APPENDIX

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UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

No. 17-1994

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims, No. 1:16-cv-00649-TCW

Decided: June 14, 2018

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

OPINION

PROST, *Chief Judge*.

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

contract grounds. The government appeals. We reverse.

BACKGROUND

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

I. The ACA

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

Because insurers lacked reliable data to estimate the cost of providing care for the expanded pool of individuals seeking coverage via the new exchanges, insurers faced significant risk if they elected to offer plans in these exchanges. The ACA established three programs designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk

corridors. 42 U.S.C. §§ 18061-63. This case concerns the risk corridors program.

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

> (a) In general
>
> The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. §§ 1395w-101 et seq.].
>
> (b) Payment methodology
>
> (1) Payments out
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

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

(2) Payments in

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

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

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

(c) Definitions

In this section:

(1) Allowable costs

> (A) In general
>
> The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.
>
> (B) Reduction for risk adjustment and reinsurance payments
>
> Allowable costs shall [be] reduced by any risk adjustment and reinsurance payments received under section[s] 18061 and 18063 of this title.
>
> (2) Target amount
>
> The target amount of a plan for any year is an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan.

42 U.S.C. § 18062.

Briefly, section 1342 directed the Secretary of HHS to establish a program whereby participating plans whose costs of providing coverage exceeded the premiums received (as determined by a statutory formula) would be paid a share of their excess costs by the Secretary—"payments out." Conversely, participating plans whose premiums exceeded their costs (according to the same formula) would pay a share of their profits to the Secretary—"payments in." The risk corridors program "permit[ted] issuers to lower [premiums] by not adding a risk premium to account for perceived uncertainties in the 2014

through 2016 markets." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (Mar. 11, 2013).

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

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

II. Implementing Regulations

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

The regulations also provided that insurers offering qualified health plans in the exchanges "will receive payment from HHS in the following amounts, under the following circumstances" and it recited the same formula set forth in the statute for payments out. 45 C.F.R. § 153.510(b). The regulations similarly provided that insurers "must remit charges to HHS" according to the statutory formula for payments in. *Id.* § 153.510(c).

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

III. Transitional Policy

The ACA established several reforms for insurance plans—such as requiring a minimum level of coverage—scheduled to take effect on January 1, 2014. ACA § 1255. Non-compliant plans in effect prior to the passage of the ACA in 2010, however, received

a statutory exemption from certain requirements. 42 U.S.C. § 18011. This meant that insurers expected the pool of participants in the exchanges to include both previously uninsured individuals as well as individuals whose previous coverage terminated because their respective plans did not comply with the ACA and did not qualify for the grandfathering exemption.

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

This dampened ACA enrollment in states implementing the policy, especially by healthier individuals who elected to maintain their lower level of coverage, leaving insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums. *See* Milliman, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 Individual Market 1 (July 2016) ("Our analysis indicates that issuers in states that implemented the transitional policy generally

have higher medical loss ratios in the individual market."), http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf.

HHS acknowledged that "this transitional policy was not anticipated by health insurance issuers when setting rates for 2014" but noted "the risk corridor program should help ameliorate unanticipated changes in premium revenue." *Id.* HHS later extended the transitional period to last the duration of the risk corridor program. J.A. 448-62.

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

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

In April 2014, CMS, the division of HHS responsible for administering the risk corridors program, released guidance regarding "Risk Corridors

and Budget Neutrality." J.A. 229-30. It explained a new budget neutrality policy as follows:

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

J.A. 229.

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

IV. Appropriations

In February 2014, after HHS had proposed its adjustments to account for the transitional policy (but before HHS had finalized the adjustments), Congress asked the Government Accountability Office ("GAO") to determine what sources of funds could be used to make any payments in execution of the risk corridors program. *See* Dep't of Health & Human Servs.—Risk Corridors Program ("GAO Report"), B-325630, 2014 WL 4825237, at *1 (Comp. Gen. Sept. 30, 2014) (noting request). GAO responded that it had identified two potential sources of funding in the appropriations for "Program Management" for CMS in FY 2014. That appropriation included a lump sum in excess of three billion dollars for carrying out certain responsibilities, including "other responsibilities" of CMS as well as "such sums as may be collected from authorized user fees." *Id.* at *3 (citing Pub. L. No. 113-76, div. H, title II, 128 Stat. 5,374 (Jan. 17, 2014)).

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

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

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

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

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

> Representative Harold Rogers, then-Chairman of the House Committee on Appropriations, explained his view of the appropriations rider upon its inclusion in the appropriations bill for FY 2015: In 2014, HHS

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

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

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

V. Subsequent Agency Action

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

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[1] Continuing resolutions in advance of the 2017 appropriations retained the same restrictions on funds. Continuing Appropriations Act, 2017, Pub. L. No. 114- 223, div. C, §§ 103-04, 130 Stat. 857, 908-09; Further Continuing and Security Assistance Appropriations Act, 2017, Pub. L. No. 114-254, § 101, 130 Stat. 1005, 1005-06.

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

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

VI. Procedural History

Moda commenced this action in the Court of Federal Claims under the Tucker Act in July 2016. It seeks the balance between the prorated payments it received and the full amount of payments out according to section 1342. The Court of Federal Claims denied the government's motion to dismiss for lack of jurisdiction and for failure to state a claim and granted Moda's cross-motion for partial summary judgment as to liability.

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

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

States, 133 Fed. Cl. 1 (2017) (ruling for the government).

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

DISCUSSION

Moda advances claims based on two theories. First, Moda contends that section 1342 itself obligates the government to pay insurers the full amount indicated by the statutory formula for payments out, notwithstanding the amount of payments in collected. Second, Moda contends that HHS made a contractual agreement to pay the full amount required by the statute in exchange for Moda's performance (by offering a compliant plan in an exchange), and the government breached that agreement by failing to pay the full amount according to the statutory formula for payments out.

We review the Court of Federal Claims' legal conclusion that the government was liable on both

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

theories de novo. *See Starr Int'l Co. v. United States*, 856 F.3d 953, 963 (Fed. Cir. 2017).

I. Statutory Claim

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

We begin with the statute.

A. Statutory Interpretation

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

Section 1342 is unambiguously mandatory. It provides that "[t]he Secretary *shall* establish and administer" a risk corridors program pursuant to

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

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

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

The government's amicus suggests it is "inconceivable" that CBO would have declined to analyze the budgetary impact of the risk corridors program, given its obligation to prepare "an estimate of the costs which would be incurred in carrying out such bill." Br. of Amicus Curiae U.S. House Rep. in Supp. of Appellant at 7 (quoting 2 U.S.C. § 653). Not so. It is entirely plausible that CBO expected

payments in would roughly equal payments out over the three year program, especially since CBO could not have predicted the costly impact of HHS's transitional policy, which had not been contemplated at that time. Without more, CBO's omission of the risk corridors program from its report can be viewed as nothing more than a bare failure to speak. Moreover, even if CBO interpreted the statute to require budget neutrality, that interpretation warrants no deference, especially in light of HHS's subsequent interpretation to the contrary. CBO's silence simply cannot displace the plain meaning of the text of section 1342.

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

In *United States v. Langston*, 118 U.S. 389 (1886), Congress appropriated only five thousand dollars for the salary of a foreign minister, though a statute provided that the official's salary would be seven thousand five hundred dollars. The Supreme Court held that the statute fixing the official's salary could not be "abrogated or suspended by the subsequent enactments which merely appropriated a less amount" for the services rendered, absent "words that expressly, or by clear implication, modified or repealed the previous law." *Id.* at 393. That is, the government's

statutory obligation to pay persisted independent of the appropriation of funds to satisfy that obligation.

Our predecessor court noted long ago that "[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties." *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) ("It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute.").

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

For the same reason, it is immaterial that Congress provided that the risk corridors program

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

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

We conclude that the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program. We next consider whether, notwithstanding that

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

statutory requirement, Congress has suspended or repealed that obligation.

B. The Effect of the Appropriations Riders

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

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

Moda contends, however, this issue is also controlled by *Langston*. There, as discussed above, the Supreme Court held that a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation because it carried no implication of

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

Congress's intent to amend or suspend the substantive law at issue. *Langston*, 118 U.S. at 394.

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

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

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

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

The question before us, then, is whether the riders on the CMS Program Management appropriations supplied the clear implication of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question, as in *Mitchell*, or if Congress merely appropriated a less amount for the risk corridors program, as in *Langston*.

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

In *United States v. Vulte*, 233 U.S. 509 (1914), the Supreme Court considered a series of enactments concerning bonuses for Marine Corps officers serving abroad. A 1902 act established a ten percent bonus for all such officers and appropriated funds accordingly. In 1906 and 1907, appropriations for the payment of that bonus carried a rider specifying that the funds could be used to pay officers serving "beyond the limits of the states comprising the Union of the territories of the United States contiguous thereto (*except P[ue]rto Rico and Hawaii*)." *Id.* at 512-13 (emphasis added)

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

(citations omitted). The appropriations for 1908 contained no such rider and stated the increase of pay for officers serving abroad "shall be as now provided by law." *Id.* at 513 (citation omitted).

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

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

The appropriations bill for the fiscal year ending in 1939 repeated that language. *Id.* at 555. Floor debates showed that Congress intended the new language to carry the same restriction expressed in

the earlier appropriations bills. *Id.* at 557-61. The Supreme Court held that the appropriations bill for the fiscal year ending in 1939 evinced Congress's intent to suspend the reenlistment bonus in light of persuasive evidence to that effect. *Id.* at 561.

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

The dispute in *Will* concerned whether the effect of the appropriations riders ran afoul of the Compensation Clause of the Constitution. Before reaching that issue, however, the Supreme Court first rejected the judges' contention that the appropriations bills did "no more than halt *funding* for the salary increases." *Id.* at 221. Acknowledging the general rule disfavoring repeals by implication and its "especial force" when the alleged repeal occurred in an appropriations bill, the Court held that in each of the four appropriations acts in question, "Congress intended to repeal or postpone previously authorized increases." *Id.* at 221-22. This was true although the

riders in years 1, 3, and 4 were "phrased in terms of limiting funds." *Id.* at 223. The Court's conclusion was bolstered by floor debates occurring in year 3 of the appropriations riders as well as language expressly suspending the pay raises in year 2, but it concluded the rider in year 1 indicated that same clear intent:

> These passages indicate[d] clearly that Congress intended to rescind these rates entirely, not simply to consign them to the fiscal limbo of an account due but not payable. The clear intent of Congress in each year was to stop for that year the application of the Adjustment Act.

Id. at 224.

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

those decisions altered statutory payment methodologies.[6]

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

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

Moda suggests that restricting access to funds from "any other act" was necessary to foreclose HHS from using funds that remained available. It points to the CMS Program Management appropriation for FY 2014 (before the risk corridors program began and before any appropriations riders had been enacted) as

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

well as the Judgment Fund, a standing appropriation for the purpose of paying certain judgments against the government. We address each in turn.

In response to a request of Congress, GAO concluded that the FY 2014 CMS Program Management fund "would have been available for risk-corridors payments." *See* GAO Report at *3. According to Moda, this means HHS could have used funds from the FY 2014 appropriation to make risk corridors payments for the 2015 benefit year (which concluded in FY 2015). Not so. GAO's opinion only addressed what funds from FY 2014 would have been available for risk corridors payments had any such payments been among the "other responsibilities" of CMS *for that fiscal year*. That appropriation expired in FY 2014. *See* 128 Stat. at 5 ("The following sums in this Act are appropriated . . . for the fiscal year ending September 30, 2014."). GAO specifically noted that "for funds to be available for this purpose in FY 2015, the CMS PM appropriation for FY 2015 must include language similar to the language included in the CMS PM appropriation for FY 2015." *Id.* at *5. Of course, Congress enacted the rider for FY 2015 instead.

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

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

Moda's reliance on the Judgment Fund is also misplaced. The Judgment Fund is a general appropriation of "[n]ecessary amounts" in order "to pay final judgments" and other amounts owed via litigation against the government, subject to several conditions. 31 U.S.C. § 1304(a). The Judgment Fund "does not create an allpurpose fund for judicial disbursement." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 431 (1990). Rather, access to the Judgment Fund presupposes liability. Moda's contention that the government's liability persists because it could pay what it owed under the statutory scheme from the Judgment Fund reverses the inquiry. The question is what Congress intended, not what funds might be used if Congress did *not* intend to suspend payments in exceeding payments out.

As discussed above, Congress's intent to temporarily cap payments out at the amount of payments in was clear from the appropriations riders and their legislative history. It did not need to use Moda's proposed magic words, "or any other act," to foreclose resort to the Judgment Fund. We simply cannot infer, as Moda's position would require, that upon enacting the appropriations riders, Congress intended to preserve insurers' statutory entitlement to

full risk corridors payments but to require insurers to pursue litigation to collect what they were entitled to. That theory cannot displace the plain implication of the language and legislative history of the appropriations riders.

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

It is also irrelevant that the President signed the bills containing the appropriations riders, even as he threatened to veto any bill rolling back the ACA, as Moda points out. *See, e.g.*, Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA TODAY, Nov. 19, 2014 (noting that President Obama had threatened to veto twelve different bills that would have repealed or amended the ACA),

http://www.usatoday.com/story/news/politics/2014/11/19/obama-veto-threats/19177413/. Again, we do not hold that the appropriations riders effected any permanent amendment. Moreover, Moda has offered no evidence that President Obama expressed any specific views of the implications of these appropriations riders before or after signing, much less evidence that could overcome the clear implication of the text of the riders and the surrounding legislative history.

