IMPOSED WAS NOT A STATUTORY VIOLATION GIVING RISE TO DAMAGES

Petitioners' core assertion is that HHS violated a statutory duty to make "payments out" pursuant to Section 1342's formula by limiting its risk-corridors disbursements to the sum Congress appropriated for that purpose: amounts collected as "payments in." That contention has matters backwards. HHS was obligated by statute (and the Constitution) *not* to expend funds in excess of appropriations, which Congress alone can make. Section 1342 must be read together with the statutes embodying that fundamental principle. HHS's faithful compliance with Congress's complete statutory framework certainly did not constitute a statutory *violation* furnishing a valid basis for claims for money damages. Congress was free to determine whether and to what extent to appropriate funds to implement the risk-corridors program. Nothing in the ACA suggests that Congress authorized damages suits based on its own funding determinations. Moreover, even if the ACA as originally enacted could properly be read to impose such liability, Congress's subsequent actions eliminated it.

A. The ACA Did Not Impose An Obligation, Enforceable Through Private Actions For Damages, To Make Risk-Corridors Payments In Excess Of Appropriations

Petitioners seek damages from the United States in actions under the Tucker Act. That Act provides in pertinent part that the "Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States founded" on "any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States." 28 U.S.C. 1491(a)(1). As that text reflects, the Tucker Act and its companion statutes—the Little Tucker Act, 28 U.S.C. 1346(a)(2), and the Indian Tucker Act, 28 U.S.C. 1505—"'are simply jurisdictional provisions that operate to waive sovereign immunity for claims premised on other sources of law,'" and "do not themselves 'creat[e] substantive rights.'" *United States* v. *Bormes*, 568 U.S. 6, 10 (2012) (citation omitted; brackets in original). Another source of law must establish the asserted right and remedy.

The Court has accordingly held that, to proceed on a damages claim under those Acts, there are "two hurdles that must be cleared." *United States* v. *Navajo Nation*, 556 U.S. 287, 290 (2009). First, the claimant "must identify a substantive source of law that establishes specific fiduciary or other duties, and allege that the Government has failed faithfully to perform those duties." *Ibid.* (citation omitted). Second, the claimant must show that the substantive law "can fairly be interpreted as mandating compensation for damages sustained as a result of a breach of the duties [the governing law] impose[s]." *Id.* at 291 (citation omitted; brackets in original). Thus, to obtain damages on their statutory claim here, petitioners must show *both* a "failure to perform an obligation

undoubtedly imposed on the Federal Government" by statute *and* "a right to monetary relief." *Bormes*, 568 U.S. at 15-16; cf. *Alexander* v. *Sandoval*, 532 U.S. 275, 286-287 (2001). Petitioners fail at both steps. The judgments below can and should be affirmed on that basis. See, *e.g.*, *Dahda* v. *United States*, 138 S. Ct. 1491, 1498-1500 (2018) (affirming on alternative ground).

1. The ACA's provision for HHS to make risk-corridors "payments out" was contingent on appropriations

Petitioners' statutory claim for risk-corridors subsidies is premised on Section 1342. Nothing in that provision, however, confers on insurers an entitlement to such subsidies (or a particular amount) without regard to funding. Section 1342's text does not refer to any rights of insurers at all. Instead, by its terms Section 1342 merely directed HHS to "establish and administer" a risk-corridors program through which HHS would make "payments out" to insurers under certain conditions in accordance with a statutory formula. 42 U.S.C. 18062. Petitioners' attempt to infer an unqualified, individual entitlement to subsidies from that direction to the agency fails because Section 1342's direction was always qualified by the Appropriations Clause, Art. I, § 9, Cl. 7, and statutes implementing it. Those qualifications made HHS's payments contingent on appropriations by Congress.

a. Under the "straightforward and explicit command of the Appropriations Clause," "'no money can be paid out of the Treasury unless it has been appropriated by an act of Congress.'" *OPM* v. *Richmond*, 496 U.S. 414, 424 (1990) (citation omitted). Congress permits an agency to incur financial obligations on behalf of the government and to spend federal funds by providing the

agency with "budget authority"—such as through "provisions of law that make funds available for obligation and expenditure." 2 U.S.C. 622(2)(A)(i). Congress confers that type of budget authority through "appropriations," which are "'authorization[s] by an act of the Congress that permit[] Federal agencies to incur obligations and to make payments out of the Treasury for specified purposes'" and "'represent limitations of amounts which agencies may obligate during the time period specified in the respective appropriations acts.'" *Andrus* v. *Sierra Club*, 442 U.S. 347, 359 n.18 (1979) (quoting Comptroller Gen. of the U.S., *Terms Used in the Budgetary Process* 3 (1977)); see 31 U.S.C. 701(2); cf. 2 U.S.C. 622(2)(A)(ii)-(iv) (other forms of "budget authority" include "borrowing authority," "contract authority," and authority to offset receipts and collections); 2 U.S.C. 622(9) (defining "entitlement authority").

Congress has additionally provided that appropriations must be express and cannot be inferred from other statutory directives. "A law may be construed to make an appropriation out of the Treasury * * * only if the law specifically states that an appropriation is made." 31 U.S.C. 1301(d). Appropriations by implication do not exist. See *American Fed'n of Gov't Emps., AFL-CIO* v. *Federal Labor Relations Auth.*, 388 F.3d 405, 410 (3d Cir. 2004).

The Anti-Deficiency Act enforces that command by forbidding federal agencies from making payments or incurring obligations unless and until Congress provides the necessary appropriation. That Act provides in relevant part that, except as otherwise specified, a federal officer or employee may not "make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or

obligation." 31 U.S.C. 1341(a)(1)(A). That prohibition is no mere nicety. Knowingly and willfully violating the Act is a federal crime, punishable by a fine and up to two years of imprisonment. See 31 U.S.C. 1350.

To be sure, Congress sometimes enacts a statute that expressly authorizes the expenditure of funds in advance of ordinary appropriations legislation. For example, the provision governing the Medicare Part D risk-corridors program states that "[t]his section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary [of HHS] to provide for the payment of amounts provided under this section." 42 U.S.C. 1395w-115(a)(2); see also, *e.g.*, ACA § 2707(e)(1)(B), 124 Stat. 327 (42 U.S.C. 1396a note). Such a statute explicitly provides authority to obligate federal funds and thus confirms the rule that agencies may not obligate federal funds without congressional authorization.

It follows that a federal statute instructing an agency official to pay money, without more, neither requires nor empowers the official to disburse the funds. Instead, when such a statute is read together with the Anti-Deficiency Act, Congress's complete direction to the official under the statutory framework is to pay the money specified *if and only if* Congress also provides the necessary appropriation.

b. It is uncontested that the ACA did not appropriate funds for risk-corridors payments. Unlike certain other ACA programs for which the ACA either directly appropriated funds or provided funding by amending existing appropriations, see p. 7, *supra*, the ACA did neither for risk corridors. Nor did Congress otherwise grant HHS authority to commit federal funds in advance of appropriations legislation for that purpose.

In that respect, Section 1342 contrasts starkly with the provision governing the existing Medicare Part D risk-corridors program, on which Section 1342 stated that the ACA's parallel program "shall be based." 42 U.S.C. 18062(a). As noted, the Medicare Part D provision states that the provision itself "constitutes budget authority in advance of appropriations Acts," and imposes an "obligation" on the agency, "to provide for the payment of amounts provided under this section." 42 U.S.C. 1395w-115(a)(2). In Section 1342, Congress omitted that or any similar language. Congress thus ensured that Section 1342 would not, standing alone, cause payments under the ACA's risk-corridors program to be an obligation of the federal government. Instead, Congress's instruction to HHS was to establish a program through which it would make such payments only if and to the extent funds were appropriated, and HHS's obligation to make payments was thus contingent on the existence of such appropriations. Congress reserved to itself the determination whether and to what extent to make such appropriations.

Congress subsequently made that determination in the appropriations acts that governed each year the ACA's risk-corridors program operated. Those acts appropriated for making "payments out" only those funds HHS collected under the program as "payments in." See p. 10 & n.3, *supra*. Indeed, Congress expressly prohibited HHS from using the only other source of funding that GAO had identified as potentially available to make risk-corridors "payments out": the lump-sum appropriation for management of particular CMS programs. Consistent with Congress's funding decisions, HHS made "payments out" using only the amounts collected as "payments in." See pp. 8-11, *supra*.

Petitioners here seek damages for the difference—*i.e.*, the amounts calculated under the statutory formula in excess of what HHS collected as "payments in." Yet they do not identify any law appropriating funds from which HHS could have made those further payments. The trial court in Moda's case suggested that HHS could have used the lump sum that was appropriated for fiscal year 2014 and carried forward by continuing resolutions until December 2014 (in fiscal year 2015). Pet. App. 129 & n.13 (Wheeler, J.); see Land of Lincoln Br. 38; Moda Br. 14-15. But, contrary to Land of Lincoln's contention (Br. 38), the court of appeals expressly and correctly rejected that suggestion. Pet. App. 27-29. As it explained, the appropriations the trial court cited expired in December 2014, but under the terms of Section 1342, "payments out" could not be made until 2015. *Id.* at 29. Petitioners identify no error in the panel's analysis; indeed, they do not confront its reasoning on this point at all.[5]

In short, Section 1342's direction to HHS to establish and administer a risk-corridors program of payment adjustments came with a condition: HHS was neither required nor authorized to make such payments except to the extent Congress appropriated funds. Because Congress did not appropriate funds beyond the amounts collected as "payments in," HHS's statutory duty and

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[5] The trial court in Moda's case suggested in a subsequent decision that the Judgment Fund provides a "third option" for funding risk-corridors payments. *Molina Healthcare of California, Inc.* v. *United States*, 133 Fed. Cl. 14, 35 (2017). As the trial court in Maine Community's case correctly observed, however, the existence of the Judgment Fund is immaterial because "[r]etreat to the Judgment Fund assumes a liability in the first instance." 18-1023 Pet. App. 119a.

authority extended only to disbursing those collected amounts.

c. Moda, Blue Cross, and Land of Lincoln never mention the Anti-Deficiency Act. Maine Community briefly addresses it, contending (Br. 33) that the Anti-Deficiency Act "merely places limits on the ability of government agents and agencies to create binding commitments for the United States" but "does not place limits on Congress itself." To be sure, the Anti-Deficiency Act itself does not preclude Congress from making binding commitments—for example, by granting budget authority in advance of appropriations, as in the Medicare Part D risk-corridors program. But Section 1342 did not do so. See pp. 22-23, *supra*. Congress also could authorize agencies to enter contracts that obligate the government. But Section 1342 did not take that approach either. See pp. 53-56, *infra*.

To the extent Maine Community contends that the Anti-Deficiency Act does not disable future Congresses from repealing or making exceptions to that Act's restrictions—or to the rule of construction in 31 U.SC. 1301(d) that appropriations must be specifically stated—that is true but beside the point. Subject to constitutional limitations, Congress can always repeal or amend an existing statute. See, *e.g.*, *Dorsey* v. *United States*, 567 U.S. 260, 274 (2012) (citing *Fletcher* v. *Peck*, 10 U.S. (6 Cranch) 87, 135 (1810)). But Section 1342 cannot fairly be read as overriding the Anti-Deficiency Act and as obligating HHS to pay billions of dollars that Congress chose not to appropriate.

"[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),

and to harmonize even seemingly inconsistent provisions absent an "irreconcilable conflict," *Radzanower* v. *Touche Ross & Co.*, 426 U.S. 148, 155 (1976); see, *e.g.*, *Ricci* v. *DeStefano*, 557 U.S. 557, 580-584 (2009). Section 1342 and the Anti-Deficiency Act are readily reconciled by understanding Section 1342 as directing HHS to make payments if and to the extent funds are appropriated to do so.

The Federal Circuit's decision in *Highland Falls-Fort Montgomery Central School District* v. *United States*, 48 F.3d 1166, 1171, cert. denied, 516 U.S. 820 (1995), is illustrative. In *Highland Falls*, the substantive statute provided that certain school districts "shall be entitled" to receive amounts of financial assistance calculated under a statutory formula. *Id.* at 1168 (citation omitted). But the amounts that Congress appropriated in annual appropriations acts were insufficient for the Secretary of Education to pay districts the full amounts under that formula. See *id.* at 1169. The Secretary thus reduced the payments pro rata. *Ibid.* The Federal Circuit rejected the school district's claim for damages, reasoning that, by making pro rata reductions in the amounts to which school districts were entitled, the Secretary "harmonized the requirements of [the substantive statute] and the appropriations statutes with the requirements of [the Anti-Deficiency Act]." *Id.* at 1171. Because the Secretary faithfully followed Congress's directions under the governing statutory framework, including the Anti-Deficiency Act, there was no statutory violation. See *ibid.*

So, too, Section 1342 and the Anti-Deficiency Act are properly harmonized by interpreting Section 1342 to direct HHS to make "payments out" only to the extent

of appropriations. That reading avoids any conflict between the two statutes. And it avoids imputing to Congress the unlikely intention to depart obliquely from well-settled principles of appropriations law under the Constitution and implementing statutes by requiring an agency to expend funds that Congress has not, by law, chosen to appropriate.