Moda also contends that two decisions from our predecessor court, *New York Airways*, 369 F.2d at 743, and *Gibney v. United States*, 114 Ct. Cl. 38 (1949), demonstrate that the appropriations riders here do not carry such strong implications. In *New York Airways*, our predecessor court held that Congress's failure to appropriate sufficient funds to pay for services at a rate set by a government agency did not defeat the obligation to pay the full amount. 369 F.2d at 746. Floor debates indicated that "Congress was well-aware that the Government would be legally obligated to pay . . . even if the appropriations were deficient." *Id.* The court noted that Congress viewed the obligation "as a contractual obligation enforceable in the courts which could be avoided only by changing the substantive law under which the Board set the rates, rather than by curtailing appropriations," and the agency made its similar view of the obligation clear to Congress. *Id.* at 747.

Here, the risk corridors program is an incentive program, not a quid pro quo exchange for services rendered like that in *New York Airways*. Moreover, it is much clearer here that Congress understood the

appropriations riders to suspend substantive law, inasmuch as the appropriations riders directly responded to GAO's identification of only two sources of funding for the program.

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

That rider, according to the *Gibney* court, constituted "a mere limitation on the expenditure of a particular fund and had no other effect," so it could not limit the overtime rate available to an INS agent. *Id.* at 51. But the court's holding ultimately rested on a different point—that limiting overtime payments "as provided in" the new acts had no effect on the rate for INS agents, since the new acts expressly preserved their special overtime rate. The appropriations rider did "not even purport to affect the right of immigration inspectors to overtime pay as provided in the" earlier act. *Id.* at 55. The interpretation of the appropriations riders in *Gibney* cannot be viewed in isolation of its alternative holding, and there is no safety valve built into the ACA to preserve the government's obligation

notwithstanding Congress's suspension of it. Accordingly, *Gibney* is inapposite.

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

According to Moda, this refutes the government's positions on its statutory claims. In particular, Moda states, "if the appropriation riders had substantively amended the ACA, the government would have no basis now to be proposing to appropriate funds to fulfill the entirety of its [risk corridor] obligations." Moda 28(j) Letter at 2.

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

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

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

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

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

Thus, Moda's statutory claim cannot stand.

II. Contract Claim

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

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

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

Id. (quoting *Dodge v. Board of Educ.*, 302 U.S. 74, 79 (1937)). This is because the legislature's function is to make laws establishing policy, not contracts, and policies "are inherently subject to revision and repeal." *Id.* at 466.

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

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

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

government's position that the regulations constituted a mere invitation to make an offer, holding instead that the regulation itself constituted "an offer, which ripened into a contract when it was accepted by the plaintiff's putting itself into a position to supply the ore or the refined uranium described in it." *Id.* at 405.

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

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

Additionally, the parties in *Radium Mines*, one of which was the government, never disputed that the government intended to form some contractual relationship at some time throughout the exchange. The only question there was whether the regulations themselves constituted an offer, or merely an invitation to make offers. *Radium Mines* is only precedent for what it decided. *See Orenshteyn v. Citrix Sys., Inc.*, 691 F.3d 1356, 1360 (Fed. Cir. 2012) ("Generally, when an issue is not discussed in a decision, that decision is not binding precedent.").

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

Accordingly, Moda cannot state a contract claim.

* * *

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

CONCLUSION

Although section 1342 obligated the government to pay participants in the exchanges the full amount indicated by the formula for risk corridor payments, we hold that Congress suspended the government's

obligation in each year of the program through clear intent manifested in appropriations riders. We also hold that the circumstances of this legislation and subsequent regulation did not create a contract promising the full amount of risk corridors payments. Accordingly, we hold that Moda has failed to state a viable claim for additional payments under the risk corridors program under either a statutory or contract theory.

REVERSED

COSTS

The parties shall bear their own costs.

NEWMAN, *Circuit Judge*, dissenting.

The United States and members of the health insurance industry, in connection with the program referred to as "Obamacare," agreed to a three-year plan that would mitigate the risk of providing low-cost insurance to previously uninsured and underinsured persons of unknown health risk. This risk-abatement plan is included in the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA). As described by the Court of Federal Claims,[1] the "risk corridors" provision accommodates the unpredictable risk of the extended healthcare programs. By this provision, the government will "'share in profits or losses resulting from inaccurate rate setting from 2014 to 2016.'" Fed. Cl. Op., 130 Fed. Cl. at 444 (quoting *HHS Notice of Benefit and Payment Parameters for 2014*, 77 Fed. Reg. 73,118, 73,121 (Dec. 7, 2012)). The risk corridors program was enacted as Section 1342 of the Affordable Care Act, and is codified in Section 18062 of Title 42. Subsection (a) is as follows:

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

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

> participating provider organizations under part D of [the Medicare Act].

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

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

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

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

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

> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

42 U.S.C. § 18062(b). In March 2012, HHS issued regulations for the risk corridors program, stating that Qualified Health Plans (QHPs) "will receive payment" or "must remit charges" depending on their gains or losses. 45 C.F.R. § 153.510(b), (c). In March 2013, HHS stated:

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

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

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

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

The risk corridors obligations were not cancelled by the appropriations riders

In April 2014, HHS-CMS issued an "informal bulletin" stating, "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall." Memorandum from CMS CCIIO, Risk Corridors and Budget Neutrality (Apr. 11, 2014) (JA229). HHS also stated "that the Affordable Care Act requires the Secretary to make full payments to issuers," and that it was "recording those amounts that remain

unpaid . . . [as an] obligation of the United States Government for which full payment is required." Memorandum from CMS CCIIO, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) (JA245).

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

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

A statute cannot be repealed or amended by inference

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

The mounting problems with the Affordable Care Act did not go unnoticed. In September 2014, the

General Accountability Office (GAO) responded to an inquiry from Senator Jeff Sessions and Representative Fred Upton, and stated that "the CMS PM [Centers for Medicare Services-Program Management] appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1)." Letter from Susan A. Poling, GAO Gen. Counsel, to Sen. Jeff Sessions and Rep. Fred Upton 4 (Sept. 30, 2014) (JA237) ("Poling Letter"). The GAO also stated that "payments under the risk corridors program are properly characterized as user fees" and could be used to make payments out. *Id.* at 6 (JA239). This review also cited the available recourse to the general CMS assessment. However, in December 2014, the appropriations bill for that fiscal year contained a rider that prohibited HHS from using various funds, including the CMS PM funds, for risk corridors payments. The rider stated:

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

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

cover 2014 losses, and that no payments out would be made for the 2015 plan year. Moda states: "The Government owed Moda $89,426,430 for 2014 and $133,951,163 for 2015, but only paid $14,254,303 for 2014 and nothing for 2015, leaving a $209,123,290 shortfall." Moda Br. 10.

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

In *United States v. Will*, the Court explained that "when Congress desires to suspend or repeal a statute in force, '[t]here can be no doubt that . . . it could accomplish its purpose by an amendment to an appropriation bill, or otherwise.'" 449 U.S. 200, 222 (1980) (citing *United States v. Dickerson*, 310 U.S. 554, 555 (1940)). However, this intent to suspend or repeal the statute must be expressed: "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883).

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

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

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

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

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

My colleagues dispose of *Langston* as an "extreme example," stating that subsequent decisions are more useful since *Langston* is a "century and a half" old. Maj. Op. at 21-22. Indeed it is, and has stood the test of a century and a half of logic, citation, and compliance. Nonetheless discarding *Langston*, the panel majority finds intent to change the

government's obligations under the risk corridors statute. The majority concludes that "Congress clearly indicated its intent" to change the government's obligations, reciting two factors:

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

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

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

160 Cong. Rec. H9307, H9838 (daily ed. Dec. 11, 2014) (explanatory statement submitted by Rep. Rogers, Chairman of the House Comm. on Appropriations,

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

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

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

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

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

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

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

The panel majority does not suggest that intent to repeal can be found in the rider itself. Nor can intent be inferred from any evidence in the record. It is clear

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

that Congress knew what intent would have looked like, because members of Congress tried, and failed, to achieve budget neutrality in the risk corridors program.

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

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

repealed, and he was entitled to the 1908 bonus. *Id.* at 514.

The panel majority concludes that *Vulte* established a rule of "effective suspensions-by-appropriations." Maj. Op. at 26. That is not a valid conclusion. The Court held that, by altering the bonus for 1906 and 1907, Congress cannot have intended to effectuate a permanent repeal of the 1902 statute. *Vulte*, 233 U.S. at 514-15. And *Vulte* did not retroactively strip the officers of pay for duties they had performed while subject to the higher pay. On the question of whether an annual appropriations rider can permanently abrogate a statute, the *Vulte* Court stated:

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

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

The panel majority also relies on *United States v. Mitchell*, 109 U.S. 146 (1883), to support the majority's ruling of "temporary suspension." Again, the case does not support the position taken by my colleagues. In *Mitchell* an appropriations act initially set the salaries of interpreters at $400 or $500. A subsequent appropriation, five years later, set "the appropriation

for the annual pay of interpreters [at] $300 each, and a large sum was set apart for their additional compensation, to be distributed by the secretary of the interior at his discretion." *Id.* at 149. The Court stated, "[t]he whole question depends on the intention of congress as expressed in the statutes," *id.* at 150, and observed that the statute clearly stated the number of interpreters to be hired, the salary for those interpreters, and the appropriation of an additional discretionary fund to cover additional compensation. *Id.* at 149.

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

The panel majority's theory is not supported by *Mitchell* and *Vulte*, for the statutes in both cases contain the clearly stated intent to modify existing

appropriations. Moda's situation is more like that in *Langston*, where the Court stated:

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

Langston, 118 U.S. at 394. Similarly, it is not probable that Congress would abrogate its obligations under the risk corridors program, undermining a foundation of the Affordable Care Act, without stating its intention to do so. The appropriations riders did not state that the government would not and need not meet its statutory commitment.

Precedent supports the decision of the Court of Federal Claims

In *New York Airways, Inc. v. United States*, the Court of Claims held that the "mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." 369 F.2d 743, 748 (Ct. Cl. 1966) (citing *Vulte*, *supra*). The Civil Aeronautics Board had provided subsidies to helicopter carriers according to a statute whose appropriation provision stated:

> For payments to air carriers of so much of the compensation fixed and determined by the Civil Aeronautics Board under section 406 of the Federal Aviation Act of 1958 (49 U.S.C. § 1376), as is payable by the Board, including

> not to exceed $3,358,000 for subsidy for helicopter operations during the current fiscal year, $82,500,000, to remain available until expended.

Id. at 749 (citing 78 Stat. 640, 642 (1964)). However, the appropriation cap was not sufficient to cover the statutory obligation. The Court of Claims held that the insufficient appropriation did not abrogate the government's obligations to make payments. The court stated that "the failure of Congress or an agency to appropriate or make available sufficient funds does not repudiate the obligation; it merely bars the accounting agents of the Government from disbursing funds and forces the carrier to a recovery in the Court of Claims." *Id.* at 817.

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

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

Id. at 555. The rider in *Dickerson* cut off funding from *all* sources, stating "no part of any appropriation

contained in this or any other Act . . . shall be available." *Id.* The Court held that the new language continued to suspend the bonus statute, for the words, and the accompanying Congressional Record, display the clear intent to discontinue the bonus payment. The Record stated: "We have not paid [the enlistment bonus] for 5 years, and the latter part of this amendment now before the House is a Senate amendment which discontinues for another year the payment of the reenlistment allowances." 83 Cong. Rec. 9677 (1938) (statement of Rep. Woodrum). The Record and the statutory language left no doubt of congressional intent to continue the suspension of reenlistment bonuses. The panel majority recognizes that the Court in *Dickerson* found "persuasive evidence" of "Congress's intent to suspend the reenlistment bonus." Maj. Op. at 23.

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

year, the language stated the clear intent that federal funds not be used for these cost-of-living adjustments.

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

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

The riders cannot have retroactive effect after inducing participation

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

The government argued before the Court of Federal Claims that its obligations to insurers did not come due until the conclusion of the three year risk corridors program, and that "HHS has until the end of

2017 to pay Moda the full amount of its owed risk corridors payments, and Moda's claims are not yet ripe because payment is not yet due." Fed. Cl. Op., 130 Fed. Cl. at 451. We have received no advice of payments made at the end of 2017 or thereafter.

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

Removal of Moda's right to risk corridors payments would "impair rights a party possessed when [it] acted," a "disfavored" application of statutes, for "a statute shall not be given retroactive effect unless such construction is required by explicit language or by necessary implication." *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (quoting *United States v. St. Louis, S.F. & Tex. Ry. Co.*, 270 U.S. 1, 3 (1926)). Such premises are absent here.

Moda has recourse in the Judgment Fund

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

> The United States Court of Federal Claims shall have jurisdiction to render judgment

> upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort.

28 U.S.C. § 1491.

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

The contract claim is also supported

The Court of Federal Claims also found that the risk corridors statute is binding contractually, for the insurers and the Medicare administrator entered into mutual commitments with respect to the conditions of performance of the Affordable Care Act. The Court of Federal Claims correctly concluded that an implied-in-fact contract existed between Moda and the government. I do not share my colleagues' conclusion that "Moda cannot state a contract claim." Maj. Op. at 35.

CONCLUSION

The government's ability to benefit from participation of private enterprise depends on the

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

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

Appendix B

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

No. 17-2154

Blue Cross and Blue Shield of North Carolina,
Plaintiff-Appellant,

v.

United States,
Defendant-Appellee.

Decided: July 9, 2018

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

OPINION AND JUDGMENT

PROST, *Chief Judge*.

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

Appellant's motion for entry of judgment and previous motions to allow argument are denied as moot.

AFFIRMED

Appendix C

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

No. 17-1994

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

17-1224

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

Plaintiff-Appellant,

v.

UNITED STATES,

Defendant-Appellee.

17-2395

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
Plaintiff-Appellant,
v.
UNITED STATES,
Defendant-Appellee.

Decided: November 6, 2018
Per Curiam

Before Prost, *Chief Judge*, Newman, Lourie, Dyk, Moore, Reyna, Wallach, Taranto, Chen, Hughes, and Stoll, *Circuit Judges*[*]

ORDER

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

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

appeals, and thereafter to the circuit judges who are in regular active service. A poll was requested, taken, and failed.

Upon consideration thereof,

IT IS ORDERED THAT:

The petitions for panel rehearing are denied.

The petitions for rehearing en banc are denied.

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

FOR THE COURT

November 6, 2018
Date

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

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

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

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

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

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

profits would be turned over to the government—the "risk corridors" program.

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

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

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

> The panel majority's opinion, however, now makes it a risky business to rely upon the government's assurances. That deals a crippling blow to health insurance providers' business relationships with the government, which depend upon the providers' ability to trust that the government will act as a fair partner.

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

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

In the national interest, there is even more at stake than these promises to the health insurance industry. The government's access to private sector products and services is undermined if non-payment is readily achieved after performance by the private sector. The Court has stated that "[i]f the Government

could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012).

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

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

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

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

to make risk corridors payments, I respectfully dissent from the denial of the petition for rehearing en banc.

DISCUSSION

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

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

> shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan [("QHP")] offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums.

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

omitted)). HHS explained "[t]he risk corridors program is not statutorily required to be budget neutral . . . HHS will remit payments as required under [§] 1342." *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013).

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

I agree with the majority that § 1342 obligates the Government to make risk corridors payments. I begin with the plain language of § 1342. *See BedRoc Ltd. v. United States*, 541 U.S. 176, 183 (2004) (providing that statutory interpretation "begins with the statutory text"); *see also Sandifer v. U.S. Steel Corp.*, 571 U.S. 220, 227 (2014) ("It is a fundamental cannon of statutory construction that . . . words will be interpreted as taking their ordinary, contemporary, common meaning." (internal quotation marks and citation omitted)). Section 1342 uses the word shall to define HHS's risk corridors obligations. *See* 42 U.S.C. § 18062(a) (reciting that HHS "*shall* establish and administer a program of risk corridors" (emphasis added)), (b)(1) (dictating that HHS "*shall* provide under the program" certain payments out (emphasis added)), (b)(1)(A) (stating that when "a participating

plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, [HHS] *shall pay* to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount" (emphasis added)), (b)(1)(B) (stating that when "a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, [HHS] *shall pay* to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount" (emphasis added)).

The word shall typically sets forth a command. *See* 1A N. Singer & J. Singer, Sutherland on Statutes and of the word [shall] as a command is now firmly fixed, both in common speech, in the second and third persons, and in legal phraseology."). "Dictionaries from the era of . . . enactment," *Sandifer*, 571 U.S. at 228, establish that shall generally imposes a mandatory duty, *see Shall*, *Black's Law Dictionary* (9th ed. 2009) (defining shall as "[h]as a duty to; more broadly, is required to" and explaining "[t]his is the mandatory sense that drafters typically intend and that courts typically uphold"); *Shall*, *Webster's New World College Dictionary* (4th ed. 2009) (explaining that shall is often "used . . . to express determination, compulsion, obligation, or necessity"). Although the "circumstances, or the context of an act" may indicate that the word shall is to be interpreted as "merely permissive, rather than imperative," Sutherland § 32A:11, nothing in § 1342 or the ACA indicates that the use of the word shall in relation to the Government's obligation to make risk corridors payments was intended to be interpreted in the

permissive sense, rather than the imperative, *see* 42 U.S.C. § 18062. *See generally* Pub. L. No. 111-148, 124 Stat. 119. Indeed, the Supreme Court has routinely treated the word shall as an imperative. *See SAS Inst. Inc. v. Iancu*, 138 S. Ct. 1348, 1352 (2018) ("The word 'shall' generally imposes a nondiscretionary duty . . . ."); *Kingdomware Techs., Inc. v. United States*, 136 S. Ct. 1969, 1977 (2016) ("Unlike the word 'may,' which implies discretion, the word 'shall' usually connotes a requirement."); *Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998) ("[T]he mandatory 'shall[]' . . . normally creates an obligation impervious to judicial discretion." (citation omitted)). Therefore, the plain language of § 1342 requires HHS to make certain payments out in accordance with the statutory formula provided therein. *See* 42 U.S.C. § 18062(b)(1).

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

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

"As a general rule, repeals by implication are not favored. This rule applies with *especial force* when the provision advanced as the repealing measure was enacted *in an appropriations bill*." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphases added) (internal quotation marks and citations omitted). "The whole question depends on the intention of Congress as expressed in the statutes." *United States v. Mitchell*, 109 U.S. 146, 150 (1883). The Supreme Court looks for "words that expressly, or by clear implication, modified or repealed the previous law." *United States v. Langston*, 118 U.S. 389, 394 (1886).

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

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

Consolidated and Further Continuing Appropriations Act, 2015 ("FY 2015 Appropriations"), Pub. L. No. 113-235, div. G, § 227, 128 Stat. 2130, 2491 (emphases added). Appropriations riders for fiscal years 2016 and 2017 included identical language. Consolidated Appropriations Act, 2017 ("FY 2017 Appropriations"),

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

These appropriations riders do not clearly establish that Congress intended to repeal the Government's obligation to make risk corridors payments. The riders do not address *whether the obligation remains payable* and, at most, only address *from whence the funds to pay the obligation may come. See, e.g.*, FY 2015 Appropriations § 227. The present case is similar to *Langston*, in which the Supreme Court held that "a statute fixing the annual salary of a public officer at a named sum, without limitation as to time," was not "deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount . . . and which contained no words that expressly, or by clear implication, modified or repealed the previous law." 118 U.S. at 394. There, the claimant held a position, for which a statute indicated a person serving in that position "shall be entitled to a salary of $7,500 a year." *Id.* at 390 (internal quotation marks and citation omitted). While in some subsequent appropriations acts Congress appropriated the full

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

$7,500, Congress appropriated only $5,000 for that particular position in appropriations acts for fiscal years 1883 and 1884. *See id.* at 391. The Supreme Court held the claimant was still due $7,500 for 1883 and 1884 because the salary "was originally fixed at the sum of $7,500," and "[n]either of the acts appropriating $5,000 . . . contains any language to the effect that such sum shall be 'in full compensation' for those years" nor did either contain "an appropriation of money 'for additional pay,' from which it might be inferred that [C]ongress intended to repeal the act fixing his annual salary at $7,500." *Id.* at 393. The Supreme Court found it "not probable that [C]ongress" would "make a permanent reduction of [claimant's] salary, without indicating its purpose to do so, either by express words of repeal, or by such provisions as would compel the courts to say that harmony between the old and the new statute was impossible." *Id.* at 394.

Similarly, the appropriations riders at issue, enacted after Congress imposed the risk corridors payment obligation in the ACA, appropriated a lower amount. The riders *do not state* that this lower amount serves as full satisfaction of the Government's obligation under § 1342. *See, e.g.*, FY 2015 Appropriations § 227. Nor do the appropriations riders cut off *all* sources of funding for the risk corridors program. *See, e.g.*, *id.* (specifying particular funds from which risk corridors payments may not be made). In *Gibney v. United States*, our predecessor court held that appropriations language similar to the riders here was "a mere limitation on the expenditure of a particular fund," and "d[id] not have the effect of either repealing or even suspending an existing

statutory obligation any more than the failure to pay a note in the year in which it was due would cancel the obligation stipulated in the note." 114 Ct. Cl. 38, 50-51 (1949); *see N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 752 (Ct. Cl. 1966) (explaining "the failure of Congress . . . to appropriate or make available sufficient funds does not repudiate the obligation").

Akin to the situation here, the appropriations bill in *Gibney* stated "*none of the funds* appropriated for the Immigration and Naturalization Service *shall be used to pay* compensation for overtime services." 114 Ct. Cl. at 48 (emphases added); *see* FY 2015 Appropriations § 227 ("*None of the funds* made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the 'Centers for Medicare and Medicaid Services-Program Management' account, *may be used for payments* under [§] 1342(b)(1) . . . " (emphases added)); *see also Beer v. United States*, 696 F.3d 1174, 1185 (Fed. Cir. 2012) (en banc) (holding that a 2001 amendment to an appropriations bill did not impliedly repeal a 1989 law that guaranteed judicial cost of living adjustments). Because I believe § 1342 is "reasonabl[y] constru[ed]" as setting forth the Government's obligation to make risk corridors payments out and the appropriations riders as simply designating from which funds the payments out may not be made, I believe we must "give effect to the provisions of each," rather than finding the statutory obligation impliedly repealed. *Langston*, 118 U.S. at 393.

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

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

160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). However, the Supreme Court has indicated "[t]he whole question depends on the intention of [C]ongress *as expressed in the statutes*." *Mitchell*, 109 U.S. at 150. It is not appropriate to rely on Chairman Rogers's statement to inject ambiguity into the appropriations riders' plain meaning. *See Gibney*, 114 Ct. Cl. at 53 ("We must take what the [appropriations bill] says and not what one member of [Congress] might have been under the impression it contained."). Even if it is appropriate to look beyond the text of the statutes, the above statement does not support the majority's position. Chairman Rogers did not say that the 2015

appropriations rider sought to make the risk corridors program budget neutral; instead, he said that such was the goal of *an HHS regulation* and that the 2015 appropriations rider sought to designate from which funds the payments out may not be made. *See* 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014). Chairman Rogers said nothing about the 2015 appropriations rider's effect on the Government's *obligation* to make payments out. *See id.*

If anything, I believe it is more probative of legislative intent that Congress, eight months before it passed the first appropriations rider, introduced legislation to repeal the Government's obligation to make full risk corridors payments by requiring budget neutrality, but failed to pass that legislation. *See* Obamacare Taxpayer Bailout Protection Act, S. 2214, § 2, 113th Cong. (2014) (proposing to add to § 1342 a subsection that states that HHS "shall ensure that payments out and payments in . . . are provided for in amounts that [HHS] determines are necessary to reduce to zero the cost"); *see also Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962) ("When the repeal of a highly significant law is urged upon [Congress] and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide by that decision."), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union, Local 770*, 398 U.S. 235 (1970). Less than two months after enacting the first of the appropriations riders, Congress considered but did not pass legislation solely meant to make the risk corridors program budget neutral. *See* Taxpayer Bailout Protection Act, H.R. 724, § 2, 114th Cong. (2015) (providing that payments out should not exceed

payments in); Taxpayer Bailout Protection Act, S. 359, § 2, 114th Cong. (2015) (same). While we are generally "reluctant to draw inferences from the failure of Congress to act," *Pac. Gas & Elec. Co. v. State Energy Res. Conservation & Dev. Comm'n*, 461 U.S. 190, 220 (1983), I understand these facts to support a finding that Congress did not intend the appropriations riders either to repeal the Government's obligation to make risk corridors payments or to decrease the Government's exposure to liability by temporarily capping the amount of payments by making the program budget neutral, *see id.* (stating "it would . . . appear improper for us to give a reading to [an a]ct that Congress considered and rejected").

While the majority attempts to cast its opinion as holding "that Congress enacted *temporary* measures capping risk corridor payments out at the amount of payments in," *Moda*, 892 F.3d at 1327 (emphasis added), this characterization does not withstand scrutiny. Under the majority's holding, the appropriations riders have substantively altered the Government's § 1342 obligations for *every year* of the risk corridors program by no longer requiring the Government to make payments out subject to the statutory formula. *See id.* at 1322; *see also* 42 U.S.C. § 18062(b)(1) (providing the statutory formula for payments out). For instance, in the case of Moda, the Government has not made the full payments out in 2014, as calculated by the formula, and has not made *a single* payment out in 2015. *See Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 448 (2017). Accordingly, I believe the majority erred in its consideration of the appropriations riders.

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

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

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

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

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

The Government's refusal to honor its obligation has important consequences. "Based on the Government's own official calculations, QHP [i]ssuers are owed about $12.3 billion dollars for the 2014-2016 plan years." Health Republic Ins. Co. & Common Ground Healthcare Cooperative's Amicus Br. ("Health Republic Amicus Br.") 9, *Land of Lincoln Health Ins. Co. v. United States*, No. 2017-1224, ECF No. 189; *see Moda*, 892 F.3d at 1319 (acknowledging that the Government's shortfall of payments out equaled "more than $12 billion"). These shortfalls have negatively affected not only health insurance providers but also

health insurance recipients. For instance, by the end of 2016, eighteen of twenty-four health cooperatives that were participating in the exchanges were no longer in business because a lack of capital, in part, due to the lack of risk corridors payments. Nat'l Ass'n of Ins. Comm'rs Amicus Br. 12-13, *Moda Health Plan, Inc. v. United States*, No. 2017-1994, ECF No. 51. Several health insurance companies "withdrew from the ACA exchanges entirely," and others still offering plans "had to compensate for this uncertainty in payment by offering health plans at *higher prices* than before." Health Republic Amicus Br. 11 (emphasis added). These consequences, which impact the cost of health care insurance for virtually all Americans, make this case fit for en banc consideration.