Indeed, that conclusion is especially clear with respect to Section 1342. Some statutes, like that *Highland Falls*, expressly confer an "entitle[ment]." 48 F.3d at 1168 (citation omitted); see also, *e.g.*, *United States* v. *Langston*, 118 U.S. 389, 390 (1886) (statute provided that "the representative at Hayti shall be entitled to a salary of $7500 a year" (citation omitted)). As *Highland Falls* correctly held, even that kind of language is properly understood as qualified by the Anti-Deficiency Act. See 48 F.3d at 1171. Section 1342, however, does not even refer to entitlements. It consists solely of a direction to the agency to establish a program for "payments in" and "payments out," which necessarily must be read together with the remainder of Congress's instructions. Even if statutory language expressly conferring an entitlement to payment were sufficient without more to overcome the Anti-Deficiency Act's qualification, Section 1342 plainly is not.

Maine Community additionally observes (Br. 28-29) that some statutes—including some other ACA provisions—contain qualifications making particular obligations "subject to the availability of appropriations" or words to similar effect. Maine Community asserts (Br. 29) that those provisions would be "surplusage" if the "statutory obligations were impliedly conditioned on whether Congress later appropriated money to meet the obligation." But there is nothing "implied[]"

about the Anti-Deficiency Act's explicit prohibition on expending federal funds in excess of appropriations. In any event, even assuming that the Anti-Deficiency Act rendered some or all of those qualifications in other provisions superfluous, that alone could not warrant disregarding the Act's command. This Court has specifically observed that the "'preference for avoiding surplusage constructions'" is not "a particularly useful guide" in interpreting the ACA. *King* v. *Burwell*, 135 S. Ct. 2480, 2492 (citation omitted).

Moreover, "the canon against superfluity" assists "only where a competing interpretation gives effect 'to every clause and word of a statute.'" *Microsoft Corp.* v. *i4i Ltd. P'ship*, 564 U.S. 91, 106 (2011) (citation omitted). Here, Maine Community's own position would result in surplusage. On its view, a statutory directive to an agency to make payment should be interpreted as an unqualified obligation unless the Anti-Deficiency Act's prohibition or a similar qualification is repeated in the substantive statute. That cannot explain why other statutes expressly state that a payment mandate is an obligation of the agency. The Medicare Part D risk-corridors provision, for example, both directs HHS to make Part D payments, see 42 U.S.C. 1395w-115(e)(2)(B), and states that the provision "represents the obligation of the Secretary to provide for the payment[s]" mandated, 42 U.S.C. 1395w-115(a)(2). Maine Community's position would render such language redundant. See also *Prairie County* v. *United States*, 782 F.3d 685, 691 (Fed. Cir.) (noting similar language in other legislation), cert. denied, 136 S. Ct. 319 (2015).

Petitioners thus have offered no valid basis for disregarding the Anti-Deficiency Act or 31 U.S.C. 1301(d) in construing Section 1342. Read together, the provisions

imposed a conditional obligation on HHS to make "payments out" only if and to the extent Congress appropriated funds. HHS accordingly did not breach any statutory duty by disbursing only the funds appropriated.

2. The ACA did not mandate compensation to insurers as a remedy for Congress's own determinations of whether and to what extent to fund risk-corridors subsidies

Petitioners also fail to demonstrate that the ACA "mandat[ed] compensation," *Navajo Nation*, 556 U.S. at 290 (citation omitted), for "payments out" that were not paid as a direct result of Congress's funding decisions. Nothing in the statutory text or context indicates that Congress intended its own funding decisions to provide a basis for damages actions against the United States. Had the Congress that enacted the ACA wished to ensure that risk-corridors subsidies would be paid, it could easily have done so directly by appropriating funds up front, or by authorizing expenditures in advance of appropriations legislation—as it did for other ACA programs. But it did not.

It is implausible that Congress eschewed that direct approach in favor of the roundabout, cumbersome remedy of Tucker Act suits, with eventual recourse to the Judgment Fund. See Act of July 27, 1956, ch. 8, § 1302, 70 Stat. 694-695 (31 U.S.C. 1304(a)). Congress could not have viewed after-the-fact litigation as superior to up-front appropriations. Such suits would consume the time and resources of all concerned—the government, insurers, and the courts. And in petitioners' own telling, damages awards would come too late to prevent the purportedly adverse effects on the nation's health-insurance market that they ascribe to Congress's funding decisions. Moda Br. 58; Land of Lincoln Br. 19.

We are unaware of any decision of this Court that interpreted a substantive statute as mandating damages for Congress's own decisions not to fund the full amount of payments provided by statute (as opposed to contract). Petitioners rely heavily on *Langston*, *supra*, but that case did not present the issue. The substantive statute in *Langston* provided that "[t]he representative" of the United States "at Hayti shall be entitled to a salary of $7500 a year." 118 U.S. at 390 (quoting Rev. Stat. § 1683 (1878)). The question presented in *Langston* was whether Congress—which had appropriated the full sum of $7500 for many years—intended to modify that "entitle[ment]" when it appropriated only $5000 in later years. *Ibid.* (citation omitted); see *id.* at 390-392. Although this Court concluded that Congress did not so intend, it did not hold that the official was entitled to damages. The Tucker Act granted the Court of Claims jurisdiction, see Act of Mar. 3, 1887, ch. 359, 24 Stat. 505, but no damages could be awarded because no appropriation for such awards yet existed. The Judgment Fund was not established until 1956. The Court of Claims had rendered judgment for the plaintiff in the amount claimed, see *Langston*, 118 U.S. at 392, but that judgment was merely declaratory absent an appropriation. A further Act of Congress was required to pay the amount owed. Act of Aug. 4, 1886, ch. 903, 24 Stat. 275, 281-282.

The *Langston* Court thus had no occasion to apply the framework the Court later articulated for Tucker Act suits seeking damages from the Judgment Fund, by determining whether the particular substantive statute on which the plaintiff relied "mandat[ed] compensation" and thus had authorized a money-damages remedy. *Navajo Nation*, 556 U.S. at 290 (citation omitted). The only relief the claimant could obtain—a declaration of

the government's obligation—did not require the Court to decide that separate issue. Moreover, even if the *Langston* Court had addressed the issue and concluded that Congress's conferral of an "entitle[ment] to a salary" for the official's services, 118 U.S. at 390 (citation omitted), also evinced its intention to confer a personal right to recover, that would not speak to the appropriations issues that arise where a statute merely gives a direction to an agency to establish a program to collect and distribute funds but confers no personal entitlement.

Maine Community also relies (Br. 24) on the statement in the dissent in *Bowen* v. *Massachusetts*, 487 U.S. 879 (1988), that "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." *Id.* at 923 (Scalia, J., dissenting). The Court, however, did not adopt the dissent's view. In that case, a State brought suit against the government alleging that HHS had wrongfully refused to disburse funds, which Congress had appropriated, to reimburse the State for certain services under its Medicaid program. *Id.* at 882, 887-888; see 42 U.S.C. 1396 (1976); *Springdale Convalescent Ctr.* v. *Mathews*, 545 F.2d 943, 950 (5th Cir. 1977), abrogated on other grounds, *Good Samaritan Hosp.* v. *Shalala*, 508 U.S. 402, 409-420 (1993); see, *e.g.*, Department of Health, Education, and Welfare Appropriation Act, 1979, Pub. L. No. 95-480, Tit. II, 92 Stat. 1576. The State's suit was premised on a statutory provision that "provide[d] that [HHS] 'shall pay' certain amounts for appropriate Medicaid services." *Massachusetts*, 487 U.S. at 900 (quoting 42 U.S.C. 1396b(a) (1988)).

This Court held that the means for enforcing such a statute directing the agency to expend appropriated funds is a suit under the Administrative Procedure Act (APA), 5 U.S.C. 701 *et seq.* See *Massachusetts*, 487 U.S. at 882-883, 891-908. Permitting such an APA suit to enforce an alleged statutory requirement to disburse money does not disrespect Congress's funding decisions because such a suit can proceed only if funds are appropriated. A court in an APA suit could not order an agency to pay money that Congress did not appropriate. See, *e.g.*, *In re Aiken County*, 725 F.3d 255, 259 (D.C. Cir. 2013) (Kavanaugh, J.) ("[I]f Congress appropriates no money for a statutorily mandated program, the Executive obviously cannot move forward.").

Having concluded that a suit under the APA was available, this Court did not decide whether, as the dissent posited, a claim for damages could proceed instead under the Tucker Act to enforce a requirement to pay already-appropriated funds. But it expressed skepticism that such relief would be available. See *Massachusetts*, 487 U.S. at 905 n.42. The test for "determin[ing] whether one may bring, pursuant to Tucker Act jurisdiction, a 'claim against the United States founded . . . upon . . . any Act of Congress,'" the Court explained, is whether it "'can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained.'" *Ibid.* (citations omitted). The Court contrasted Section 1396b(a) with statutes that had been held to satisfy that test. *Id.* at 906 n.42. Those statutes all "attempt[ed] to compensate a particular class of persons for past injuries or labors," whereas Section 1396b(a) "direct[ed] the [agency] to pay money to the State, not as compensation for a past wrong, but to subsidize" the State's Medicaid

program. *Ibid.* The Court found it "likely that while Congress intended 'shall pay' language" in those other statutes "to be self-enforcing—*i.e.*, to create both a right and a remedy—it intended similar language in § 1396b(a) of the Medicaid Act to provide merely a right." *Ibid.*

Indeed, even the dissent in *Massachusetts* made clear that its view—that a statutory direction to pay money "impliedly authorizes" damages—is merely a general rule and applies only "absent other indication." 487 U.S. at 923 (Scalia, J., dissenting). Congress's determination not to appropriate funds for a subsidy program is a contrary "indication" that would rebut the dissent's general presumption. The dissent did not suggest that a damages remedy can or should be recognized where, as here, an agency's nonpayment of particular amounts is the direct result of Congress's determination not to appropriate the necessary funds to pay those amounts.

The lower-court decisions on which petitioners rely (*e.g.*, Maine Community Br. 25-26 & n.10) did not award damages as a remedy for Congress's decision not to fund, in whole or in part, a statutory program. Those decisions include contract cases, such as *Ferris* v. *United States*, 27 Ct. Cl. 542 (1892), and *New York Airways, Inc.* v. *United States*, 369 F.2d 743 (Ct. Cl. 1966) (per curiam), which are inapposite as discussed below, see pp. 34-40, *infra*; cases in which the government prevailed, such as *Greenlee County* v. *United States*, 487 F.3d 871 (Fed. Cir. 2007), cert. denied, 552 U.S. 1142 (2008); and cases that addressed jurisdiction, not the merits, such as *Slattery* v. *United States*, 635 F.3d 1298 (Fed. Cir. 2011) (en banc), and *Fisher* v. *United States*, 402 F.3d 1167 (Fed. Cir. 2005) (en banc in part). Petitioners have identified

no relevant precedent that supports the extraordinary remedy they seek.[6]

3. Petitioners' contrary arguments invoking contract-law principles lack merit

Unable to carry their burden of showing both (1) that Section 1342 imposed an unqualified obligation to make "payments out" irrespective of appropriations and (2) that Congress authorized damages suits as a remedy, petitioners attempt to lighten that burden by invoking inapposite contract-law principles and rhetoric. Moda and Blue Cross, for example, repeatedly refer to Section 1342 as a statutory "promise" (Br. i, 2, 4, 9, 15, 24-27, 46, 54-55, 58-59) that induced "reliance" by insurers (Br. 2, 24, 33, 44-46, 48-49, 53, 58) and that implicates "the government's integrity as a contracting partner" (Br. 25); see Maine Community Br. 4, 20, 23, 27, 29, 45, 46-47, 57; Land of Lincoln Br. 2, 21, 35-36, 41-43, 46-49. Petitioners apparently hope that, by recasting Section 1342's qualified instruction to HHS as an unconditional congressional promise, they can sidestep the showing required by this Court's decisions for bringing private suits under the Tucker Act. That effort fails.