CONCLUSION

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

Appendix D

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

No. 16-649C

MODA HEALTH PLAN, INC.,
Plaintiff,
v.
UNITED STATES,
Defendant.

Filed: February 9, 2017

OPINION AND ORDER

WHEELER, Judge.

Plaintiff Moda Health Plan, Inc. ("Moda") offers health insurance plans through Health Benefit Exchanges created under the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010). To encourage insurers like Moda to offer health insurance on the exchanges, the ACA created a system of risk corridors under which the Government would pay insurers if they suffered losses during the first three years of the ACA's implementation (2014-2016). Conversely, insurers would pay the Government a percentage of any profits they received in each of these first three years. Moda suffered losses on its health insurance plans during 2014 and 2015. To date, the Government has paid 12.6

percent of Moda's claimed risk corridors payment for 2014, and has made no risk corridors payments for 2015.

Moda brought this case in June 2016 to obtain full risk corridors payments for the 2014 and 2015 plan years—in total, over $214 million. Moda primarily alleges that the Government is liable for the payments under the ACA and its implementing regulations, and argues in the alternative that the ACA's risk corridors program created an implied-infact contract between insurers and the Government. The Government has moved to dismiss this case under Rules 12(b)(1) and 12(b)(6) of the Court of Federal Claims ("RCFC"). It argues that the court lacks jurisdiction over this case because risk corridor payments are not "presently due," and that the case is not ripe because the Government has until the end of 2017 to make full risk corridors payments. On the merits, the Government also argues mainly that (1) the risk corridors program is required to be budget-neutral, so the Government only owes risk corridors payments to the extent that profitable insurers pay money into the program; and (2) Congress's failure to appropriate money for risk corridors payments constitutes either a repeal of the Government's risk corridors obligations or an amendment that makes the program budget-neutral. The Government further argues that the ACA and its implementing regulations did not form a contract between insurers and the Government. Moda has cross-moved for partial summary judgment on the issue of liability.

The Court held oral argument on the cross-motions on January 13, 2017. After considering the

parties' arguments in court and in their filings, the Court finds that the Government has unlawfully withheld risk corridors payments from Moda, and is therefore liable. The Court finds that the ACA requires annual payments to insurers, and that Congress did not design the risk corridors program to be budget-neutral. The Government is therefore liable for Moda's full risk corridors payments under the ACA. In the alternative, the Court finds that the ACA constituted an offer for a unilateral contract, and Moda accepted this offer by offering qualified health plans on the Health Benefit Exchanges. The Government's motion to dismiss is therefore DENIED, and Moda's cross-motion for partial summary judgment is GRANTED.

Background

Congress passed the ACA in 2010 in a dramatic overhaul of the nation's healthcare system. Central to the Act's infrastructure was a network of "Health Benefit Exchanges" ("Exchanges") on which insurers would offer Qualified Health Plans ("QHPs") to eligible purchasers. ACA §§ 1311, 1321, 42 U.S.C. §§ 18031, 18041 (2012). The ACA also drastically enlarged the pool of eligible insurance purchasers. It expanded Medicaid eligibility, ACA § 2001, and provided subsidies to low-income insurance purchasers, ACA §§ 1401, 1402; 42 C.F.R. § 155.305(f), (g). It also prohibited insurers from denying coverage or setting increased premiums based on a purchaser's medical history. ACA § 1201(2)(A); 42 U.S.C. §§ 300gg-1–300gg-5 (2012).

In short, the ACA created a tectonic shift in the insurance market. It gave insurers like Moda access to

a large new customer base, but insurers also had to comply with the ACA's rules if they wanted to offer QHPs on the Exchanges. To help insurers adjust to the Exchanges, Congress included three provisions in the ACA—commonly known as the "3Rs"—that reduced insurers' risk: reinsurance, risk corridors, and risk adjustment. *See* ACA §§ 1341-43. The second of these 3Rs, the risk corridors program, is the subject of this case.

A. Congress Creates the Risk Corridors Program

Section 1342 of the ACA sets out the risk corridors program. It reads as follows:

> (a) IN GENERAL.—The Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.
>
> (b) PAYMENT METHODOLOGY.—
>
> > (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
> >
> > > (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108

percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and

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

(2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—

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

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

> (c) DEFINITIONS.—In this section:
>
> (1) ALLOWABLE COSTS.—
>
> (A) IN GENERAL.—The amount of allowable costs of a plan for any year is an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan.
>
> (B) REDUCTION FOR RISK ADJUSTMENT AND REINSURANCE PAYMENTS.—Allowable costs shall [be] reduced by any risk adjustment and reinsurance payments received under section 1341 and 1343.
>
> (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.

ACA § 1342 (codified at 42 U.S.C. § 18062 (2012)). Congress did not specifically appropriate funds for the risk corridors program in the ACA.

B. HHS Implements the Risk Corridors Program

1. HHS Promulgates a Final Rule

To "establish and administer" the risk corridors program in accordance with Section 1342, the Department of Health and Human Services ("HHS") subsequently began its rulemaking process. After a notice and comment period, HHS published its final

rule on March 23, 2012. That rule states, in pertinent part:

> (a) General requirement. A QHP issuer must adhere to the requirements set by HHS in this subpart and in the annual HHS notice of benefit and payment parameters for the establishment and administration of a program of risk corridors for calendar years 2014, 2015, and 2016.
>
> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
>
> > (1) When a QHP's allowable costs for any benefit year are more than 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
> >
> > (2) When a QHP's allowable costs for any benefit year are more than 108 percent of the target amount, HHS will pay to the QHP issuer an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (c) Health insurance issuers' remittance of charges. QHP issuers must remit charges to HHS in the following amounts, under the following circumstances:

> (1) If a QHP's allowable costs for any benefit year are less than 97 percent but not less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to 50 percent of the difference between 97 percent of the target amount and the allowable costs; and
>
> (2) When a QHP's allowable costs for any benefit year are less than 92 percent of the target amount, the QHP issuer must remit charges to HHS in an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

Risk Corridors Establishment and Payment Methodology, 77 Fed. Reg. 17251 (Mar. 23, 2012) (codified at 45 C.F.R. § 153.510). In another rule it released that day, HHS added, "A QHP issuer must submit to HHS data on the premiums earned with respect to each QHP that the issuer offers in the manner and timeframe set forth in the annual HHS notice of benefit and payment parameters." Risk Corridors Data Requirements, 77 Fed. Reg. 17251 (Mar. 23, 2012) (codified at 45 C.F.R. § 153.530(a)).

In the same publication, HHS also released an impact analysis of its proposed rules in which it cited the findings of the Congressional Budget Office. As HHS noted, the CBO did not score the risk corridors program in its projections:

> CBO estimated program payments and receipts for reinsurance and risk

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

Impact Analysis, 77 Fed. Reg. 17,220, 17,244 (Mar. 23, 2012).

Furthermore, HHS did not set deadlines in its new rules by which HHS needed to pay insurers, but it indicated that it was considering setting such deadlines:

> We suggested, for example, that a QHP issuer required to make a risk corridors payment may be required to remit charges within 30 days of receiving notice from HHS, and that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers. We sought comment on these proposed payment deadlines in the preamble to the proposed rule.

Id. at 17,237.

2. CMS Promulgates an Additional Rule Governing the Schedule of the Risk Corridors Program

HHS had also delegated rulemaking authority for the risk corridors program to the Centers for Medicare and Medicaid Services ("CMS"), one of HHS's subsidiary agencies. *See* Delegation of Authorities, 76 Fed. Reg. 53,903-04 (Aug. 30, 2011). Pursuant to that authority, CMS on December 7, 2012 proposed adding language that would give the program an annual schedule. In its proposed rule's prefatory remarks, CMS noted that "[t]he temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016. In this proposed rule, we propose . . . an annual schedule for the program and standards for data submissions." HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,121 (Dec. 7, 2012). To that end, CMS proposed a deadline of "July 31 of the year following the applicable benefit year" by which insurers would submit charges to HHS under the risk corridors program. Risk Corridors Establishment and Payment Methodology, 77 Fed Reg. 73,164 (proposed Dec. 7, 2012).

CMS's final rule, issued March 11, 2013, made two changes in HHS's earlier regulations. First, the rule added the following subsection to 45 C.F.R. § 153.510: "(d) Charge submission deadline. A QHP issuer must remit charges to HHS within 30 days after notification of such charges." Risk Corridors Establishment and Payment Methodology, 78 Fed. Reg. 15,531 (Mar. 11, 2013). It also amended Section

153.530 by adding the following subsection: "(d) Timeframes. For each benefit year, a QHP issuer must submit all information required under this section by July 31 of the year following the benefit year." Risk Corridors Data Requirements, 78 Fed. Reg. 15,531 (Mar. 11, 2013).

On the same day it released its rule governing the schedule of the risk corridors program, CMS also addressed several comments it had received about a potential situation in which HHS's required "payments out" could exceed profitable insurers' "payments in" to the program. CMS responded, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the [ACA]." 78 Fed. Reg. at 15,473.

C. Moda Offers QHPs on the Exchanges, and HHS Announces the Transitional Policy

With the final risk corridors program rules in place, Moda submitted its QHPs and premium rates to state healthcare regulators in Alaska and Oregon. The state regulators approved the plans in July 2013. *See* App'x to Pl. Cross-Mot. ("Pl. App'x") at A7-22. As required by HHS regulations, Moda began selling QHPs to consumers on the Exchanges on October 1, 2013, with coverage effective January 1, 2014. See 45 C.F.R. § 155.410(b)-(c).

Shortly after Moda and other insurers began selling QHPs, it became apparent that some consumers' health insurance coverage would be terminated because it did not comply with the ACA.

To minimize the hardship that these large-scale health insurance terminations would cause, HHS announced a transitional policy in November 2013.[1] Under the transitional policy, health plans in the individual or small group market that were in effect on October 1, 2013 were "not . . . considered to be out of compliance with the [ACA's] market reforms" for the 2014 plan year. Transitional Policy Letter at 1-2. This change was significant because consumers with non-compliant healthcare plans now were not required to purchase insurance on the Exchanges from insurers like Moda. These consumers tended to be healthier, so excluding them from the exchanges left a sicker (and therefore, potentially more expensive) group of potential insurance buyers.[2] HHS acknowledged the transitional policy's impact on insurers in its announcement, stating, "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance."

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[1] *See* Ltr. From Gary Cohen, Dr., Ctr. For Consumer Info. and Ins. Oversight ("CCIIO"), to State Ins. Comm'rs (Nov. 14, 2013), https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter- 11-14-2013.pdf ("Transitional Policy Letter").

[2] *See, e.g.*, HHS 2015 Health Policy Standards Fact Sheet (Mar. 5, 2014) ("Because issuers' premium estimates did not take the transitional policy into account, the transitional policy could potentially lead to unanticipated higher average claims costs for issuers of plans that comply with the 2014 market rules."), https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2014-Fact-sheets-items/2014-03-05- 2.html.

Transitional Policy Letter at 3. HHS has renewed the transitional policy twice, and it will now extend through October 1, 2017.[3]

Although HHS cited the risk corridors program as an ameliorating force in the Transitional Policy Letter, it noted in further rulemaking on March 11, 2014—three months after the QHPs Moda had sold were in effect—that it "intend[ed] to implement this program in a budget neutral manner." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014). It elaborated:

> Our initial modeling suggests that th[e] adjustment for the transitional policy could increase the total risk corridors payment amount made by the Federal government and decrease risk corridors receipts, resulting in an increase in payments. However, we estimate that even with this change, the risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government.

Id. at 13,829.

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[3] *See* Gary Cohen, Dir., CCIIO, Insurance Standards Bulletin Series—Extension of Transitional Policy through October 1, 2016, CMS (Mar. 5, 2014), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/transition-to-compliant-policies-03-06-2015.pdf; Kevin Counihan, Dir., CCIIO, Insurance Standards Bulletin Series—INFORMATION—Extension of Transitional Policy through Calendar Year 2017, CMS (Feb. 29, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/final-transition-bulletin-2-29-16.pdf

In adopting budget neutrality as a goal for the risk corridors program, HHS reversed the statement it had made exactly one year earlier. *Compare* 79 Fed. Reg. at 13,787 *with* 78 Fed. Reg. at 15,473. Furthermore, the CBO apparently disagreed with HHS's budgetneutral interpretation. In February 2014—before HHS's first statement on budget neutrality—the CBO released a report that addressed the ACA's effects on the federal budget.[4] Addressing the risk corridors program, the CBO noted:

> By law, risk adjustment payments and reinsurance payments will be offset by collections from health insurance plans of equal magnitudes; those collections will be recorded as revenues. As a result, those payments and collections can have no net effect on the budget deficit. In contrast, risk corridor collections (which will be recorded as revenues) will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit. CBO projects that the government's risk corridor payments will be $8 billion over three years and that its collections will be $16 billion over that same period . . . .

CBO Report at 59. Thus, while the CBO believed the risk corridors program would result in a net gain of $8 billion for the Government, it specifically noted that

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[4] *See The Budget and Economic Outlook: 2014 to 2024* (Feb. 2014), https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf. ("CBO Report").

the program—unlike the risk adjustment and reinsurance programs—was not budget-neutral.

D. HHS Grapples with Budget Neutrality

HHS, like CBO, expected that "payments in" to the risk corridors program would equal or exceed "payments out" of the program. Still, HHS realized that implementing the program in a budget-neutral manner at least hypothetically might result in a shortfall in risk corridors payments to insurers. On April 11, 2014, it released a memorandum to address such a situation in the form of questions and answers.[5] HHS stated, in pertinent part:

> Q1: In [prior rulemaking], HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?
>
> A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the

[5] *See* HHS, Risk Corridors and Budget Neutrality (Apr. 11, 2014), https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf ("Risk Corridors Mem.").

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

* * *

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

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

* * *

> Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?
>
> A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

Risk Corridors Mem. at 1-2. Therefore, HHS acknowledged that it would make annual "payments out" to lossmaking QHP issuers, but it would reduce these payments pro rata if "payments in" did not equal its liability for "payments out."

HHS elaborated on its two-page memorandum in further notice and comment rulemaking on May 27, 2014. It acknowledged that it "intend[ed] to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually," despite several commenters' concerns that such an approach would violate the intent of Section 1342. Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014). Still, HHS recognized its obligation under the ACA to make full risk corridors payments:

> [W]e anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. That said, we appreciate that some commenters believe that there are uncertainties associated with rate setting,

> given their concerns that risk corridors collections may not be sufficient to fully fund risk corridors payments. In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

Id.

In sum, HHS decided in 2014 that it would administer the risk corridors program in a budget-neutral manner over the three-year life of the program. It considered a shortfall in "payments in" unlikely, and believed that "payments in" would balance "payments out" of the program. Importantly, it recognized that a shortfall in "payments in" would not vitiate its statutory duty to make full "payments out."

E. Congress Restricts Appropriations to the Risk Corridors Program

1. The GAO Opines on Risk Corridors Funding

On September 30, 2014, the Government Accountability Office ("GAO") responded to a request from Senator Jeff Sessions and Congressman Fred Upton. *See* GAO Op., Pl. App'x at A151. The two members of Congress had asked the GAO for an "opinion regarding the availability of appropriations" for risk corridors payments. *Id.* The GAO found that the CMS Program Management appropriation for fiscal year 2014 "would have been available" for risk

corridors payments. *Id.* at A154. It further found that the "payments in" from profitable insurers under Section 1342(b)(2) of the ACA were available for risk corridors payments because they were "properly characterized as user fees." *Id.* at A156. In other words, profitable QHP issuers who paid into the program were "paying for the certainty that any potential losses related to [their] participation in the Exchanges [were] limited to a certain amount." *Id.* The letter also noted that HHS itself had not identified the CMS Program Management appropriation as available for risk corridors payments, but that it had identified the "user fees" paid under Section 1342(b)(2). *Id.* The GAO concluded that HHS could continue to access user fees from "payments in" in future plan years. *Id.* In contrast, it stated that Congress would need to include similar appropriations language in future CMS Program Management appropriations to allow HHS to continue to access the CMS Program Management account for risk corridors payments. *Id.*

2. Congress Restricts Appropriations for Risk Corridors Payments in 2015 and 2016

In fiscal years 2015 and 2016, Congress made the CMS Program Management appropriation unavailable for risk corridors payments. On December 16, 2014, Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, for the 2015 fiscal year. In the HHS appropriation, the Act states:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust

> Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services-Program Management" account, may be used for payments under section 1342(b)(1) of [the ACA] (relating to risk corridors).

Id. at div. G, tit. II, § 227, 128 Stat. at 2491. The Chairman of the House Committee of Appropriations explained this provision as follows:

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

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

Congress included the exact same funding restriction in the Consolidated Appropriations Act, 2016, Pub. L. No. 114-113 at div. H, tit. II, § 225, 129 Stat. 2242, 2624. The 2016 Act also included a further funding provision related to risk corridors:

> In addition to the amounts otherwise available for "Centers for Medicare and Medicaid Services, Program Management", the Secretary of Health and Human Services may transfer up to $305,000,000 to such account from the Federal Hospital Insurance Trust Fund and the Federal Supplementary

> Medical Insurance Trust Fund to support program management activity related to the Medicare program: *Provided*, That except for the foregoing purpose, such funds may not be used to support any provision of [the ACA] or Public Law 111-152 (or any amendment made by either such Public Law) or to supplant any other amounts within such account.

Id. at div. H, tit. II, § 226, 129 Stat. at 2625. To explain this language, the Senate Committee on Appropriations noted in a June 25, 2015 report that "[t]he Committee continues bill language requiring the administration to operate the Risk Corridor program in a budget neutral manner by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program." S. Rep. No. 114-74, at 12.

F. HHS Pays Insurers a Fraction of Their Risk Corridors Claims

On October 1, 2015, HHS announced that it owed insurers $2.87 billion in Risk Corridors payments for the 2014 plan year.[6] Insurers' "payments in" under Section 1342(b)(2), however, were only $362 million. 2014 Proration Notice at 1. HHS therefore adopted the pro rata payment methodology it had announced in April 2014, which meant that it would only pay insurers 12.6 percent of the amounts they were owed. *Id.* HHS owed Moda $1,686,016 in Alaska risk

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[6] *See* CMS, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf ("2014 Proration Notice").

corridors payments, and $87,740,414.38 in Oregon risk corridors payments. With the proration, HHS paid Moda $212,739 for Alaska and $11,070,968 for Oregon. *See* Decl. of James Francesconi ¶ 20, Pl. App'x at A4.

HHS explained its proration policy to Robert Gootee, president and CEO of Moda, in a letter dated October 8, 2015. *See* Pl. App'x at A101-02. In the letter, the HHS representative noted:

> I wish to reiterate to you that [HHS] recognizes that the [ACA] requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States Government for which full payment is required.

Id. at A102.

On September 9, 2016, HHS announced that it would not make any payments toward its 2015 risk corridors obligations, and would instead use all money it received from profitable plans in 2015 to offset its obligations for the 2014 plan year.[7] For the 2015 plan year, Moda submitted documentation showing that HHS owed it $136,253,654 in risk corridors payments ($31,531,143 for Alaska, $93,362,051 for Oregon, and $11,360,460 for Washington). Decl. of James Francesconi ¶ 21, Pl. App'x at A4. In its 2015

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[7] *See* CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016), https://www.cms.gov/CCIIO/Programsand- Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.pdf ("2015 Payment Notice").

announcement, CMS once again noted that it recognized its liability to insurers for the full amount of its risk corridors obligations. 2015 Payment Notice at 1. To date, HHS has made no further payments to Moda under the risk corridors program. Moda claims it is owed $214,396,377 for the 2014 and 2015 plan years. Decl. of James Francesconi ¶ 22, Pl. App'x at A4.

It is important to note that the Government now disagrees with the statements HHS has made throughout the risk corridors program's implementation. HHS has repeatedly recognized its obligation to pay insurers the full amount of their owed risk corridors payments. At oral argument, however, the Government stated that HHS has no obligation to pay Moda the full amount it is owed if Congress fails to appropriate additional funds for the program. *See* Oral Arg. Tr. 25:6-12, Dkt. No. 22 (Jan. 13, 2017). In other words, the Government contends not merely that HHS had the authority to decide to administer the risk corridors program in a budget-neutral manner over the three-year life of the program, but that the program itself was budget-neutral from the beginning (or at least, that it became budget-neutral later).

G. Procedural History

Moda filed its complaint on June 1, 2016, seeking damages equal to the difference between the amount it received in risk corridors payments for 2014 and 2015 and the amount it should have received under Section 1342. *See* Compl. at 34, Dkt. No. 1. Moda's complaint asserts causes of action under the ACA and under an implied-in-fact contract theory. The

Government moved to dismiss pursuant to RCFC 12(b)(1) and 12(b)(6) on September 30, 2016. *See* Mot. to Dismiss, Dkt. No. 8. It argues first that this Court has no subject matter jurisdiction because (1) Moda's claims are not for "presently due" money damages, and (2) Moda's claims are not ripe. It further argues that Moda's claims do not state a claim upon which relief may be granted because (1) the ACA does not require HHS to make risk corridors payments in excess of amounts collected from profitable plans; (2) in the alternative, Congress permissibly made the risk corridors program budget-neutral through its subsequent appropriations riders; and (3) no contract existed between Moda and the Government.

In response to the Government's motion, Moda cross-moved for partial summary judgment as to the Government's liability. *See* Cross Mot., Dkt. No. 9 (filed Oct. 25, 2016). Before the Government could respond, Judge Charles Lettow of this Court issued a decision in a related case: *Land of Lincoln Mutual Health Insurance Co. v. United States*, 129 Fed. Cl. 81 (2016), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016). Judge Lettow's decision addressed all of the issues in this case and found in the Government's favor on the merits. The Government subsequently filed a motion to stay this case pending the outcome of the plaintiff's appeal in *Land of Lincoln*, and this Court denied the motion. *See* Order, Dkt. No. 12 (filed Nov. 28, 2016).

After the parties completed their briefing on the cross-motions, Judge Margaret Sweeney of this Court issued a decision in another related case: *Health Republic Insurance Co. v. United States*,—Fed. Cl.—,

2017 WL 83818 (2017). In *Health Republic*, the Government had moved to dismiss solely under RCFC 12(b)(1). *See id.* at *1. Judge Sweeney held that the Court had subject matter jurisdiction over Health Republic's claims, *see id.* at *10-12, and that those claims were ripe because the Government owed insurers annual payments under Section 1342, *see id.* at *12-18. Though the parties here could not address the *Health Republic* decision in their briefs, they had the opportunity to do so at oral argument on January 13, 2017. Several other insurers have filed similar suits against the Government in this Court, but *Health Republic* remains the most recent risk corridors decision.

DISCUSSION

A. The Court Has Subject-Matter Jurisdiction Over Moda's Claims

1. Standard of Review

When a defendant moves to dismiss a complaint under RCFC 12(b)(1), the Court must "assume all factual allegations to be true and . . . draw all reasonable inferences in plaintiff's favor." *Wurst v. United States*, 111 Fed. Cl. 683, 685 (2013) (quoting *Henke v. United States*, 60 F.3d 795, 797 (Fed. Cir. 1995)). Still, the plaintiff must support its jurisdictional allegations with "competent proof." *McNutt v. Gen. Motors Acceptance Corp. of Indiana*, 298 U.S. 178, 189 (1936). Accordingly, a plaintiff must establish that jurisdiction exists "by a preponderance of the evidence." *Wurst*, 111 Fed. Cl. at 685 (citing *Reynolds v. Army & Air Force Exch. Serv.*, 846 F.2d 746, 748 (Fed. Cir. 1988)).

2. The Court Has Subject-Matter Jurisdiction Over Moda's Statutory and Contractual Claims

As sovereign, the United States is immune from suit unless it consents to be sued. *United States v. Sherwood*, 312 U.S. 584, 586 (1941). The Tucker Act, 28 U.S.C. § 1491(a)(1) (2012), waives sovereign immunity for claims predicated on the Constitution, a federal statute or regulation, or a contract with the Government. Still, the Tucker Act does not create a separate right to money damages, so a plaintiff suing the Government for money damages must base its claims upon a separate source of law that does create such a right. *See United States v. Testan*, 424 U.S. 392, 398 (1976). Here, Moda first predicates its claims on Section 1342 of the ACA and its implementing regulations. In the alternative, it claims damages for the breach of an implied-in-fact contract with the United States.

Where a plaintiff bases its claims on a statutory or regulatory provision, courts generally find that the provision is money-mandating if it provides that the Government "shall" pay an amount of money. *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007). On their face, Section 1342 of the ACA and its implementing regulation, 45 C.F.R. § 153.510, require the Government to pay money to Moda and other similarly situated insurers. Section 1342 states that the Secretary of HHS "shall pay" specific amounts to insurers that offer QHPs, and the regulation states that "QHP issuers will receive payment from HHS." 45 C.F.R. § 153.510(b). Thus, these provisions are

clearly money-mandating, and the Court has subject-matter jurisdiction over Moda's statutory claim.

Where a plaintiff claims that the Government has breached an implied-in-fact contract, it need only make a "non-frivolous *allegation* of a contract with the government." *Mendez v. United States*, 121 Fed. Cl. 370, 378 (2015) (quoting *Engage Learning, Inc. v. Salazar*, 660 F.3d 1346, 1353 (Fed. Cir. 2011)) (emphasis in original). To show jurisdiction, a plaintiff must therefore plead the elements of a contract with the Government: "(1) mutuality of intent to contract; (2) consideration; (3) an unambiguous offer and acceptance; and (4) actual authority on the part of the government's representative to bind the government." *Fisher v. United States*, 128 Fed. Cl. 780, 785 (2016) (quoting *Biltmore Forest Broad. FM, Inc. v. United States*, 555 F.3d 1375, 1380 (Fed. Cir. 2009) (citation omitted)).

Here, Moda alleges that the Government showed mutuality of intent to contract by establishing the risk corridors program, which offers monetary payments to insurers if they offer QHPs on the Exchanges. Moda further alleges that the parties exchanged consideration: Moda agreed to offer QHPs on the exchanges pursuant to HHS requirements in exchange for the Government's promise to make risk corridors payments if Moda's QHPs turned out to be unprofitable. Under Moda's theory, HHS extended an offer for a unilateral contract that insurers could accept by offering QHPs on the exchanges, and Moda accepted this offer when it began offering QHPs. Moda further alleges that the Secretary of HHS has the authority to bind the Government. Finally, Moda

alleges that the Government breached its contract with Moda by paying it less than Moda is owed under the terms of the contract. At the jurisdictional stage, these non-frivolous allegations are all that is required. Therefore, the Court also has subject-matter jurisdiction over Moda's contract claim. *Accord Land of Lincoln*, 129 Fed. Cl. at 98-99.