a. The government routinely incurs contractual obligations to private entities, but a distinct, well-developed legal framework governs government contracts. Any

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[6] Recently, in cases involving the cost-sharing subsidies authorized by Section 1402 of the ACA, the Court of Federal Claims has ruled that insurers are entitled to damages for subsidies not paid due to the absence of an appropriation. See, *e.g.*, *Community Health Choice, Inc.* v. *United States*, 141 Fed. Cl. 744 (2019) (Sweeney, C.J.), appeal pending, No. 19-1633 (Fed. Cir. filed Mar. 8, 2019). The lead appeals are fully briefed but not yet scheduled for argument.

claim seeking to enforce putative contractual obligations of the government to make risk-corridors payments must stand or fall under that framework. Indeed, petitioners separately asserted claims for breach of an express or implied contract, which the court of appeals correctly rejected. See pp. 11-12 & n.4, 14, *supra*. Only the implied-contract claim is at issue in this Court, see Br. in Opp. 30-31 & n.7, and it lacks merit for the reasons explained below. See pp. 53-56, *infra*.[7]

Contract-law precepts have no application to petitioners' *statutory* claim. Their attempt to elide the distinction between those two distinct bodies of law by borrowing contract-law labels improperly disregards the fundamental difference between statutes and contracts. "[A]bsent some clear indication that the legislature intends to bind itself contractually, the presumption is that 'a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *National R.R. Passenger Corp.* v. *Atchison, Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-466 (1985) (*Amtrak*) (quoting *Dodge* v. *Board of Educ.*, 302 U.S. 74, 79 (1937)); see also *Rector, Church Wardens, & Vestrymen, of Christ Church* v. *County of Philadelphia*, 65 U.S. (24 How.) 300, 302 (1861). "This well-established presumption is grounded in the elementary proposition

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[7] Although Maine Community now contends (Br. 27) that the risk-corridors program "had all of the indicia of a specific contractual exchange," it never asserted a contract claim below. See Br. in Opp. 31 n.7; 18-1023 Pet. App. 91a. And although Land of Lincoln asserts (Br. 46) that respecting Congress's limits on funding for risk-corridors payments will "wreak havoc on public-private partnerships," it abandoned the contract claims it had brought by failing to address them in its petition for a writ of certiorari. Br. in Opp. 31 n.7.

that the principal function of a legislature is not to make contracts, but to make laws that establish the policy of the state." *Amtrak*, 470 U.S. at 466. It reflects the reality that "[p]olicies, unlike contracts, are inherently subject to revision and repeal," and so "to construe laws as contracts when the obligation is not clearly and unequivocally expressed would be to limit drastically the essential powers of a legislative body." *Ibid.*

Nothing in Section 1342 overcomes that presumption. See Pet. App. 36-38. Section 1342 "contains no promissory language" from which an intent to contract could be found. *Id.* at 36. Petitioners' refrain that HHS breached a statutory promise by paying only the amounts that Congress appropriated thus rings hollow.

b. Petitioners' reliance on cases from the contract-law context is likewise misplaced. In particular, petitioners cite *Salazar* v. *Ramah Navajo Chapter*, 567 U.S. 182 (2012), in contending that Congress's limitations on funding to make risk-corridors "payments out" are irrelevant to the government's obligation to make such payments. Maine Community Br. 28; Moda Br. 30, 35, 57; Land of Lincoln Br. 27, 46, 48. But *Ramah*'s reasoning turned critically on the fact that the obligations at issue were contractual.

The statute at issue in *Ramah*, the Indian Self-Determination and Education Assistance Act (ISDA), directed the Secretary of the Interior to enter into contracts with willing tribes, pursuant to which those tribes would provide services such as education and law enforcement that otherwise would have been provided by the federal government. *Ramah*, 567 U.S. at 185. ISDA directed the Secretary to pay the full amount of "contract support costs" incurred by tribes in performing their contracts. *Ibid.* The Court held that the government was required

to "pay each tribe's contract support costs in full" if "Congress appropriate[d] sufficient funds to pay in full any individual contractor's contract support costs," even if Congress did not appropriate "enough funds to cover the aggregate amount due every contractor." *Ibid.*; see *id.* at 189-201.

The *Ramah* Court stated that its conclusion "followed directly from well-established principles of Government contracting law" and "safeguards both the expectations of Government contractors and the long-term fiscal interests of the United States." 567 U.S. at 190-191. The Court explained that "the Government's obligation to pay contract support costs should be treated as an ordinary contract promise," noting that ISDA "'uses the word 'contract' 426 times to describe the nature of the Government's promise.'" *Id.* at 189 (quoting *Cherokee Nation of Oklahoma* v. *Leavitt*, 543 U.S. 631, 639 (2005)). And "Congress expressly provided in ISDA that tribal contractors were entitled to sue for 'money damages' under the Contract Disputes Act upon the Government's failure to pay." *Id.* at 198 (citation omitted).

As the Federal Circuit has recognized, the contract-law context was central to *Ramah*'s determination that the lack of sufficient appropriations to pay support costs for all of the contracts did not limit the government's obligations to any individual contractor. See *Prairie County*, 782 F.3d at 689. ISDA contained a proviso stating that "the provision of funds under ISDA is subject to the availability of appropriations." *Ramah*, 567 U.S. at 186 (quoting 25 U.S.C. 450j-1(b) (2012)) (brackets omitted). The Court construed that proviso as being satisfied so long as Congress appropriated adequate, legally unrestricted funds to pay each individual contract, even if

the appropriation was insufficient to pay all of the contracts in full. *Id.* at 189-190. That conclusion followed, the Court stated, from the rule "in the case of ordinary contracts" that, "if the amount of an unrestricted appropriation is sufficient to fund the contract, the contractor is entitled to payment even if the agency has allocated the funds to another purpose or assumes other obligations that exhaust the funds." *Id.* at 189 (citation and emphasis omitted).

Similarly, in rejecting the government's argument that its holding "could cause the Secretary to violate the Anti-Deficiency Act," the *Ramah* Court pointed to the contractual nature of the claims. 567 U.S. at 197. The Court reasoned that "the Anti–Deficiency Act's requirements 'apply to the official, but they do not affect the rights in this court of the citizen honestly contracting with the Government.'" *Ibid.* (citation omitted); see also *id.* at 197-198 n.7 (expressing "doubt" as to whether the Anti-Deficiency Act would bar an agency official "obeying an express statutory command to enter a contract" but reserving judgment on that question because the "case concern[ed] only the contractual rights of tribal contractors"). In other words, when the government validly enters a "binding" contractual agreement, *id.* at 193, it incurs legal obligations to its contracting partner that a lack of sufficient appropriations to satisfy all of those obligations does not, standing alone, erase.

The court of appeals thus was mistaken when it stated, in dictum, that *Ramah* required it to interpret Section 1342 without regard to the Anti-Deficiency Act. Pet. App. 19. The panel believed it was "of no moment" that HHS could not have made risk-corridors payments beyond amounts appropriated "without running afoul of the Anti-Deficiency Act," stating that *Ramah* "rejected

the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government." *Ibid.* But *Ramah*'s analysis of contract claims has no logical application to claims like petitioners' that are premised on statutory directives to agency officials to pay money Congress has not appropriated.

In the case of a contract, the government's obligations are created by the agreement and can be determined by consulting the agreement itself (subject to any applicable laws). In contrast, when a claim is predicated on a statute, what obligation if any the statute imposes on the government in the first place—and whether that obligation is enforceable in a damages action—must be determined by examining that particular statute and any other relevant enactments. Congress is free, subject to constitutional principles not at issue here, to qualify agencies' statutory authority and duties, and courts adjudicating claims asserting statutory obligations of the government must take account of all of Congress's instructions. Here, the putative statutory obligation that petitioners seek to enforce is premised on Section 1342's instruction to HHS to administer a risk-corridors subsidy program. But Section 1342's instruction was qualified from its inception by the Appropriations Clause and Anti-Deficiency Act's provision implementing the Clause by forbidding the expenditure of funds Congress has not appropriated. See *Highland Falls*, 48 F.3d at 1171.

Moreover, *Ramah* emphasized that a contractor has an individualized relationship with the government. 567 U.S. at 191. "[I]t is not reasonable," the Court explained, "to expect the contractor to know how much of [the applicable] appropriation remains available for it at any given time." *Ibid.* (citation omitted). In contrast,

Section 1342 directed HHS to establish a *general* program applicable to regulated entities in a marketplace, under which insurers would be dealt with collectively.

Congress is well-equipped to authorize contracts when it wishes to do so. But the choice is one for Congress. The Court in *Ramah* emphasized that Congress can maintain its usual control over appropriations by declining to mandate or authorize contracts. "Congress [wa]s not short of options" in that case and could have "remove[d] the statutory mandate compelling the [agency] to enter into self-determination contracts." See 567 U.S. at 200. Section 1342 never imposed a mandate to enter contracts in the first place. *Ramah*'s reasoning and conclusion thus do not apply.

c. Petitioners' insistence that they relied on Section 1342's purported promise of "payments out" in electing to participate in the Exchanges—connoting notions of estoppel—is similarly unavailing. Under this Court's precedent, the dispositive questions are (1) whether the statute imposed the claimed obligation on the government, and (2) if so, whether the statute, fairly interpreted, mandates a damages remedy. See pp. 19-20, *supra*. A private party's reliance on its reading of Section 1342 in isolation, ignoring the constitutional and statutory provisions governing appropriations, is irrelevant. In any event, petitioners' reliance argument fails on its own terms.

To the extent petitioners relied on an expectation that Congress would fully fund risk-corridors payments, that reliance was inherently unreasonable. In contrast to contractual commitments that the government is legally obligated to fulfill, private parties can have no judicially cognizable expectation that a subsidy program will be funded by future Congresses at all,

much less to the full extent envisioned by the Congress that enacted it. Petitioners thus could not have reasonably relied on Section 1342 as assurance of future funding.

Nor could an agency's regulations or statements create a payment obligation that Congress did not authorize. "From [this Court's] earliest cases, [it] ha[s] recognized that equitable estoppel will not lie against the Government as it lies against private litigants." *Richmond*, 496 U.S. at 419. That is especially true in the context of claims seeking to compel the payment of money by the government based on alleged representations by the Executive. The Appropriations Clause is a restraint on the Executive Branch. "If agents of the Executive were able, by their unauthorized oral or written statements to citizens, to obligate the Treasury for the payment of funds, the control over public funds that the Clause reposes in Congress in effect could be transferred to the Executive," which would "render the Appropriations Clause a nullity." *Id.* at 428. Accordingly, it is well settled that "[a] regulation may create a liability on the part of the government only if Congress has enacted the necessary budget authority." GAO, *Principles of Federal Appropriations Law* 2-2 (rev. 4th ed. 2016). Likewise, "[i]f a given transaction is not sufficient to constitute a valid obligation, recording it will not make it one." 2 GAO, *Principles of Federal Appropriations Law* 7-8 (3d ed. 2004).

Moreover, HHS repeatedly made clear that its ability to make risk-corridors payments was subject to the availability of appropriations. In a May 2014 regulation addressing (*inter alia*) risk corridors, HHS stated that, if collections were ultimately insufficient to fund payments, "HHS w[ould] use other sources of funding for the risk corridors payments, *subject to the availability*

of appropriations." 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) (emphasis added). It repeated that notice in 2015 and 2016. See 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (same); C.A. App. 546 (similar). As the trial judge who ruled in Moda's favor noted, "HHS stated repeatedly that it 'intended to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually.'" Pet. App. 120 (brackets and citation omitted). "In other words," that court observed, "HHS announced that it would not make full annual payments." *Ibid.* (emphasis omitted). If insurers nevertheless structured their business activities on the assumption that HHS would make risk-corridors "payments out" in excess of "payments in," they did so at their own risk.[8]

Petitioners also attempt to attribute the shortfall of "payments in" relative to "payments out" to a transitional policy that HHS announced in November 2013, after insurers had set their premiums for 2014. *E.g.*, Moda Br. 10-11. Under the transitional policy, HHS did not enforce the ACA's market reforms against issuers that continued certain noncompliant coverage that they otherwise would have terminated. See C.A. App. 429-431. Petitioners suggest that the transitional policy

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[8] Citing a letter from an HHS official to state insurance commissioners, Land of Lincoln incorrectly states that, "[i]n the summer of 2015, HHS instructed state insurance commissioners who were reviewing issuers' proposed 2016 benefit-year rates to assume that issuers would receive full risk-corridor payments." Br. 13 & n.16 (citing 17-1224 C.A. App. 289). Land of Lincoln omits the statement in the letter that, "[t]his spring, CMS announced that preliminary information about 2014 risk corridors payments and charges will be made available on August 14, 2015," and that "*these payments* should be taken into account before decisions are made on final rates." 17-1224 C.A. App. 289 (emphasis added).

had the "marked and predictable effects" of "'dampen[ing] . . . enrollment' on the [E]xchanges, 'especially by healthier individuals.'" Moda Br. 10-11 (citation omitted); see *id.* at 59; see also Land of Lincoln Br. 8-9, 19; Maine Community Br. 14-15. Even if petitioners were correct that, but for the transitional policy, "payments in" would have sufficed to cover "payments out," that could not provide a basis for HHS to make, or the courts below to order, payments of federal funds that Congress did not permit. The particular reason the funding source Congress appropriated proved inadequate for a particular purpose is beside the point because Congress did not impose an unqualified obligation to make "payments out" irrespective of appropriations that is enforceable through damages actions.[9]

B. Congress's Subsequent Appropriations Legislation Superseded Any Obligation To Make Risk-Corridors Payments Beyond The Amounts Appropriated

Even assuming arguendo that Section 1342 could fairly have been read to impose an unqualified duty to make "payments out" that could be enforced through damages actions, the court of appeals correctly determined that Congress eliminated any such obligation through the subsequent appropriations acts. Pet. App. 21-35. The only plausible interpretation of those acts in context is that Congress intended to limit "payments out" to the amounts collected as "payments in."

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[9] Moreover, although Moda notes (Br. 10) that it had set premiums for 2014 before the transitional policy was first announced, Moda neglects to mention that the transitional policy's extension to 2015 and 2016 was announced in March 2014—before insurers set their premiums for the 2015 and 2016 years. C.A. App. 449-451.

1. Congress's express bar on using the only potentially available source of funds other than "payments in" to make "payments out" limited HHS's obligation to disbursing the amounts collected as "payments in"

"[W]hen Congress desires to suspend or repeal a statute in force, 'there can be no doubt that . . . it c[an] accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" *United States* v. *Will*, 449 U.S. 200, 222 (1980) (quoting *United States* v. *Dickerson*, 310 U.S. 554, 555 (1940)) (brackets omitted). "The whole question depends on the intention of Congress as expressed in the statutes," *United States* v. *Mitchell*, 109 U.S. 146, 150 (1883), not on whether the later enactment concerns appropriations or other matters.

In decisions dating back more than a century, this Court has repeatedly applied that principle to find that appropriations acts did suspend or repeal existing obligations. In *Will*, for example, the Court concluded that appropriations acts enacted "in Years 1, 3, and 4, although phrased in terms of limiting funds, * * * nevertheless were intended by Congress to block the increases" in judges' salaries that an earlier statute "otherwise would generate." 449 U.S. at 223. Similarly, in *Dickerson*, the Court held that an appropriations act prohibiting the use of funds to pay military reenlistment allowances superseded permanent legislation providing that such allowances shall be paid. 310 U.S. at 554-555. And in *Mitchell*, the Court held that, "by the appropriation acts which cover the period for which the appellee claim[ed] compensation, Congress expressed its purpose to suspend the operation of" a prior statute fixing salaries for interpreters "and to reduce for that period the salaries of the appellee and other interpreters of the same class." 109 U.S. at 148.

Applying that same principle, the court of appeals correctly determined that Congress intended its appropriations acts to limit risk-corridors "payments out" to the amounts collected as "payments in." Pet. App. 21-35. That conclusion follows from the appropriations acts Congress enacted for all relevant years, which simultaneously authorized the use of "payments in" while expressly barring resort to the only other arguably available funding source. By the time Congress enacted the appropriations act for the first year (2015) in which risk-corridors payments would be made, only two potential sources of funding had been identified: "payments in," and the lump sum annually appropriated from CMS trust accounts for the management of certain CMS programs. Petitioners have not identified any other available funding source.

In the 2015 Appropriations Act, Congress permitted use of the first funding source ("payments in") but expressly barred HHS from using the second (the lump sum) to make "payments out." § 227, 128 Stat. 2491. Congress reenacted those provisions for each subsequent year of the program. See p. 10 & n.3, *supra*. The "necessary and unavoidable" conclusion, *Harford* v. *United States*, 12 U.S. (8 Cranch) 109, 109-110 (1814) (Story, J.), is that any duty Section 1342 would otherwise have imposed to make "payments out" as provided in the statutory formula was limited to the amounts collected as "payments in." As the court of appeals recognized, "Congress could have meant nothing else but to cap the amount of payments out at the amount of payments in for each of the three years it enacted appropriations riders to that effect." Pet. App. 34. Congress "clearly did not intend" to "consign risk corridors payments 'to the fiscal limbo of an account due but not payable.'" *Id.* at

27 (quoting *Will*, 449 U.S. at 224). Instead, "Congress made the policy choice to cap payments out, and it remade that decision for each year of the program." *Id.* at 35. As the court put it, "What else could Congress have intended?" *Id.* at 27.

Petitioners offer no plausible alternative explanation of the appropriations restrictions. Moda and Blue Cross note (Br. 44) that the appropriations acts "limited the use of funds only from one specific source," and they contrast this language with the appropriations acts in *Dickerson* that barred the use of funds "in this Act *or any other Act*" for payment of reenlistment bonuses. Moda Br. 43. But that distinction is immaterial here because petitioners have not established that any other funding source existed from which HHS could have made "payments out." Land of Lincoln argues (Br. 50) that the appropriations provisos could not have modified HHS's purported obligation to make "payments out" because those provisos were "*temporary*," included within time-limited appropriations statutes. That is incorrect. As in *Dickerson* and *Will*, each appropriations act capped Section 1342's payment directive for the period in which the appropriations act was in effect. Together, the acts covered all years of the program. Maine Community argues (Br. 34) that Congress merely intended to delay "full payment" until the end of the three-year program. But as Moda and Blue Cross acknowledge (Br. 14-15 n.3), Congress reenacted the same appropriations proviso after the program ended. Congress thus ensured that no taxpayer funds could be used for risk-corridors payments.

2. Petitioners' contrary arguments lack merit

Petitioners nevertheless maintain that the appropriations acts left intact a purported obligation of HHS to pay the full sum calculated under Section 1342's formula. But they offer no sound basis for that conclusion.

a. Petitioners contend that the court of appeals erred by considering the appropriations acts' context and history and should have searched exclusively in those acts' text for an express statement that they modified Section 1342. *E.g.*, Moda Br. 27-39; Maine Community Br. 21-27. That contention lacks merit. This Court has repeatedly looked to legislative context and history to ascertain Congress's intent in enacting funding restrictions. In *Will*, for example, it relied on "[f]loor remarks in both Houses" and committee reports in determining that Congress's intent was to block increases in judges' salaries that the underlying legislation would otherwise generate. 449 U.S. at 223. Likewise, *Dickerson* cited floor statements and other legislative history in determining that funding restrictions were intended to suspend reenlistment bonuses for the covered years. 310 U.S. at 557-562. Rejecting the argument that it should disregard such materials, the Court explained that it would be "anomalous to close our minds to persuasive evidence of intention." *Id.* at 562.

The context and history of the risk-corridors appropriations are at least as probative as the contextual support considered in *Dickerson* and *Will*. Petitioners do not suggest that it was mere coincidence that the appropriations acts prohibited HHS from using the only other source of funding besides "payments in" that GAO had identified. Nor do they contend that the explanatory statement by the Chairman of the House Committee on

Appropriations was ambiguous in confirming that the proviso codified in statute HHS's announced intention to operate the risk-corridors program in a budget-neutral manner, "meaning that the federal government will never pay out more than it collects from issuers over the three year period risk corridors are in effect." 160 Cong. Rec. at H9838 (statement of Rep. Rogers).

In any event, the appropriations acts themselves clearly evince Congress's intention to limit HHS's obligation to make "payments out" to the amounts collected as "payments in." Even accepting petitioners' premise that Section 1342's formula created an entitlement in insurers to "payments out," the appropriations acts superseded the applicable formula, confining "payments out" to "payments in." The appropriations acts are simply irreconcilable with the proposition that HHS had authority, much less an enforceable duty, to expend more than amounts collected as "payments in"—or that Congress left intact any entitlement insurers otherwise would have had to receive such payments. No additional legislative explanation is needed if a later statute contradicts an earlier one as a matter of simple arithmetic. See 1 William Blackstone, *Commentaries* 89 (1765) (if an earlier statute provides "that a juror * * * shall have twenty pounds a year" but "a new statute" provides "he shall have twenty marks," the "latter statute" controls).

Similarly, petitioners' assertion that Congress did not enact proposed bills that would have achieved the same result even more explicitly, *e.g.*, Land of Lincoln Br. 11-12, is beside the point. Drawing a negative inference from Congress's failure to act is especially unwarranted here, where Congress accomplished the objective by other means. Exercising control over the funding of government programs is the central purpose of

the annual appropriations process. Moda's description (Br. 2) of the unbroken string of appropriations acts as "obscure[]" likewise misses the mark. If, as petitioners posit, those congressional funding decisions caused start-up insurers to fail and caused premiums to increase, see Moda Br. 59-60, then Congress was fully accountable.

b. Petitioners incorrectly contend that *Langston*, *supra*, is inconsistent with the court of appeals' conclusion here. Maine Community Br. 39-40, 49; Moda Br. 39-41; Land of Lincoln Br. 28-31. As noted, see pp. 30-31, *supra*, *Langston* involved a statute providing that "[t]he representative" of the United States "at Hayti shall be entitled to a salary of $7500 a year." 118 U.S. at 390 (quoting Rev. Stat. § 1683 (1878)). For many years, Congress had appropriated annually the full sum of $7500, but then for three subsequent years Congress appropriated only $5000. See *id.* at 390-392. Based on a close analysis of the text and context of the appropriations acts, this Court declined to infer that, by "merely appropriat[ing] a less amount" than the official's full salary, Congress had intended to reduce his salary for the services he rendered in those years. *Id.* at 394. The Court deemed it "not probable that Congress"—presumed to be aware that the official "had, in virtue of a statute whose object was to fix his salary, received annually a salary of $7500 from the date of the creation of his office"—"ma[de] a permanent reduction of his salary without indicating its purpose to do so." *Ibid.*

Langston's holding that Congress had not intended to deprive the official of his full salary for his services provides no support for petitioners' claims for subsidies here. Unlike the statute in *Langston*, Section 1342

never conferred on petitioners any "entitle[ment]" to risk-corridors subsidies in the first instance. 118 U.S. at 390 (citation omitted). And in contrast to *Langston*—where Congress had appropriated the full amount of the official's salary for multiple years before abruptly appropriating a lesser sum without explanation—here Congress never appropriated any funds for risk-corridors subsidies before the 2015 Appropriations Act. Its determination in that law—when it confronted for the first time the question whether and to what extent to fund the program established by HHS—to appropriate only the amounts collected as "payments in" reflects a calibrated decision. It was not an inadvertent or unacknowledged failure to renew an appropriation to fulfill an express statutory entitlement. To the contrary, the appropriations acts in this case specifically refer to the statutory provision on which petitioners rely and expressly limit the availability of appropriations to make payments under that law. See, *e.g.*, 2015 Appropriations Act § 227, 128 Stat. 2491 (none of the funds for CMS management "may be used for payments under section 1342(b)(1) of Public Law 111-148 (relating to risk corridors)"). As the Court has recognized for more than a century, where the context of an appropriations act reflects "a broader purpose" and consists of "more than the mere omission to appropriate a sufficient sum," courts must give effect to that intent. *United States* v. *Vulte*, 233 U.S. 509, 515 (1914).