The Government does not dispute that both of Moda's claims could conceivably create a right to money damages. Instead, the Government argues that any money the Government is required to pay Moda is not "presently due" because it is not due until the end of 2017. It claims that this "presently due" requirement bars the Court's jurisdiction over both of Moda's claims. *See* Mot. to Dismiss at 15-19. However, the Court finds Health Republic persuasive on this point. *See* 2017 WL 83818 at *11-12. The *Health Republic* court correctly construed the Government's "presently due" argument as a ripeness argument in disguise. *Id.* at *12. The cases from which the Government draws the requirement go to whether equitable relief would be necessary before a court could award the plaintiff monetary relief. *See id.* at *11 (distinguishing the Government's cases). In such a situation, monetary damages are not "presently due" because their availability depends on prior equitable relief, so the plaintiff has not alleged a claim under a money-mandating source of law. *See Todd v. United States*, 386 F.3d 1091, 1093-94.

Obviously, the situation is quite different in this case. Here, the statutory and regulatory provisions Moda cites either require immediate monetary damages or they do not—no equitable relief is

involved. The same is true of Moda's contract claims. Therefore, in rejecting the Government's "presently due" requirement, the Court merely finds, as a threshold matter, that it has subject-matter jurisdiction over Moda's statutory and contractual claims pursuant to the Tucker Act. Whether those claims are ripe is a separate question that deserves a more in-depth treatment.

B. Moda's Claims are Ripe

Even where a court has subject-matter jurisdiction over a plaintiff's claims, it cannot adjudicate those claims if they are not ripe for judicial review. *Health Republic*, 2017 WL 83818 at *12. Though Article III courts developed the ripeness doctrine, its principles are equally applicable in this Article I Court. *See CW Gov't Travel, Inc. v. United States*, 46 Fed. Cl. 554, 557-58 (2000). "Ripeness is a justiciability doctrine that prevents the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements." *Shinnecock Indian Nation v. United States*, 782 F.3d 1345, 1348 (Fed. Cir. 2015) (citations and internal punctuation omitted). Therefore, "[a] court should dismiss a case for lack of ripeness when the case is abstract or hypothetical . . . . A case is generally ripe if any remaining questions are purely legal ones; conversely, a case is not ripe if further factual development is required." *Rothe Dev. Corp. v. Dep't of Def.*, 413 F.3d 1327, 1335 (Fed. Cir. 2005).

The Government argues that Section 1342 of the ACA does not set a risk corridors payment schedule. It follows that HHS has no responsibility to make annual risk corridors payments, but may exercise its

discretion to decide when it will make payments over the three-year span of the program. The last plan year in the program—2016—just ended, and insurers are not required to submit claims for their 2016 plan years until mid-2017. Therefore, the Government argues, HHS has until the end of 2017 to pay Moda the full amount of its owed risk corridors payments, and Moda's claims are not yet ripe because payment is not yet due.[8]

The *Health Republic* court dealt exhaustively with the Government's arguments in its comprehensive opinion. It found (1) that Section 1342 and its legislative history require annual risk corridors payments, and (2) in the alternative, that HHS also has interpreted Section 1342 to require annual payments. *See Health Republic*, 2017 WL 83818 at *12-18. Therefore, the insurer's claims were ripe for adjudication because two annual payments were due (for the 2014 and 2015 plan years). *Id.* at *18. This Court concurs in full with the *Health Republic* court's analysis, so there is no need to reinvent a perfectly good wheel. Still, for the sake of clarity, the Court will summarize that analysis here.

1. Section 1342 Requires Annual Risk Corridors Payments

The *Health Republic* court first turned to Section 1342 itself. *See id.* at *13-14. That Section does not set a specific payment schedule for the risk corridors

[8] The Court notes, parenthetically, that this ripeness argument is at odds with the Government's argument on the merits of the case. In its ripeness argument, the Government argues that full payment is not due until the end of 2017. In its merits argument, it argues that full payment may never be due.

program. Still, Section 1342 does offer clues as to Congress's intent. It directs the Secretary of HHS to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," rather than a program for "calendar years 2014 through 2016." *Id.*; 18 U.S.C. § 18062(a). HHS also must calculate "payments in" and "payments out" of the program on the basis of insurers' costs in "any plan year," not over the life of the program. 18 U.S.C. § 18062(b)(1), (b)(2), (c)(1), (c)(2). These two references to distinct years in Section 1342, while not dispositive, tend to suggest that Congress wanted HHS to make annual payments. *Health Republic*, 2017 WL 83818 at *14.

Next, the *Health Republic* court noted that Section 1342 explicitly based the risk corridors program on the Medicare Part D program. *See id.* at *14; 18 U.S.C. § 18062(a). The statute that created the Medicare Part D program requires the Secretary of HHS to establish a risk corridor "[f]or each plan year," and sets out the requirements that govern each "risk corridor for a plan for a year." 42 U.S.C. § 1395w-115(e)(3)(A). In that statute's implementing regulations, HHS clearly sets out an annual payment schedule for the Medicare Part D risk corridors, and HHS in fact follows an annual payment schedule. *See* 42 C.F.R. § 423.336(c); *Health Republic*, 2017 WL 83818 at *14. As the *Land of Lincoln* court noted, the Medicare Part D statute and Section 1342 are worded differently, so the fact that Section 1342 is "based on" Medicare Part D does not necessarily mean that Section 1342 adopted Medicare Part D's annual payment structure. *See Land of Lincoln*, 129 Fed. Cl. at 105-06. Still, though the two statutes are worded differently, the differences do not mean Section 1342

rejected an annual payment structure. Indeed, one possible reading of Section 1342 is that the statute incorporates Medicare Part D's annual payment structure by reference. *See, e.g., Lorillard v. Pons*, 434 U.S. 575, 581 (1978) ("[W]here . . . Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the interpretation given to the incorporated law, at least insofar as it affects the new statute."). Therefore, although Congress's reference to Medicare Part D is not dispositive, it at least tends to show that Congress "approved" of annual risk corridors payments. *Health Republic*, 2017 WL 83818 at *14.

Finally, the *Health Republic* court analyzed the function of the risk corridors program. *Id.* at *15. The program is part of the 3Rs trifecta: reinsurance, risk adjustment, and risk corridors. All three of these programs reflect "a concern that insurers' costs would detrimentally exceed the premiums collected." *Id.* (describing each of the three programs). The risk corridors program specifically helps avoid this problem by cushioning the initial financial blow to insurers who "underestimated their allowable costs and accordingly set their premiums too low." *Id.* As such, Congress was aware that if the 3Rs "did not provide for prompt compensation to insurers upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges." *Id.* This incentive alone indicates that a three-year payment framework is unlikely, given that courts generally do not "interpret federal statutes to negate their own stated purposes." *N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973); *see also*

King v. Burwell, 135 S. Ct. 2480, 2496 (2015) ("Congress passed the [ACA] to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."). Furthermore, an insurer's risk corridors payment for a plan year is reduced if the insurer receives payments under the risk-adjustment or reinsurance programs for the same year. *See* 42 U.S.C. § 18062(c)(1)(B). Therefore, the function and structure of the risk corridors program as part of the ACA's 3Rs suggest that Congress envisioned annual risk corridors payments.

In sum, this Court concurs with the Health Republic court in finding that the above factors—the text of Section 1342, its reference to the Medicare Part D program, and the Section's function—together mean that Congress required HHS to make annual risk corridors payments.[9] Thus, Moda's injury is not abstract or hypothetical because the annual payment deadlines for the 2014 and 2015 plan years have passed, and Moda's claims are ripe.

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[9] Even were the Court to accord less weight to these factors, this result would be reasonable because courts read statutes to preserve common law principles. *See United States v. Texas*, 507 U.S. 529, 534 (1993). Under the common law, a statute that does not set a specific payment timetable nevertheless requires parties to make payments within a reasonable period of time. *See Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013); *Goodman v. Praxair, Inc.*, 494 F.3d 458, 465 (4th Cir. 2007). Insurers offer their QHPs on a yearly schedule, so yearly payments are reasonable.

2. HHS Also Interprets Section 1342 to Require Annual Risk Corridors Payments

Even if Section 1342 were ambiguous as to the risk corridors payment schedule, HHS's interpretation of the program shows that annual payments are required. Courts defer to an agency's interpretation of ambiguous provisions in a governing statute if that interpretation is reasonable. *Chevron U.S.A., Inc. v. Nat'l Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). This standard applies "if Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) (quoting *United States v. Mead Corp.*, 533 U.S. 218, 229 (2001)). Finally, courts "must give substantial deference to an agency's interpretation of its own regulations." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (citation omitted).

In Section 1342, Congress delegated to the Secretary of HHS the authority to "establish and administer a program of risk corridors." 42 U.S.C. § 18062(a). So, as *Health Republic* noted, if Section 1342 is ambiguous as to the risk corridors payment schedule, its delegation of authority to HHS unquestionably gave HHS the power to create that schedule. *See* 2017 WL 83818 at *16. Under its statutory grant of authority, HHS promulgated final regulations that govern the risk corridors program.

Those rules also are ambiguous as to the program's payment schedule, so the Court therefore must analyze and give deference to HHS's interpretation of its own rules.

Before going on, a clarification is necessary. There are two similar but conceptually distinct questions in this case: (1) whether *annual* payments are required, and (2) whether *full* annual payments are required. The former is a ripeness question, and the latter goes to the merits of this case. There has been considerable confusion on this distinction. The payment schedule alone—*i.e.*, whether *annual* payments are required—is relevant to the Court's ripeness analysis because it alone determines whether Moda's injury is fixed or hypothetical. If annual payments are not required, then payment for the entire risk corridors program would only be due at the end of the program—*i.e.*, sometime in 2017. In that case, it would not matter whether the risk corridors program were budget-neutral; Moda's claims would not be ripe because the Government could conceivably still pay Moda for the 2014 and 2015 plan years. In other words, its injury would be hypothetical. If, as the Court finds, annual payments *are* required, then the case is ripe (regardless of whether full payment was required every year) because the 2014 and 2015 payment deadlines have passed. In the latter case, Moda's damages, if any, for each of the two years are fixed, and any further payments HHS makes to Moda for those years would merely mitigate those damages.[10]

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[10] This point is easily overlooked. For example, *Land of Lincoln* analyzed the risk corridors payment schedule as a merits issue, reasoning that "[t]he government's argument addresses the

The Government argues that HHS's interpretation "established a three-year payment framework . . . with final payment not due until the final payment cycle in 2017." *See* Mot. to Dismiss at 17. This argument conflates the merits question with the ripeness question. It is true HHS stated repeatedly that it "intend[ed] to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually." 79 Fed. Reg. at 30,260. In this and similar statements, however, HHS merely announced that it intended to pay out only what it took in from profitable QHPs over the program's three years. In other words, HHS announced that it would not make *full* annual payments. This statement goes to the required quantum of HHS's annual payments—a merits issue the Court analyzes below—but it is, at most, ambiguous as to HHS's actual payment schedule.

So, the Court turns to HHS's interpretation of its payment schedule under its promulgated regulations. To that end, it is significant that HHS (through CMS) indicated repeatedly that it would make payments every year. *See* 77 Fed. Reg. at 17,237 (Mar. 23, 2012) ("QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers."); 77 Fed. Reg. 73,121 (Dec. 7, 2012) ("[W]e propose . . . an annual schedule for the program and standards for data submissions."); Risk Corridors Mem. at 1 ("[I]f risk

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merits of whether and when [Plaintiff] is entitled to recover money under the statute. . . ." 129 Fed. Cl. at 98. For ripeness purposes, separating the "when" from the "whether" is a necessary step.

corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall."). Furthermore, HHS in fact calculated payments on an annual basis. For the 2014 plan year, HHS actually paid insurers, albeit in prorated amounts. HHS did not make payments for the 2015 plan year, but its notice to insurers shows that it calculated the amount it owed insurers for that plan year and recognized its obligation to pay that amount. *See* 2015 Payment Notice. Importantly, none of HHS's pronouncements or actions indicate that it believed it could "choose not to make annual risk corridors payments to insurers" if it had the funds to make payments. *Health Republic*, 2017 WL 83818 at *16. Instead, HHS followed a rigid annual schedule in practice as well as in interpretation. In sum, the Court finds that HHS interpreted Section 1342 and its own regulations as requiring annual risk corridors payments to insurers.

Both Section 1342 and HHS's interpretation of Section 1342 require annual payments to insurers. Moda's injury is "not abstract or hypothetical, and resolution of the issues in this case "does not rest upon contingent events." *Id.* As a result, the Court can quite easily determine whether or not full risk corridors payments were required for the 2014 and 2015 plan years. Moda's claims are therefore ripe for adjudication.

C. Moda is Entitled to Partial Summary Judgment on the Issue of Liability

The parties have filed cross-motions that address the merits of this case. First, the Government has

moved to dismiss this case under RCFC 12(b)(6) for failure to state a claim upon which relief may be granted. Under that Rule, a court should dismiss a plaintiff's claims "when the facts asserted by the [plaintiff] do not entitle [it] to a legal remedy." *Lindsay v. United States*, 295 F.3d 1252, 1257 (Fed. Cir. 2002). The Court also must construe allegations in the complaint favorably to the plaintiff. *See Extreme Coatings, Inc. v. United States*, 109 Fed. Cl. 450, 453 (2013). Still, "a complaint must contain sufficient factual matter, accepted as true, to state a claim to relief that is plausible on its face." *Id.* (quoting *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted)).