Unable to shoehorn these cases into *Langston*'s narrow holding, petitioners seek to extend it far beyond its facts. But *Langston*'s reasoning was focused on the specific enactments and circumstances in that case. See 118 U.S. at 390-392. And more than a century ago—just seven years after *Langston*—the Court cautioned

against overreading the decision. In *Belknap* v. *United States*, 150 U.S. 588 (1893), the Court warned that *Langston*'s ruling in the claimant's favor marked "the limit in that direction." *Id.* at 595. Rather than reflexively extend *Langston*, the Court in *Belknap* examined the statutes and context before it and concluded that a claimant's salary was limited to amounts subsequently appropriated. See *id.* at 595-597. The court of appeals here likewise properly declined to extend *Langston* and instead faithfully applied the principles established by decades of this Court's decisions.[10]

c. Finally, petitioners incorrectly argue that the presumption against retroactivity requires the Court to interpret the appropriations acts as not affecting any preexisting obligation of HHS to make "payments out." See, *e.g.*, Maine Community Br. 45-48. That presumption is inapposite here. "Statutes are disfavored as retroactive when their application 'would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed.'" *Fernandez-Vargas* v. *Gonzales*, 548 U.S. 30, 37 (2006) (citation omitted). In this respect, "[t]he modern law thus follows Justice Story's definition of a retroactive statute, as 'taking away or impairing vested rights acquired under existing laws, or creating a new obligation,

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[10] Petitioners also rely on *Tennessee Valley Authority* v. *Hill*, 437 U.S. 153 (1978). *E.g.*, Maine Community Br. 42. That case held (as relevant) only that acts appropriating funds for a particular dam were not intended to override the substantive requirements of the Endangered Species Act of 1973, 16 U.S.C. 1531 *et seq.* See 437 U.S. at 189-191. Here, by contrast, Congress imposed explicit funding conditions that eliminated the only potential source of funding for a particular program other than revenue generated by the program itself.

imposing a new duty, or attaching a new disability, in respect to transactions or considerations already past.'" *Ibid.* (quoting *Society for the Propagation of the Gospel* v. *Wheeler*, 22 F. Cas. 756, 767 (C.C.D.N.H. 1814) (Story, J.)) (brackets omitted).

The appropriations provisos here do not implicate those principles. Neither in appropriating certain funds for risk-corridors payments nor in forbidding HHS from using other funds for that purpose did Congress impair any already-existing rights, increase any existing liability for past conduct, or impose new duties on insurers. Unlike the employees' "fixed and vested" right to certain compensation in the *Twenty Per Cent Cases*, 87 U.S. (20 Wall.) 179, 186 (1874), for example, which Land of Lincoln cites (Br. 43-44), insurers had no vested right to future subsidies. The ACA itself, which directed the Secretary to establish the risk-corridors program, appropriated no funds for that program. Congress addressed funding for the first time in the appropriations act for fiscal year 2015, which simultaneously appropriated "payments in" by authorizing expenditures from user fees, and foreclosed resort to the lump-sum program-management appropriation for "payments out." That is not retroactive legislation. Indeed, insurers could not have had any entitlement to "payments out" before 2015 because payments for 2014—the first year of operation—could not even be calculated until the conclusion of the 2014 calendar year and the submission of data by plans.

In any event, even if the presumption against retroactivity were implicated, it is overcome where Congress's intent to do so is clear. See, *e.g.*, *Usery* v. *Turner Elkhorn Mining Co.*, 428 U.S. 1, 16 (1976). Congress's intent to foreclose "payments out" in excess of

"payments in" for the duration of the risk-corridors program is unambiguous. The program operated for only three years, and Congress included the proviso in appropriations enactments governing that entire period.

II. NEITHER SECTION 1342 NOR HHS'S ACTIONS CREATED AN IMPLIED-IN-FACT CONTRACT WITH INSURERS ENTITLING THEM TO "PAYMENTS OUT"

Petitioners' contention that they were "promised" risk-corridors "payments out" (Moda Br. i, 2, 4, 15, 59) is a contract claim. The only contract claim before the Court—that of Moda and Blue Cross alleging an implied-in-fact contract, which they now address only briefly and in the alternative (Br. 50-53)—fails under well-settled precedent. The court of appeals correctly rejected it. Pet. App. 35-38.

A. Section 1342 did not create a contract between insurers and the government by directing the Secretary to establish a program for more profitable plans to cross-subsidize less profitable plans. As noted above, "absent some clear indication that the legislature intends to bind itself contractually, the presumption is that 'a law is not intended to create private contractual or vested rights but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *Amtrak*, 470 U.S. at 456-466 (citation omitted); see *American Bankers Ass'n* v. *United States*, 932 F.3d 1375, 1381-1382 (Fed. Cir. 2019). This Court has found an intent to contract when a statute "provide[s] for the execution of a written contract on behalf of" the government or "speak[s] of a contract" with the government. *Amtrak*, 470 U.S. at 467 (emphasis added); see, *e.g.*, *Hall* v. *Wisconsin*, 103 U.S. 5, 8-9 (1880) (statute's text directed governor to "make a written contract with each of the commissioners * * * expressly stipulating and

setting forth the nature and extent of the services to be rendered by each, and the compensation therefor"); *Indiana ex rel. Anderson* v. *Brand*, 303 U.S. 95, 105 (1938) (state law's title and text indicated legislature's intention to enter binding contracts).

In contrast, this Court determined in *Dodge* that Illinois' Miller Law did not clearly express the government's intent to contract. 302 U.S. at 80. As originally enacted, the Miller Law established a compulsory retirement age for public-school teachers and provided for the payment of annuities to retired teachers. *Id.* at 76. The law stated that teachers "who served in the public schools of such city for twenty or more years prior to such retirement, shall be paid the sum of fifteen hundred dollars ($1,500.00) annually and for life from the date of such retirement." *Ibid.* Nearly ten years after it was passed, the Miller Law was amended to reduce annuity payments to $500 for all retired teachers, including those who had retired prior to the amendment. *Id.* at 77. The teachers who filed suit against the Board of Education argued that they were contractually entitled to annuity payments at $1500 because the Miller Law constituted an offer to contract, which they had accepted by remaining in service for at least 20 years. *Id.* at 76. The Court rejected that argument, concluding that neither the statutory language nor context indicated a legislative intent to create binding contractual obligations. *Id.* at 79-81; see also *Wisconsin & Michigan Ry. Co.* v. *Powers*, 191 U.S. 379, 384 (1903) (no contract created by statute that imposed tax on railroads but suspended its operation for ten years for railroads that undertook particular railroad-building projects); cf. *Bowen* v. *Public Agencies Opposed to Social Sec. Entrapment*, 477 U.S. 41, 51-56 (1986) (Congress did not

effect taking by amending statute to prohibit States from terminating existing agreements with federal agency).

The court of appeals correctly applied those principles here. Pet. App. 36-38. As it explained, nothing in Section 1342 overcomes the long-established presumption against interpreting a statute to bind the government in contract. Moda did not dispute below that Section 1342 "contains no promissory language" from which an intent to contract could be found. *Id.* at 36. Moreover, insurers that participated in the Exchanges sold insurance to—and entered into contracts with—individuals and small businesses. They did not furnish any product or services to the government, which would typically be an essential element of a contract with the government.

Petitioners' observation (Moda Br. 52) that insurers were obligated to make "payments in" regardless of the funding that Congress provided for "payments out" underscores that Section 1342 was not a contractual undertaking. That provision was instead one of many regulatory requirements applicable to insurers that opted to sell plans through the Exchanges. Insurers had powerful business incentives to participate in the Exchanges, which are the only commercial channel through which insurers can reach consumers receiving federal subsidies, see 26 U.S.C. 36B (2012 & Supp. V 2017), a market segment that numbers in the millions.[11] Notably, insurers continue to sell plans on the Exchanges today, even though the risk-corridors program ended in 2016. In any event, the fact that Congress imposed those regulatory requirements on this particular market without

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[11] See, *e.g.*, CMS, HHS, *Early 2019 Effectuated Enrollment Snapshot*, https://go.usa.gov/xVSET (approximately 9.25 million individuals received advance premium tax credits in February 2019).

establishing a reciprocal obligation on the federal fisc confirms that it did not create a contract.

B. Moda and Blue Cross have abandoned their prior contention that HHS entered into contracts to make risk-corridors payments in excess of the funds appropriated. That argument lacks merit in any event for two reasons. First, as the court of appeals explained, none of the agency's statements "evinced an intention to form a contract." Pet. App. 38. The regulations simply tracked the language of Section 1342, see 45 C.F.R. 153.510(b) and (c), and HHS repeatedly recognized that its ability make payments was subject to appropriations, see pp. 41-42, *supra*.

Second, HHS would not have had authority to enter into binding contracts to make risk-corridors payments in excess of appropriations. "A law may be construed * * * to authorize making a contract for the payment of money in excess of an appropriation only if the law specifically states that * * * such a contract may be made." 31 U.S.C. 1301(d). Without such "special authority," this Court has held, an "officer cannot bind the Government in the absence of an appropriation." *Cherokee Nation*, 543 U.S. at 643. Section 1342 did not give HHS any authority to make contracts for risk-corridors payments, much less authority to enter into contracts in excess of appropriations.

CONCLUSION

The judgments of the court of appeals should be affirmed.

Respectfully submitted.

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APPENDIX

1. U.S. Const. Art. I, § 9, Cl. 7 provides:

No money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law; and a regular Statement and Account of the Receipts and Expenditures of all public Money shall be published from time to time.

2. 2 U.S.C. 622(2)(A) provides:

Definitions

For purposes of this Act—

(2) BUDGET AUTHORITY AND NEW BUDGET AUTHORITY.—

(A) IN GENERAL.—The term "budget authority" means the authority provided by Federal law to incur financial obligations, as follows:

(i) provisions of law that make funds available for obligation and expenditure (other than borrowing authority), including the authority to obligate and expend the proceeds of offsetting receipts and collections;

(ii) borrowing authority, which means authority granted to a Federal entity to borrow and obligate and expend the borrowed funds, including through the issuance of promissory notes or other monetary credits;

(iii) contract authority, which means the making of funds available for obligation but not for expenditure; and

(iv) offsetting receipts and collections as negative budget authority, and the reduction thereof as positive budget authority.

3. 28 U.S.C. 1491 provides:

Claims against United States generally; actions involving Tennessee Valley Authority

(a)(1) The United States Court of Federal Claims shall have jurisdiction to render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort. For the purpose of this paragraph, an express or implied contract with the Army and Air Force Exchange Service, Navy Exchanges, Marine Corps Exchanges, Coast Guard Exchanges, or Exchange Councils of the National Aeronautics and Space Administration shall be considered an express or implied contract with the United States.

(2) To provide an entire remedy and to complete the relief afforded by the judgment, the court may, as an incident of and collateral to any such judgment, issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records, and such orders may be issued to any appropriate official of the United States. In any case within its jurisdiction, the court shall have the power to remand appropriate matters to any administrative or executive body or official with such direction as it may deem proper and just. The Court of Federal

Claims shall have jurisdiction to render judgment upon any claim by or against, or dispute with, a contractor arising under section 7104(b)(1) of title 41, including a dispute concerning termination of a contract, rights in tangible or intangible property, compliance with cost accounting standards, and other nonmonetary disputes on which a decision of the contracting officer has been issued under section 6[1] of that Act.

(b)(1) Both the Unites[2] States Court of Federal Claims and the district courts of the United States shall have jurisdiction to render judgment on an action by an interested party objecting to a solicitation by a Federal agency for bids or proposals for a proposed contract or to a proposed award or the award of a contract or any alleged violation of statute or regulation in connection with a procurement or a proposed procurement. Both the United States Court of Federal Claims and the district courts of the United States shall have jurisdiction to entertain such an action without regard to whether suit is instituted before or after the contract is awarded.

(2) To afford relief in such an action, the courts may award any relief that the court considers proper, including declaratory and injunctive relief except that any monetary relief shall be limited to bid preparation and proposal costs.

(3) In exercising jurisdiction under this subsection, the courts shall give due regard to the interests of national defense and national security and the need for expeditious resolution of the action.

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[1] See References in Text note below.

[2] So in original. Probably should be "United".

(4) In any action under this subsection, the courts shall review the agency's decision pursuant to the standards set forth in section 706 of title 5.

(5) If an interested party who is a member of the private sector commences an action described in paragraph (1) with respect to a public-private competition conducted under Office of Management and Budget Circular A-76 regarding the performance of an activity or function of a Federal agency, or a decision to convert a function performed by Federal employees to private sector performance without a competition under Office of Management and Budget Circular A-76, then an interested party described in section 3551(2)(B) of title 31 shall be entitled to intervene in that action.

(6) Jurisdiction over any action described in paragraph (1) arising out of a maritime contract, or a solicitation for a proposed maritime contract, shall be governed by this section and shall not be subject to the jurisdiction of the district courts of the United States under the Suits in Admiralty Act (chapter 309 of title 46) or the Public Vessels Act (chapter 311 of title 46).

(c) Nothing herein shall be construed to give the United States Court of Federal Claims jurisdiction of any civil action within the exclusive jurisdiction of the Court of International Trade, or of any action against, or founded on conduct of, the Tennessee Valley Authority, or to amend or modify the provisions of the Tennessee Valley Authority Act of 1933 with respect to actions by or against the Authority.

4. 31 U.S.C. 701 provides:

Definitions

In this chapter—

(1) "agency" includes the District of Columbia government but does not include the legislative branch or the Supreme Court.

(2) "appropriations" means appropriated amounts and includes, in appropriate context—

(A) funds;

(B) authority to make obligations by contract before appropriations; and

(C) other authority making amounts available for obligation or expenditure.

5. 31 U.S.C. 1301(a) provides:

Application

(a) Appropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided by law.

6. 31 U.S.C. 1304 provides:

Judgments, awards, and compromise settlements

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

(1) payment is not otherwise provided for;

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

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

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

(B) under section 3723 of this title;

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

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

(b)(1) Interest may be paid from the appropriation made by this section—

(A) on a judgment of a district court, only when the judgment becomes final after review on appeal or petition by the United States Government, and then only from the date of filing of the transcript of the judgment with the Secretary of the Treasury through the day before the date of the mandate of affirmance; or

(B) on a judgment of the Court of Appeals for the Federal Circuit or the United States Court of Federal Claims under section 2516(b) of title 28, only from the date of filing of the transcript of the judgment with the Secretary of the Treasury through the day before the date of the mandate of affirmance.

(2) Interest payable under this subsection in a proceeding reviewed by the Supreme Court is not allowed after the end of the term in which the judgment is affirmed.

(c)(1) A judgment or compromise settlement against the Government shall be paid under this section and sections 2414, 2517, and 2518[1] of title 28 when the judgment or settlement arises out of an express or implied contract made by—

(A) the Army and Air Force Exchange Service;

(B) the Navy Exchanges;

(C) the Marine Corps Exchanges;

(D) the Coast Guard Exchanges; or

(E) the Exchange Councils of the National Aeronautics and Space Administration.

(2) The Exchange making the contract shall reimburse the Government for the amount paid by the Government.

(d) Beginning not later than the date that is 60 days after the date of enactment of the John D. Dingell, Jr. Conservation, Management, and Recreation Act, and unless the disclosure of such information is otherwise prohibited by law or a court order, the Secretary of the Treasury shall make available to the public on a website, as soon as practicable, but not later than 30 days after the date on which a payment under this section is tendered, the following information with regard to that payment:

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[1] See References in Text note below.

(1) The name of the specific agency or entity whose actions gave rise to the claim or judgment.

(2) The name of the plaintiff or claimant.

(3) The name of counsel for the plaintiff or claimant.

(4) The amount paid representing principal liability, and any amounts paid representing any ancillary liability, including attorney fees, costs, and interest.

(5) A brief description of the facts that gave rise to the claim.

(6) The name of the agency that submitted the claim.

7. 31 U.S.C. 1341 provides:

Limitations on expending and obligating amounts

(a)(1) Except as specified in this subchapter or any other provision of law, an officer or employee of the United States Government or of the District of Columbia government may not—

(A) make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation;

(B) involve either government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law;

(C) make or authorize an expenditure or obligation of funds required to be sequestered under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985; or

(D) involve either government in a contract or obligation for the payment of money required to be sequestered under section 252 of the Balanced Budget and Emergency Deficit Control Act of 1985.

(2) This subsection does not apply to a corporation getting amounts to make loans (except paid in capital amounts) without legal liability of the United States Government.

(b) An article to be used by an executive department in the District of Columbia that could be bought out of an appropriation made to a regular contingent fund of the department may not be bought out of another amount available for obligation.

(c)(1) In this subsection—

(A) the term "covered lapse in appropriations" means any lapse in appropriations that begins on or after December 22, 2018;

(B) the term "District of Columbia public employer" means—

(i) the District of Columbia Courts;

(ii) the Public Defender Service for the District of Columbia; or

(iii) the District of Columbia government;

(C) the term "employee" includes an officer; and

(D) the term "excepted employee" means an excepted employee or an employee performing emergency work, as such terms are defined by the Office of Personnel Management or the appropriate District of Columbia public employer, as applicable.

(2) Each employee of the United States Government or of a District of Columbia public employer furloughed as a result of a covered lapse in appropriations shall be paid for the period of the lapse in appropriations, and each excepted employee who is required to perform work during a covered lapse in appropriations shall be paid for such work, at the employee's standard rate of pay, at the earliest date possible after the lapse in appropriations ends, regardless of scheduled pay dates, and subject to the enactment of appropriations Acts ending the lapse.

(3) During a covered lapse in appropriations, each excepted employee who is required to perform work shall be entitled to use leave under chapter 63 of title 5, or any other applicable law governing the use of leave by the excepted employee, for which compensation shall be paid at the earliest date possible after the lapse in appropriations ends, regardless of scheduled pay dates.

8. 31 U.S.C. 1350 provides:

Criminal penalty

An officer or employee of the United States Government or of the District of Columbia government knowingly and willfully violating section 1341(a) or 1342 of this title shall be fined not more than $5,000, imprisoned for not more than 2 years, or both.

9. 42 U.S.C. 280k-2 provides:

Authorization of appropriations

There is authorized to be appropriated to carry out this part, such sums as may be necessary.

10. 42 U.S.C. 300gg-93(e) provides:

Health insurance consumer information

(e) Funding

(1) Initial funding

There is hereby appropriated to the Secretary, out of any funds in the Treasury not otherwise appropriated, $30,000,000 for the first fiscal year for which this section applies to carry out this section. Such amount shall remain available without fiscal year limitation.

(2) Authorization for subsequent years

There is authorized to be appropriated to the Secretary for each fiscal year following the fiscal year described in paragraph (1), such sums as may be necessary to carry out this section.

11. 42 U.S.C. 1395w-115 provides:

Subsidies for part D eligible individuals for qualified prescription drug coverage

(a) Subsidy payment

In order to reduce premium levels applicable to qualified prescription drug coverage for part D eligible individuals consistent with an overall subsidy level of 74.5

percent for basic prescription drug coverage, to reduce adverse selection among prescription drug plans and MA-PD plans, and to promote the participation of PDP sponsors under this part and MA organizations under part C of this subchapter, the Secretary shall provide for payment to a PDP sponsor that offers a prescription drug plan and an MA organization that offers an MA-PD plan of the following subsidies in accordance with this section:

(1) Direct subsidy

A direct subsidy for each part D eligible individual enrolled in a prescription drug plan or MA-PD plan for a month equal to—

(A) the amount of the plan's standardized bid amount (as defined in section 1395w-113(a)(5) of this title), adjusted under subsection (c)(1) of this section, reduced by

(B) the base beneficiary premium (as computed under paragraph (2) of section 1395w-113(a) of this title and as adjusted under paragraph (1)(B) of such section).

(2) Subsidy through reinsurance

The reinsurance payment amount (as defined in subsection (b) of this section).

This section constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section.

(b) Reinsurance payment amount

(1) In general

The reinsurance payment amount under this subsection for a part D eligible individual enrolled in a prescription drug plan or MA-PD plan for a coverage year is an amount equal to 80 percent of the allowable reinsurance costs (as specified in paragraph (2)) attributable to that portion of gross covered prescription drug costs as specified in paragraph (3) incurred in the coverage year after such individual has incurred costs that exceed the annual out-of-pocket threshold specified in section 1395w-102(b)(4)(B) of this title.

(2) Allowable reinsurance costs

For purposes of this section, the term "allowable reinsurance costs" means, with respect to gross covered prescription drug costs under a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization, the part of such costs that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization or by (or on behalf of) an enrollee under the plan, but in no case more than the part of such costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were standard prescription drug coverage.

(3) Gross covered prescription drug costs

For purposes of this section, the term "gross covered prescription drug costs" means, with respect to

a part D eligible individual enrolled in a prescription drug plan or MA-PD plan during a coverage year, the costs incurred under the plan, not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year and costs relating to the deductible. Such costs shall be determined whether they are paid by the individual or under the plan, regardless of whether the coverage under the plan exceeds basic prescription drug coverage.

(4) Coverage year defined

For purposes of this section, the term "coverage year" means a calendar year in which covered part D drugs are dispensed if the claim for such drugs (and payment on such claim) is made not later than such period after the end of such year as the Secretary specifies.

(c) Adjustments relating to bids

(1) Health status risk adjustment

(A) Establishment of risk adjustors

The Secretary shall establish an appropriate methodology for adjusting the standardized bid amount under subsection (a)(1)(A) of this section to take into account variation in costs for basic prescription drug coverage among prescription drug plans and MA-PD plans based on the differences in actuarial risk of different enrollees being served. Any such risk adjustment shall be designed in a manner so as not to result in a change in the aggregate amounts payable to such plans under subsection (a)(1) of this section and through

that portion of the monthly beneficiary prescription drug premiums described in subsection (a)(1)(B) of this section and MA monthly prescription drug beneficiary premiums.

(B) Considerations

In establishing the methodology under subparagraph (A), the Secretary may take into account the similar methodologies used under section 1395w-23(a)(3) of this title to adjust payments to MA organizations for benefits under the original medicare fee-for-service program option.

(C) Data collection

In order to carry out this paragraph, the Secretary shall require—

(i) PDP sponsors to submit data regarding drug claims that can be linked at the individual level to part A and part B data and such other information as the Secretary determines necessary; and

(ii) MA organizations that offer MA-PD plans to submit data regarding drug claims that can be linked at the individual level to other data that such organizations are required to submit to the Secretary and such other information as the Secretary determines necessary.

(D) Publication

At the time of publication of risk adjustment factors under section 1395w-23(b)(1)(B)(i)(II) of this title, the Secretary shall publish the risk adjusters established under this paragraph for the succeeding year.

(2) Geographic adjustment

(A) In general

Subject to subparagraph (B), for purposes of section 1395w-113(a)(1)(B)(iii) of this title, the Secretary shall establish an appropriate methodology for adjusting the national average monthly bid amount (computed under section 1395w-113(a)(4) of this title) to take into account differences in prices for covered part D drugs among PDP regions.

(B) De minimis rule

If the Secretary determines that the price variations described in subparagraph (A) among PDP regions are de minimis, the Secretary shall not provide for adjustment under this paragraph.

(C) Budget neutral adjustment

Any adjustment under this paragraph shall be applied in a manner so as to not result in a change in the aggregate payments made under this part that would have been made if the Secretary had not applied such adjustment.

(d) Payment methods

(1) In general

Payments under this section shall be based on such a method as the Secretary determines. The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information.

(2) Requirement for provision of information

(A) Requirement

Payments under this section to a PDP sponsor or MA organization are conditioned upon the furnishing to the Secretary, in a form and manner specified by the Secretary, of such information as may be required to carry out this section.

(B) Restriction on use of information

Information disclosed or obtained pursuant to subparagraph (A) may be used by officers, employees, and contractors of the Department of Health and Human Services only for the purposes of, and to the extent necessary in, carrying out this section.

(3) Source of payments

Payments under this section shall be made from the Medicare Prescription Drug Account.

(4) Application of enrollee adjustment

The provisions of section 1395w-23(a)(2) of this title shall apply to payments to PDP sponsors under this section in the same manner as they apply to payments to MA organizations under section 1395w-23(a) of this title.

(e) Portion of total payments to a sponsor or organization subject to risk (application of risk corridors)

(1) Computation of adjusted allowable risk corridor costs

(A) In general

For purposes of this subsection, the term "adjusted allowable risk corridor costs" means, for a plan for a coverage year (as defined in subsection (b)(4) of this section)—

(i) the allowable risk corridor costs (as defined in subparagraph (B)) for the plan for the year, reduced by

(ii) the sum of (I) the total reinsurance payments made under subsection (b) of this section to the sponsor of the plan for the year, and (II) the total subsidy payments made under section 1395w-114 of this title to the sponsor of the plan for the year.

(B) Allowable risk corridor costs

For purposes of this subsection, the term "allowable risk corridor costs" means, with respect to a prescription drug plan offered by a PDP sponsor or an MA-PD plan offered by an MA organization, the part of costs (not including administrative costs, but including costs directly related to the dispensing of covered part D drugs during the year) incurred by the sponsor or organization under the plan that are actually paid (net of discounts, chargebacks, and average percentage rebates) by the sponsor or organization under the plan, but in no case more than the part of such

costs that would have been paid under the plan if the prescription drug coverage under the plan were basic prescription drug coverage, or, in the case of a plan providing supplemental prescription drug coverage, if such coverage were basic prescription drug coverage taking into account the adjustment under section 1395w-111(c)(2) of this title. In computing allowable costs under this paragraph, the Secretary shall compute such costs based upon imposition under paragraphs (1)(D) and (2)(E) of section 1395w-114(a) of this title of the maximum amount of copayments permitted under such paragraphs.