Moda has cross-moved for partial summary judgment on the issue of liability. A party is entitled to summary judgment under RCFC 56(a) if the party can show "that there is no genuine dispute as to any material fact and the [party] is entitled to judgment as a matter of law." A court may dispose of statutory interpretation issues and "other matters of law" on a motion for summary judgment. *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002). The cross motions essentially debate two legal questions: (1) whether Section 1342 requires full annual payments to insurers, and (2) whether HHS entered into and breached a contract with Moda. The Court will address each issue in turn.

1. Section 1342 Requires Full Annual Payments to Insurers

The Court already has found that HHS was required to make annual risk corridors payments, but determining the amount HHS owed Moda in each

annual payment is a merits issue that requires further analysis. Moda argues that the formula set out in Section 1342 itself requires full annual payments. The Government responds with two main arguments. First, it maintains that Congress designed the risk corridors program to be budget-neutral from the beginning. This interpretation would mean that "payments out" of the program to unprofitable insurers would be entirely contingent on the amount of "payments in" to the program from profitable insurers. Second, the Government argues that Congress subsequently affirmed its intent to make the program budget-neutral by limiting the program's funding in appropriations riders—or, alternatively, that these appropriations riders amended the program to make it budget-neutral.

a. Congress did not Design Section 1342 to be Budget-Neutral

The Court finds that Section 1342 is not budget-neutral on its face. The Section states that the Secretary of HHS "shall pay" specific amounts of money to insurance plans. *See* 42 U.S.C. § 18062(b)(1). The amount of money the Secretary must pay is tied to each respective plan's ratio of costs to premiums collected, and the Section gives the Secretary no discretion to increase or reduce this amount. *Id.*; § 18062(c). It is true that Section 1342(a) gives the Secretary the authority to "establish and administer" the risk corridors program, but the later directive that the Secretary "shall pay" unprofitable plans these specific amounts of money is unambiguous and overrides any discretion the Secretary otherwise could have in making "payments out" under the program.

Finally, there is no language of any kind in Section 1342 that makes "payments out" of the risk corridors program contingent on "payments in" to the program. Instead, Section 1342 simply directs the Secretary of HHS to make full "payments out." Therefore, full payments out he must make.

To avoid this obvious conclusion, the Government first points to the preexisting risk corridors program under Medicare Part D. That program's authorizing statute provides, "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." 42 U.S.C. § 1395w-115(a). Still, while including such language in Section 1342 may have shortened this opinion considerably, excluding it does not make a statute budget-neutral. In fact, other differences between the two statutes suggest that this was not Congress's intent. For example, the Medicare Part D statute provides only that the Government "shall establish a risk corridor," not that the Secretary of HHS "shall pay" specific amounts to insurers. The stronger payment language in Section 1342 obligates the Secretary to make payments and removes his discretion, so a further payment directive to the Secretary is unnecessary.

The Government next notes that the CBO did not score the risk corridors program when assessing the financial impact of that program, and argues that this lack of scoring means that Congress believed the program would be budget-neutral when it passed the ACA. *See, e.g., Land of Lincoln*, 129 Fed. Cl. at 104 (noting that Congress "explicitly relied on the CBO's

findings" when it enacted the ACA). However, the Court believes the CBO's failure to speak on Section 1342's budgetary impact was simply a failure to speak. After all, the CBO did score the reinsurance and risk-adjustment programs, both of which are explicitly required to be budget-neutral under their governing regulations.[11] Therefore, one would assume that it would not be particularly difficult for the CBO to simply score the risk corridors program alongside its budget-neutral sister programs if it expected the program to be budget-neutral. Instead, the CBO initially kept silent on the risk corridors program's budgetary impact.

Furthermore, the only time the CBO expressly addressed Section 1342's budgetary impact occurred after Congress had passed the ACA. At that time, the CBO baldly stated that "risk corridor collections (which will be recorded as revenues) will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit." CBO Report at 59. In sum, the CBO's initial failure to score the risk corridors program despite scoring other budget-neutral programs, together with its later

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[11] *See* 45 C.F.R. § 153.230(d) (requiring the reinsurance program to be budget-neutral); 78 Fed. Reg. at 15,441 (describing the risk-adjustment program as budget-neutral). Note that HHS regulations require these two programs to be budget-neutral, not their governing statutes. A key difference between the risk corridors program and its two sister programs is that nothing in the other programs' governing statutes requires the Secretary of HHS to pay insurers specific amounts. *See* 42 U.S.C. §§ 18061, 18063. So, it is fair to say that Congress gave HHS discretion to determine whether the risk-adjustment and reinsurance programs would be budget-neutral.

statement, suggests that the CBO may never have believed the risk corridors program to be budget-neutral.

Second, the Government argues that Congress did not appropriate additional funds to the risk corridors program specifically, so "payments in" to the program must always have been the only source of such funds available for risk corridors payments. It cites the September 30, 2014 GAO Opinion, which notes that "Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1)." Pl. App'x at A153. However, if one continues reading the GAO opinion, the GAO actually found two sources of funding for risk corridors payments: the 2014 CMS Program Management appropriation and "payments in" from profitable plans (which it characterized as "user fees"). *Id.* at A157.[12] The fiscal year 2014 CMS Program Management appropriation was $3.6 billion—more than enough to cover HHS's 2014 risk corridors obligations to Moda. *See* Consolidated Appropriations Act, 2014, Pub. L. No. 113-76 div. H, tit. II, 128 Stat. 5, 374 (2014). HHS chose not to use the Program Management appropriation for 2014 risk corridors payments, but that appropriation was available for such payments.

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[12] The Government implausibly argues that only "user fees" were available for risk corridors payments because HHS only began making payments during fiscal year 2015. *See* Def. Reply Br. at 16-17, Dkt. No. 14 (filed Dec. 9, 2016). The GAO's opinion flatly contradicts this argument. It finds that the 2014 CMS Program Management Appropriation "would have been available" for 2014 risk corridors payments. Pl. App'x at A157. The fact that HHS decided not to use the appropriation for that purpose is immaterial.

Therefore, Congress did not restrict the funding for the risk corridors program to the "payments in" under the program.

Finally, though the Court finds the unambiguous language of Section 1342 dispositive, it is worth noting that HHS itself did not believe the risk corridors program to be budget-neutral from the beginning. The *Land of Lincoln* court appeared to be under the opposite impression. In other words, the court believed HHS's view to be that HHS would never owe money to lossmaking insurers beyond the amount of "payments in" from profitable insurers. *See Land of Lincoln*, 129 Fed. Cl. at 106-07. The court even gave *Chevron* deference to HHS's supposed view. *Id.* This analysis is puzzling. In *Land of Lincoln* and in this case, the Government has only ever argued that Chevron deference is appropriate when considering HHS's three-year payment framework (a ripeness issue). *See Land of Lincoln* Oral Arg. Tr., App'x to Pl. Reply Br. at A175, Dkt. No. 18-1 (filed Dec. 22, 2016) ("We are asking for deference to the three-year program as it relates to when payments are due on the statute. [W]here we say that the statute doesn't require payments beyond collections, we are not asking for deference on that. I don't think that's an appropriate question for deference."); *see also* Def. Reply Br. at 12 n.7 (noting, in a footnote, that the Court "alternatively" could follow *Land of Lincoln*'s approach). The Government does not seriously argue that deference is appropriate on the merits issue of HHS's required payment amounts. Indeed, the gravamen of the Government's argument is that *Congress* intended Section 1342 to be budget-neutral, not that HHS understood the statute to be budget-

neutral. *See* Def. Reply Br. at 12 ("Count I Fails to State a Claim Because Congress Intended That Risk Corridors Payments Be Limited to Collections.").

It is easy to see why the Government has not argued that HHS's interpretation of its payment obligations deserves deference: it would undermine the Government's position. HHS has consistently recognized that Section 1342 is not budget-neutral. As it formulated its regulations, HHS even stated, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the [ACA]." 78 Fed. Reg. at 15,473. Though it later changed course and averred that it "intend[ed] to implement this program in a budget neutral manner," *see* 79 Fed. Reg. 13,787, its later statements show that it clearly recognized an obligation to provide full risk corridors payments to insurers at some point. *See* 79 Fed. Reg. at 30,260 (May 27, 2014) ("HHS recognizes that the [ACA] requires the Secretary to make full payments to issuers. . . . HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); Robert G. Gootee, Ltr., Pl. App'x at A102 (Oct. 8, 2015) (" [HHS] recognizes that the [ACA] requires the Secretary to make full payments to issuers, and . . . HHS is recording those amounts that remain unpaid . . . as fiscal year 2015 obligations of the United States Government for which full payment is required"); 2015 Payment Notice at 1 (Sept. 9, 2016) ("HHS recognizes that the [ACA] requires the Secretary to make full payments to issuers."). Indeed, HHS has put off answering questions as to what it plans to do if "payments in" for 2016 do not cover its

full outstanding obligations to insurers—a situation that, barring a miracle, seems certain to occur. *See* 2015 Payment Notice at 1 ("[I]n the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments."). To be sure, HHS has not been able to pay insurers because it does not have the funds to do so. Still, it has never conflated its inability to pay with the lack of an obligation to pay.

To summarize, the Court finds that Congress did not initially make Section 1342 budget-neutral. Therefore, Section 1342 only could have become budget-neutral through later repeal or amendment.

b. Later Appropriations Riders did not Vitiate HHS's Statutory Duty to Make Risk Corridors Payments

The Government argues that even if funds were initially available for risk corridors payments, Congress's subsequent appropriations riders restricted these funds' availability and made Section 1342 budget-neutral.[13] As noted above, the GAO

[13] The Court notes parenthetically that, under the GAO's logic, certain CMS Program Management appropriation funds probably were available for 2015 risk corridors payments. Congress passed three continuing resolutions in the first two-and-a-half months of fiscal year 2015. *See* Continuing Appropriations Resolution, 2015, Pub. L. 113-164, § 101(a)(8), 128 Stat. 1867, 1867 (2014); Joint Resolution, Pub. L. 113-202, 128 Stat. 2069 (2014); Joint Resolution, Pub. L. 113-203, 128

informed Congress in 2014 that two sources of funding existed for risk corridors payments: "payments in" to the program and the 2014 CMS Program Management appropriation. Congress passed appropriations riders for the fiscal years 2015 and 2016 that placed the CMS Program Management appropriation off-limits for risk corridors payments. In both years, the text of the restriction was as follows:

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

Stat. 2070 (2014). The previously-enacted 2014 appropriations statute had provided $3.6 billion to the CMS Program Management account, and the continuing resolutions continued funding this account "at a rate of operations as provided in the applicable appropriations acts for fiscal year 2014," with a small decrease of about 0.6 percent. 128 Stat. at 1867-68. Therefore, the resolutions allocated roughly $750 million of unrestricted appropriations to the CMS Program Management account for the first two-and-a-half months of fiscal year 2015. Though Congress later restricted the use of the CMS Program Management appropriation, the GAO's logic means that this $750 million likely was available for 2015 risk corridors payments. The fact that this sum would not have been enough to satisfy other insurers' risk corridors claims is immaterial for the purposes of this case. *See Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2189-90 (2012).

128 Stat. at 2491; 129 Stat. at 2624. As noted above, the 2016 Act had another funding restriction:

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

Id. at 2625.

The Government argues that these funding limitations either show that Congress initially meant for the risk corridors program to be budget-neutral or that they constitute a later amendment that made the program budget-neutral. The Court already has found that Section 1342 was not initially budget-neutral.[14] Therefore, the remaining question is whether

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[14] Furthermore, given the vagaries of the political system, it would be illogical to divine the intent of a former Congress from the actions of a later one. *See, e.g., United States v. United Mine Workers of Am.*, 330 U.S. 258, 281-82 (1947) ("We fail to see how the remarks of these Senators in 1943 can serve to change the legislative intent of Congress expressed in 1932."). If anything, this is even more true in the context of the ACA, which has been the subject of a highly public political battle since its inception.

Congress's later appropriations riders made it budget-neutral.

Generally, a funding restriction in an appropriations law does not amend or repeal a substantive law that imposes payment obligations on the Government. *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 749 (Ct. Cl. 1966). Further, "[r]epeals by implication are not favored." *United States v. Langston*, 118 U.S. 389, 393 (1886). Courts have applied this approach for practical reasons. Repealing an obligation of the United States is a serious matter, and burying a repeal in a standard appropriations bill would provide clever legislators with an end-run around the substantive debates that a repeal might precipitate. *See Gibney v. United States*, 114 Ct. Cl. 38, 51 (1949). So, "the uniform rule was that if [the restriction] were simply a withholding of funds and not a legislative provision under the guise of a withholding of funds[,] it had no effect whatever on the legal obligation." *Id.*

Therefore, for an appropriations law to affect the underlying legal obligation, "[t]he intent of Congress to effect a change in the substantive law via provision in an appropriation act must be clearly manifest." *N.Y. Airways*, 369 F.2d at 749. In general, to determine whether Congressional intent was clearly manifest, courts look first to the language of the appropriations law. *See, e.g., id.* at 750 ("If the purpose of the limiting language in the appropriation under consideration . . . was to suspend or amend section 406(c) of the Federal Aviation Act of 1958, it was not so expressed by statute."). They then look to ancillary considerations, such as the legislative history of the

appropriations law, although any congressional intent expressed therein must be "clear and uncontradicted." *Id.*

Several courts have refused to find that appropriations laws amended or repealed the Government's substantive obligations, while others have found the opposite when confronted with different statutes. To determine which category applies to the appropriations riders in this case, it therefore is necessary to examine the features courts look for in appropriations laws that result in repeal or amendment.