(2) Adjustment of payment

(A) No adjustment if adjusted allowable risk corridor costs within risk corridor

If the adjusted allowable risk corridor costs (as defined in paragraph (1)) for the plan for the year are at least equal to the first threshold lower limit of the risk corridor (specified in paragraph (3)(A)(i)), but not greater than the first threshold upper limit of the risk corridor (specified in paragraph (3)(A)(iii)) for the plan for the year, then no payment adjustment shall be made under this subsection.

(B) Increase in payment if adjusted allowable risk corridor costs above upper limit of risk corridor

(i) Costs between first and second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the

first threshold upper limit, but not greater than the second threshold upper limit, of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between such adjusted allowable risk corridor costs and the first threshold upper limit of the risk corridor.

(ii) Costs above second threshold upper limits

If the adjusted allowable risk corridor costs for the plan for the year are greater than the second threshold upper limit of the risk corridor for the plan for the year, the Secretary shall increase the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent or 90 percent if the conditions described in clause (iii) are met for the year) of the difference between the second threshold upper limit and the first threshold upper limit; and

(II) 80 percent of the difference between such adjusted allowable risk corridor costs and the second threshold upper limit of the risk corridor.

(iii) Conditions for application of higher percentage for 2006 and 2007

The conditions described in this clause are met for 2006 or 2007 if the Secretary determines with respect to such year that—

(I) at least 60 percent of prescription drug plans and MA-PD plans to which this subsection applies have adjusted allowable risk corridor costs for the plan for the year that are more than the first threshold upper limit of the risk corridor for the plan for the year; and

(II) such plans represent at least 60 percent of part D eligible individuals enrolled in any prescription drug plan or MA-PD plan.

(C) Reduction in payment if adjusted allowable risk corridor costs below lower limit of risk corridor

(i) Costs between first and second threshold lower limits

If the adjusted allowable risk corridor costs for the plan for the year are less than the first threshold lower limit, but not less than the second threshold lower limit, of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit of the risk

corridor and such adjusted allowable risk corridor costs.

(ii) Costs below second threshold lower limit

If the adjusted allowable risk corridor costs for the plan for the year are less the second threshold lower limit of the risk corridor for the plan for the year, the Secretary shall reduce the total of the payments made to the sponsor or organization offering the plan for the year under this section by an amount (or otherwise recover from the sponsor or organization an amount) equal to the sum of—

(I) 50 percent (or, for 2006 and 2007, 75 percent) of the difference between the first threshold lower limit and the second threshold lower limit; and

(II) 80 percent of the difference between the second threshold upper limit of the risk corridor and such adjusted allowable risk corridor costs.

(3) Establishment of risk corridors

(A) In general

For each plan year the Secretary shall establish a risk corridor for each prescription drug plan and each MA-PD plan. The risk corridor for a plan for a year shall be equal to a range as follows:

(i) First threshold lower limit

The first threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the first threshold risk percentage for the plan (as determined under subparagraph (C)(i)) of such target amount.

(ii) Second threshold lower limit

The second threshold lower limit of such corridor shall be equal to—

(I) the target amount described in subparagraph (B) for the plan; minus

(II) an amount equal to the second threshold risk percentage for the plan (as determined under subparagraph (C)(ii)) of such target amount.

(iii) First threshold upper limit

The first threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (i)(II).

(iv) Second threshold upper limit

The second threshold upper limit of such corridor shall be equal to the sum of—

(I) such target amount; and

(II) the amount described in clause (ii)(II).

(B) Target amount described

The target amount described in this paragraph is, with respect to a prescription drug plan or an MA-PD plan in a year, the total amount of payments paid to the PDP sponsor or MA-PD organization for the plan for the year, taking into account amounts paid by the Secretary and enrollees, based upon the standardized bid amount (as defined in section 1395w-113(a)(5) of this title and as risk adjusted under subsection (c)(1) of this section), reduced by the total amount of administrative expenses for the year assumed in such standardized bid.

(C) First and second threshold risk percentage defined

(i) First threshold risk percentage

Subject to clause (iii), for purposes of this section, the first threshold risk percentage is—

(I) for 2006 and 2007, and[1] 2.5 percent;

(II) for 2008 through 2011, 5 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary, but in no case less than 5 percent.

(ii) Second threshold risk percentage

Subject to clause (iii), for purposes of this section, the second threshold risk percentage is—

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[1] So in original. The word "and" probably should not appear.

(I) for 2006 and 2007, 5 percent;

(II) for 2008 through 2011, 10 percent; and

(III) for 2012 and subsequent years, a percentage established by the Secretary that is greater than the percent established for the year under clause (i)(III), but in no case less than 10 percent.

(iii) Reduction of risk percentage to ensure 2 plans in an area

Pursuant to section 1395w-111(b)(2)(E)(ii) of this title, a PDP sponsor may submit a bid that requests a decrease in the applicable first or second threshold risk percentages or an increase in the percents applied under paragraph (2).

(4) Plans at risk for entire amount of supplemental prescription drug coverage

A PDP sponsor and MA organization that offers a plan that provides supplemental prescription drug benefits shall be at full financial risk for the provision of such supplemental benefits.

(5) No effect on monthly premium

No adjustment in payments made by reason of this subsection shall affect the monthly beneficiary premium or the MA monthly prescription drug beneficiary premium.

(f) Disclosure of information

(1) In general

Each contract under this part and under part C of this subchapter shall provide that—

(A) the PDP sponsor offering a prescription drug plan or an MA organization offering an MA-PD plan shall provide the Secretary with such information as the Secretary determines is necessary to carry out this section; and

(B) the Secretary shall have the right in accordance with section 1395w-27(d)(2)(B) of this title (as applied under section 1395w-112(b)(3)(C) of this title) to inspect and audit any books and records of a PDP sponsor or MA organization that pertain to the information regarding costs provided to the Secretary under subparagraph (A).

(2) Restriction on use of information

Information disclosed or obtained pursuant to the provisions of this section may be used—

(A) by officers, employees, and contractors of the Department of Health and Human Services for the purposes of, and to the extent necessary in—

(i) carrying out this section; and

(ii) conducting oversight, evaluation, and enforcement under this subchapter; and

(B) by the Attorney General and the Comptroller General of the United States for the purposes of, and to the extent necessary in, carrying out health oversight activities.

(g) Payment for fallback prescription drug plans

In lieu of the amounts otherwise payable under this section to a PDP sponsor offering a fallback prescription drug plan (as defined in section 1395w-111(g)(4) of this title[2]), the amount payable shall be the amounts determined under the contract for such plan pursuant to section 1395w-111(g)(5) of this title.

12. 42 U.S.C. 18001(g)(1) provides:

Immediate access to insurance for uninsured individuals with a preexisting condition

(g) Funding; termination of authority

(1) In general

There is appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, $5,000,000,000 to pay claims against (and the administrative costs of) the high risk pool under this section that are in excess of the amount of premiums collected from eligible individuals enrolled in the high risk pool. Such funds shall be available without fiscal year limitation.

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[2] See References in Text note below.

13. 42 U.S.C. 18031(a)(1) provides:

Affordable choices of health benefit plans

(a) Assistance to States to establish American Health Benefit Exchanges

(1) Planning and establishment grants

There shall be appropriated to the Secretary, out of any moneys in the Treasury not otherwise appropriated, an amount necessary to enable the Secretary to make awards, not later than 1 year after March 23, 2010, to States in the amount specified in paragraph (2) for the uses described in paragraph (3).

14. 42 U.S.C. 18042(g) provides:

Federal program to assist establishment and operation of nonprofit, member-run health insurance issuers

(g) Appropriations

There are hereby appropriated, out of any funds in the Treasury not otherwise appropriated, $6,000,000,000 to carry out this section.

15. 42 U.S.C. 18043(c) provides:

Funding for the territories

(c) Appropriation and allocation

(1) Appropriation

Out of any funds in the Treasury not otherwise appropriated, there is appropriated for purposes of payment pursuant to subsection (a) $1,000,000,000, to

be available during the period beginning with 2014 and ending with 2019.

(2) Allocation

The Secretary shall allocate the amount appropriated under paragraph (1) among the territories for purposes of carrying out this section as follows:

(A) For Puerto Rico, $925,000,000.

(B) For another territory, the portion of $75,000,000 specified by the Secretary.

16. 42 U.S.C. 18061 provides:

Transitional reinsurance program for individual market in each State

(a) In general

Each State shall, not later than January 1, 2014—

(1) include in the Federal standards or State law or regulation the State adopts and has in effect under section 18041(b) of this title the provisions described in subsection (b); and

(2) establish (or enter into a contract with) 1 or more applicable reinsurance entities to carry out the reinsurance program under this section.

(b) Model regulation

(1) In general

In establishing the Federal standards under section 18041(a) of this title, the Secretary, in consultation with the National Association of Insurance Commissioners (the "NAIC"), shall include provisions

that enable States to establish and maintain a program under which—

(A) health insurance issuers, and third party administrators on behalf of group health plans, are required to make payments to an applicable reinsurance entity for any plan year beginning in the 3-year period beginning January 1, 2014 (as specified in paragraph (3);[1] and

(B) the applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period.

(2) High-risk individual; payment amounts

The Secretary shall include the following in the provisions under paragraph (1):

(A) Determination of high-risk individuals

The method by which individuals will be identified as high risk individuals for purposes of the reinsurance program established under this section. Such method shall provide for identification of individuals as high-risk individuals on the basis of—

(i) a list of at least 50 but not more than 100 medical conditions that are identified as high-risk conditions and that may be based on the identification of diagnostic and procedure codes that

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[1] So in original. A second closing parenthesis probably should precede the semicolon.

are indicative of individuals with pre-existing, high-risk conditions; or

(ii) any other comparable objective method of identification recommended by the American Academy of Actuaries.

(B) Payment amount

The formula for determining the amount of payments that will be paid to health insurance issuers described in paragraph (1)(B) that insure high-risk individuals. Such formula shall provide for the equitable allocation of available funds through reconciliation and may be designed—

(i) to provide a schedule of payments that specifies the amount that will be paid for each of the conditions identified under subparagraph (A); or

(ii) to use any other comparable method for determining payment amounts that is recommended by the American Academy of Actuaries and that encourages the use of care coordination and care management programs for high risk conditions.

(3) Determination of required contributions

(A) In general

The Secretary shall include in the provisions under paragraph (1) the method for determining the amount each health insurance issuer and group health plan described in paragraph (1)(A) contributing to the reinsurance program under this section is required to contribute under such paragraph for each plan year beginning in the 36-

month period beginning January 1, 2014. The contribution amount for any plan year may be based on the percentage of revenue of each issuer and the total costs of providing benefits to enrollees in self-insured plans or on a specified amount per enrollee and may be required to be paid in advance or periodically throughout the plan year.

(B) Specific requirements

The method under this paragraph shall be designed so that—

(i) the contribution amount for each issuer proportionally reflects each issuer's fully insured commercial book of business for all major medical products and the total value of all fees charged by the issuer and the costs of coverage administered by the issuer as a third party administrator;

(ii) the contribution amount can include an additional amount to fund the administrative expenses of the applicable reinsurance entity;

(iii) the aggregate contribution amounts for all States shall, based on the best estimates of the NAIC and without regard to amounts described in clause (ii), equal $10,000,000,000 for plan years beginning in 2014, $6,000,000,000 for plan years beginning[2] 2015, and $4,000,000,000 for plan years beginning in 2016; and

(iv) in addition to the aggregate contribution amounts under clause (iii), each issuer's

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[2] So in original. Probably should be followed by "in".

contribution amount for any calendar year under clause (iii) reflects its proportionate share of an additional $2,000,000,000 for 2014, an additional $2,000,000,000 for 2015, and an additional $1,000,000,000 for 2016.

Nothing in this subparagraph shall be construed to preclude a State from collecting additional amounts from issuers on a voluntary basis.

(4) Expenditure of funds

The provisions under paragraph (1) shall provide that—

(A) the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period; and

(B) amounts remaining unexpended as of December, 2016, may be used to make payments under any reinsurance program of a State in the individual market in effect in the 2-year period beginning on January 1, 2017.

Notwithstanding the preceding sentence, any contribution amounts described in paragraph (3)(B)(iv) shall be deposited into the general fund of the Treasury of the United States and may not be used for the program established under this section.

(c) Applicable reinsurance entity

For purposes of this section—

(1) In general

The term "applicable reinsurance entity" means a not-for-profit organization—

(A) the purpose of which is to help stabilize premiums for coverage in the individual market in a State during the first 3 years of operation of an Exchange for such markets within the State when the risk of adverse selection related to new rating rules and market changes is greatest; and

(B) the duties of which shall be to carry out the reinsurance program under this section by coordinating the funding and operation of the risk-spreading mechanisms designed to implement the reinsurance program.

(2) State discretion

A State may have more than 1 applicable reinsurance entity to carry out the reinsurance program under this section within the State and 2 or more States may enter into agreements to provide for an applicable reinsurance entity to carry out such program in all such States.

(3) Entities are tax-exempt

An applicable reinsurance entity established under this section shall be exempt from taxation under chapter 1 of title 26. The preceding sentence shall not apply to the tax imposed by section 511 such[3]

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[3] So in original. Probably should be preceded by "of".

title (relating to tax on unrelated business taxable income of an exempt organization).

(d) Coordination with State high-risk pools

The State shall eliminate or modify any State high-risk pool to the extent necessary to carry out the reinsurance program established under this section. The State may coordinate the State high-risk pool with such program to the extent not inconsistent with the provisions of this section.

17. 42 U.S.C. 18062 provides:

Establishment of risk corridors for plans in individual and small group markets

(a) In general

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

(b) Payment methodology

(1) Payments out

The Secretary shall provide under the program established under subsection (a) that if—

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

(B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

(2) Payments in

The Secretary shall provide under the program established under subsection (a) that if—

(A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and

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

(c) Definitions

In this section:

(1) Allowable costs

(A) In general

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

(B) Reduction for risk adjustment and reinsurance payments

Allowable costs shall[1] reduced by any risk adjustment and reinsurance payments received under section[2] 18061 and 18063 of this title.

(2) Target amount

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

18. 42 U.S.C. 18063 provides:

Risk adjustment

(a) In general

(1) Low actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall assess a charge on

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[1] So in original. Probably should be followed by "be".

[2] So in original. Probably should be "sections".

health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]).

(2) High actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) Criteria and methods

The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq., 1395w-101 et seq.]. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 18041 of this title.

(c) Scope

A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

19. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Tit. I, Subtit. E, Pt. I, Subpt. A, § 1401, 124 Stat. 213 provides in pertinent part:

SEC. 1401. REFUNDABLE TAX CREDIT PROVIDING PREMIUM ASSISTANCE FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

* * * * *

(d) CONFORMING AMENDMENTS.—

(1) Paragraph (2) of section 1324(b) of title 31, United States Code, is amended by inserting "36B," after "36A,".

(2) The table of sections for subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 is amended by inserting after the item relating to section 36A the following new item:

"Sec. 36B. Refundable credit for coverage under a qualified health plan.".

* * * * *

20. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, Tit. II, Subtit. I, § 2707(e)(1), 124 Stat. 327 (42 U.S.C. 1396a note) provides in pertinent part:

SEC. 2707. MEDICAID EMERGENCY PSYCHIATRIC DEMONSTRATION PROJECT.

(e) LIMITATIONS ON FEDERAL FUNDING.—

(1) APPROPRIATION.—

* * * * *

(B) BUDGET AUTHORITY.—Subparagraph (A) constitutes budget authority in advance of appropriations Act and represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph.

21. Department of Health and Human Services Appropriations Act, 2014, Pub. L. No. 113-76, Div. H, Tit. II, 128 Stat. 374 provides in pertinent part:

* * * * *

CENTERS FOR MEDICARE AND MEDICAID SERVICES

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PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and

the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2019: *Provided*, That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further*, That the Secretary is directed to collect fees in fiscal year 2014 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act: *Provided further*, That $22,004,000 shall be available for the State high-risk health insurance pool program as authorized by the State High Risk Pool Funding Extension Act of 2006.

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22. Department of Health and Human Services Appropriations Act, 2015, Pub. L. No. 113-235, Div. G, Tit. II, 128 Stat. 2466 provides in pertinent part:

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CENTERS FOR MEDICARE AND MEDICAID SERVICES

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PROGRAM MANAGEMENT

For carrying out, except as otherwise provided, titles XI, XVIII, XIX, and XXI of the Social Security Act, titles XIII and XXVII of the PHS Act, the Clinical Laboratory Improvement Amendments of 1988, and other responsibilities of the Centers for Medicare and Medicaid Services, not to exceed $3,669,744,000, to be transferred from the Federal Hospital Insurance Trust Fund and the Federal Supplementary Medical Insurance Trust Fund, as authorized by section 201(g) of the Social Security Act; together with all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006; and such sums as may be collected from authorized user fees and the sale of data, which shall be credited to this account and remain available until September 30, 2020: *Provided,* That all funds derived in accordance with 31 U.S.C. 9701 from organizations established under title XIII of the PHS Act shall be credited to and available for carrying out the purposes of this appropriation: *Provided further*, That the Secretary is directed to collect fees in fiscal year 2015 from Medicare Advantage organizations pursuant to section 1857(e)(2) of the Social Security Act and

from eligible organizations with risk-sharing contracts under section 1876 of that Act pursuant to section 1876(k)(4)(D) of that Act.

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OFFICE OF THE SECRETARY

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PUBLIC HEALTH AND SOCIAL SERVICES EMERGENCY FUND

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GENERAL PROVISIONS

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

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23. Department of Health and Human Services Appropriations Act, 2016, Pub. L. No. 114-113, Div. H, Tit. II, § 225, 129 Stat. 2624 provides:

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

24. Continuing Appropriations Act, 2017, Pub. L. No. 114-223, Div. C, §§ 103-104, 130 Stat. 909 provides:

SEC. 103. Appropriations made by section 101 shall be available to the extent and in the manner that would be provided by the pertinent appropriations Act.

SEC. 104. Except as otherwise provided in section 102, no appropriation or funds made available or authority granted pursuant to section 101 shall be used to initiate or resume any project or activity for which appropriations, funds, or other authority were not available during fiscal year 2016.

25. Further Continuing Appropriations Act, 2017, Pub. L. No. 114-254, Div. A, § 101, 130 Stat. 1005 provides:

SEC. 101. The Continuing Appropriations Act, 2017 (division C of Public Law 114-223) is amended by—

(1) striking the date specified in section 106(3) and inserting "April 28, 2017";

(2) striking "0.496 percent" in section 101(b) and inserting "0.1901 percent"; and

(3) inserting after section 145 the following new sections:

26. Department of Health and Human Services Appropriations Act, 2017, Pub. L. No. 115-31, Div. H, Tit. II, § 223, 131 Stat. 543 provides:

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

27. 45 C.F.R. 153.500 provides:

Definitions

The following definitions apply to this subpart:

Adjustment percentage means, with respect to a QHP:

(1) For benefit year 2014—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium in a transitional State, the percentage specified by HHS for such QHPs in the transitional State; and otherwise

(ii) Zero percent.

(2) For benefit year 2015, for a QHP offered by a health insurance issuer in any State, 2 percent.

(3) For benefit year 2016—

(i) For a QHP offered by a health insurance issuer with allowable costs of at least 80 percent of after-tax premium, the percentage specified by HHS; and otherwise

(ii) Zero percent.

Administrative costs mean, with respect to a QHP, total non-claims costs incurred by the QHP issuer for the QHP, including taxes and regulatory fees.

After-tax premiums earned mean, with respect to a QHP, premiums earned with respect to the QHP minus taxes and regulatory fees.

Allowable administrative costs mean, with respect to a QHP, the sum of administrative costs of the QHP, other than taxes and regulatory fees, plus profits earned by the QHP, which sum is limited to the sum of 20 percent and the adjustment percentage of after-tax premiums earned with respect to the QHP (including any premium tax credit under any governmental program), plus taxes and regulatory fees.

Allowable costs means, with respect to a QHP, an amount equal to the pro rata portion of the sum of incurred claims within the meaning of § 158.140 of this subchapter (including adjustments for any direct and indirect remuneration), expenditures by the QHP issuer for the QHP for activities that improve health care quality as set forth in § 158.150 of this subchapter, expenditures by the QHP issuer for the QHP related to health

information technology and meaningful use requirements as set forth in § 158.151 of this subchapter, and the adjustments set forth in § 153.530(b); in each case for all of the QHP issuer's non-grandfathered health plans in a market within a State, allocated to the QHP based on premiums earned.

Charge means the flow of funds from QHP issuers to HHS.

Direct and indirect remuneration means prescription drug rebates received by a QHP issuer within the meaning of § 158.140(b)(1)(i) of this subchapter.

Payment means the flow of funds from HHS to QHP issuers.

Premiums earned mean, with respect to a QHP, all monies paid by or for enrollees with respect to that plan as a condition of receiving coverage, including any fees or other contributions paid by or for enrollees, within the meaning of § 158.130 of this subchapter.

Profits mean, with respect to a QHP, the greater of:

(1) The sum of three percent and the adjustment percentage of after-tax premiums earned; and

(2) Premiums earned of the QHP minus the sum of allowable costs and administrative costs of the QHP.

Qualified health plan or *QHP* means, with respect to the risk corridors program only—

(1) A qualified health plan, as defined at § 155.20 of this subchapter;

(2) A health plan offered outside the Exchange by an issuer that is the same plan as a qualified health plan, as defined at § 155.20 of this subchapter, offered through

the Exchange by the issuer. To be the same plan as a qualified health plan (as defined at § 155.20 of this subchapter) means that the health plan offered outside the Exchange has identical benefits, premium, cost-sharing structure, provider network, and service area as the qualified health plan (as defined at § 155.20 of this subchapter); or

(3) A health plan offered outside the Exchange that is substantially the same as a qualified health plan, as defined at § 155.20 of this subchapter, offered through the Exchange by the issuer. To be substantially the same as a qualified health plan (as defined at § 155.20 of this subchapter) means that the health plan meets the criteria set forth in paragraph (2) of this definition with respect to the qualified health plan, except that its benefits, premium, cost-sharing structure, and provider network may differ from those of the qualified health plan (as defined at § 155.20 of this subchapter) provided that such differences are tied directly and exclusively to Federal or State requirements or prohibitions on the coverage of benefits that apply differently to plans depending on whether they are offered through or outside an Exchange.

Risk corridors means any payment adjustment system based on the ratio of allowable costs of a plan to the plan's target amount.

Target amount means, with respect to a QHP, an amount equal to the total premiums earned with respect to a QHP, including any premium tax credit under any governmental program, reduced by the allowable administrative costs of the plan.

Taxes and regulatory fees mean, with respect to a QHP, Federal and State licensing and regulatory fees paid with respect to the QHP as described in § 158.161(a) of this subchapter, and Federal and State taxes and assessments paid with respect to the QHP as described in § 158.162(a)(1) and (b)(1) of this subchapter.

Transitional State means a State that does not enforce compliance with § 147.102, § 147.104, § 147.106, § 147.150, § 156.80, or subpart B of part 156 of this subchapter for individual market and small group health plans that renew for a policy year starting between January 1, 2014, and October 1, 2014, in accordance with the transitional policy outlined in the CMS letter dated November 14, 2013.

28. 45 C.F.R. 153.510 provides:

Risk corridors establishment and payment methodology.

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

(b) *HHS payments to health insurance issuers.* QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:

(1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and

(2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

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

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

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

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

(e) A QHP issuer is not subject to the provisions of this subpart with respect to a stand-alone dental plan.

(f) *Eligibility under health insurance market rules.* The provisions of this subpart apply only for plans offered by a QHP issuer in the SHOP or the individual or small group market, as determined according to the employee counting method applicable under State

law, that are subject to the following provisions: §§ 147.102, 147.104, 147.106, 147.150, 156.80, and subpart B of part 156 of this subchapter.

(g) *Adjustment to risk corridors payments and charges.* If an issuer reported a certified estimate of 2014 cost-sharing reductions on its 2014 MLR and Risk Corridors Annual Reporting Form that is lower than the actual value of cost-sharing reductions calculated under § 156.430(c) of this subchapter for the 2014 benefit year, HHS will make an adjustment to the amount of the issuer's 2015 benefit year risk corridors payment or charge measured by the full difference between the certified estimate of 2014 cost-sharing reductions reported and the actual value of cost-sharing reductions provided as calculated under § 156.430(c) for the 2014 benefit year.