Four relevant cases have refused to find a repeal or amendment. For example, in *Langston*, the Supreme Court analyzed the Government's failure to appropriate funds to pay the U.S. Ambassador to Haiti his full salary. 118 U.S. at 393. His salary was $7,500, but Congress appropriated only $5,000 to pay him for two subsequent years. *Id.* The Supreme Court reasoned that the appropriations acts did not "contain[] any language to the effect that such sum shall be 'in full compensation' for those years; nor was there in either of them an appropriation of money 'for additional pay,' from which it might be inferred that congress intended to repeal the [salary] act." *Id.* The Court therefore found "no words that expressly, or by clear implication, modified or repealed the previous law." *Id.* at 394.

The Court of Claims (the predecessor to the Federal Circuit) subsequently decided *Gibney*. In *Gibney*, the Federal Employees Pay Act of 1946 provided that "employees should be paid, for work beyond an eight-hour day on ordinary days, one-half

day's additional pay for each two hours or major fraction thereof, and, for work on a Sunday or holiday, two additional days' pay." 114 Ct. Cl. at 48. In a later appropriations act, Congress included the following language:

> *Provided*, That none of the funds appropriated for the Immigration and Naturalization Service shall be used to pay compensation for overtime services other than as provided in the Federal Employees Pay Act of 1945 (Public Law 106, 79th Cong., 1st sess.), and the Federal Employees Pay Act of 1946 (Public Law 390, 79th Cong., 2d sess.).

Id. at 44. The Court of Claims found that this language "was a mere limitation on the expenditure of a particular fund (the funds appropriated to the Immigration and Naturalization Service) and had no other effect." *Id.* at 50.

The Court of Claims further developed its jurisprudence on the substantive effects of appropriations laws in *New York Airways*. In that case, the Civil Aeronautics Board set a monthly subsidy for helicopter companies, as authorized by statute. 369 F.2d at 744. In an appropriations law, Congress included the following provision:

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

> fiscal year, $82,500,000, to remain available until expended.

Id. at 812. The subsidy Congress granted was less than the amount the Board had fixed pursuant to its authorizing statute. *Id.* at 810-11. The Court of Claims found that the House of Representatives had included this provision "to gradually eliminate helicopter subsidies from appropriations." *Id.* at 814. Nevertheless, "key congressmen who spoke on the subject fully understood that the commitment to pay subsidy compensation decreed by the Board for helicopter carriers was a binding obligation of the Government in the courts even in the failure of Congress to appropriate the necessary funds." *Id.* at 815. Therefore, the appropriations law did not amend or repeal the Government's substantive obligation. *Id.* at 815, 818.

Finally, in *District of Columbia v. United States*, 67 Fed. Cl. 292 (2005), the Government argued that Congress's failure to appropriate funds to HHS for statutorily required building renovations necessarily narrowed the Government's liability for those renovations. *Id.* at 346. The court disagreed, finding that Congress's failure to appropriate sufficient funds did "not mean that the government's obligation ha[d] been fulfilled under the . . . Act, or that the [Plaintiff] is precluded from seeking additional funds owed to it." *Id.* at 335. Citing *New York Airways*, the court noted that "an appropriation with limited funding is not assumed to amend substantive legislation creating a greater obligation." *Id.* (citing *N.Y. Airways*, 177 F.2d at 749). Though the Government cited some legislative history that suggested an intent to partially defund

the renovations, this history was not "unambiguous," so the court did not accord it much weight. *Id.*

In contrast, two other relevant decisions have analyzed appropriations laws that suspended or repealed previous statutory obligations. First, in *United States v. Dickerson*, the Supreme Court confronted a situation where a statute promised an enlistment allowance to honorably discharged soldiers who reenlisted. 310 U.S. 554, 554-55 (1940). Congress passed an appropriations law that stated, in pertinent part:

> [N]o part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1939, shall be available for the payment of any enlistment allowance for reenlistments made during the fiscal year ending June 30, 1939, notwithstanding the applicable portions of [the act authorizing reenlistment payments].

Id. at 555 (internal punctuation omitted). The Court extensively analyzed the legislative history of the appropriations law. *Id.* at 555-62. It found "that Congress intended the legislation . . . as a continuation of the suspension enacted in each of the four preceding years." *Id.* at 561. Therefore, the plaintiff could not recover. *Id.* at 562.

Next, in *United States v. Will*, 449 U.S. 200 (1980), several appropriations laws purported to eliminate a pay raise for federal judges. Specifically, the first of the appropriations statutes the Court analyzed provided that "[n]o part of the funds appropriated in this Act or any other Act shall be used to pay the salary" of these judges at a rate that exceeded the

previous salary rate. *Id.* at 205-06. The second, enacted for the next fiscal year, stated that the raises "shall not take effect" that year. *Id.* at 206-07. For the next fiscal year, another statute provided that "[n]o part of the funds appropriated for the fiscal year . . . by this Act or any other Act may be used to pay the salary or pay of any individual in any office or position" in the judicial branch that exceeded the preexisting rate. Finally, in the fourth consecutive fiscal year, another statute stated that funds would not be appropriated to pay any judges "in excess of [a] 5.5 percent increase in existing pay and such sum if accepted shall be in lieu of the 12.9 percent due for such fiscal year." *Id.* at 208.

Faced with such unequivocal statutory language, the Court found that Congress had intended to repeal or postpone the judges' pay increases in each of these fiscal years. *Id.* at 222. The legislative history confirmed this intent, and even referred to these statutes variously as "pay freezes" or "caps." *Id.* at 223-24. Therefore, "[t]hese passages indicate[d] clearly that Congress intended to rescind these raises entirely, not simply to consign them to the fiscal limbo of an account due but not payable." *Id.* at 224.[15]

This case is more like the first group of cases than the second. First, the statutory language supports this conclusion. The appropriations riders at issue here are

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[15] The Government also cites a Tenth Circuit case with similar appropriations language. In *Republic Airlines, Inc. v. U.S. Department of Transportation*, 849 F.2d 1315 (10th Cir. 1988), a statute stated that, "notwithstanding any other provision of law," funds payable to air carriers under a certain statute "shall not exceed" $14 million. *Id.* at 1317-18. The court held that this modified the substantive statutory obligation. *Id.* at 1322.

the most similar to the funding restriction in *Gibney*. As in *Gibney*, the appropriations riders limit only the use of funds appropriated to a specific account: the "Centers for Medicare and Medicaid Services-Program Management" account. 128 Stat. at 2491; 129 Stat. at 2624. Furthermore, unlike in *Dickerson* and *Will*, the riders do not expand the limitation to other sources of funds. In *Dickerson*, the appropriations act stated that no appropriation "contained in this or any other Act" for the current fiscal year would be used to make reeinlistment payments, "notwithstanding" the law authorizing such payments. Similarly, in *Will*, no funds "appropriated in this Act or any other Act" were to be used for the judges' pay raises. In fact, one of the statutes in *Will* stated that the raises "shall not take effect" during one fiscal year. In contrast, the appropriations riders at issue here state only that "[n]one of the funds made available by this Act" from specific funds "to the 'Centers for Medicare and Medicaid Services-Program Management' account, may be used for payments." Thus, the limitation in this case singles out a specific use for a specific account. It does not, unlike *Dickerson* and *Will*, bar any appropriated funds from being used for a given purpose.

The difference in wording between the appropriations riders here and the appropriations restrictions in *Dickerson* and *Will* is not merely semantic or historical. In fact, the very same appropriations laws in which the CMS Program Management restriction appears contain appropriations restrictions that are virtually identical to those in *Dickerson* and *Will*. Consider, for example,

Section 753 of the appropriations law for fiscal year 2015:

> None of the funds made available by this Act or any other Act may be used to exclude or restrict, or to pay the salaries and expenses of personnel to exclude or restrict, the eligibility of any variety of fresh, whole, or cut vegetables (except for vegetables with added sugars, fats, or oils) from being provided under the Special Supplemental Nutrition Program for Women, Infants, and Children under section 17 of the Child Nutrition Act of 1966 . . . .

128 Stat. at 2172. The presence of this language in the 2015 appropriations law and in the *Dickerson* and *Will* statutes suggests that Congress has consistently used similar phrases whenever it wishes to block a statutory obligation in an appropriations law. In other words, Congress knows that this phrase represents a silver bullet to whatever statutory obligation it targets. With that it mind, it is telling that Congress did not use the "this act or any other act" language in the CMS Program Management restriction. The omission suggests that Congress meant only to prevent HHS from using the CMS Program Management account for risk corridors payments, not that it meant to bar all other sources of funding for such payments.

The legislative history also supports this conclusion. In the fiscal year 2015 appropriations rider, Congress indicated in an Explanatory Statement that the funding restriction was intended "to prevent the CMS Program Management

appropriation account from being used to support risk corridors payments." 160 Cong. Rec. H9838. Similarly, in the fiscal year 2016 appropriations rider, the Senate Committee Report stated that the rider "requir[es] the administration to operate the Risk Corridor program in a budget neutral manner by prohibiting any funds from the Labor-HHS-Education appropriations bill to be used as payments for the Risk Corridor program. S. Rep. No. 114-74, at 12. Both of these statements indicate that Congress knowingly cut off funding for the risk corridors program from one specific account—the CMS Program Management account—and from that account only. It did not believe it was depriving the risk corridors program of funding from other accounts. As the Senate Committee Report notes, cutting off this source of funding for risk corridors payments forced the administration to operate the program in a budget-neutral manner. It did not reduce the obligation of the Government as a whole.[16]

Importantly, this Court is not the administration, and its judgments are not paid out of the CMS Program Management account. The Government argues that limiting the availability of the CMS

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[16] Furthermore, given the then-President's strong opposition to any legislation that sought to amend or repeal the ACA, it is somewhat unlikely that Congress could have expressed an intent to effectively amend the risk corridors program. If it had, then the appropriations laws may have faced a veto threat. *See, e.g.,* Gregory Korte, *Obama Uses Veto Pen Sparingly, But Could That Change?*, USA Today, Nov. 19, 2014 (noting that President Obama had threatened to veto twelve different bills that would have repealed or amended the ACA), http://www.usatoday.com/story/news/politics/2014/11/19/obama-vetothreats/ 19177413/.

Program Management account meant that the Government was only obligated to make "payments out" equal to the "payments in" from profitable QHPs. Other than these "payments in," the logic goes, there was no appropriation left that could cover the excess cost of the "payments out." After all, "[n]o money shall be drawn from the treasury, but in consequence of appropriations made by law." U.S. Const. art I, sec. 8, cl. 7.

However, there is an appropriation here. The Judgment Fund pays plaintiffs who prevail against the Government in this Court, and it constitutes a separate Congressional appropriation. *See* 28 U.S.C. § 2517(a); 31 U.S.C. § 1304(a)(3)(A). Its authorizing statute was "intended to establish a central, government-wide judgment fund from which judicial tribunals administering or ordering judgments, awards, or settlements may order payments without being constrained by concerns of whether adequate funds existed at the agency level to satisfy the judgment." *Bath Iron Works Corp. v. United States*, 20 F.3d 1567, 1583 (Fed. Cir. 1994). The Federal Circuit has clarified that the Judgment Fund is even available where an agency has refused to pay the plaintiff because Congress has limited the funds from which the agency may draw. In *Bath Iron Works*, Congress had passed a statute that limited "payment of appropriated Defense Department funds for administrative adjustments by a Defense Department Service Secretary." *Id.* The Federal Circuit reasoned that the appropriations statute did not purport to amend either the statute that obligated the Government to pay money—the Contract Disputes Act—or the Judgment Fund statute. *Id.*; *see also*

Wetsel-Oviatt Lumber Co. v. United States, 38 Fed. Cl. 563, 571 (1997) ("[A]ssuming the [agency] does not have appropriations from which to compensate Wetsel, there exists a statutory appropriation [in the Judgment Fund] from which the government is permitted to pay Wetsel.").

At oral argument, the Government averred that the Court cannot consider the availability of the Judgment Fund at all in finding liability *ex ante*. *See* Oral Arg. Tr. at 55. The Court disagrees. In a way, the differences between the statutes in *Dickerson* and *Gibney* only become significant when one considers the availability of the Judgment Fund. If an appropriations law limits funds appropriated "in this or any other Act," for example, "any other Act" includes the Judgment Fund appropriation (31 U.S.C. § 1304), so the Government's liability in this Court is foreclosed. In contrast, making funds from a specific account unavailable to a specific agency for a specific purpose "prevents the accounting officers of the Government from making disbursements," but private parties may still recover their funds in this Court. *N.Y. Airways*, 369 F.2d at 749. As a policy matter, it is certainly unfortunate that HHS's inability to access the CMS Program Management account for risk corridors payments means that insurers like Moda must receive risk corridors payments from the Judgment Fund. However, Congress has not modified those insurers' substantive right to those payments under Section 1342, so the Judgment Fund is the only path Congress has left open. Therefore, the Court finds that the appropriations riders at issue here did not modify or repeal the Government's obligation

under Section 1342 to make "payments out" to lossmaking QHP issuers.

In conclusion, the Court finds that Moda is entitled to summary judgment on the issue of liability. Section 1342 requires full annual payments to insurers, and the Government has not made these payments. Furthermore, Congress has not modified the risk corridors program to make it budget-neutral. As a result, there is no genuine dispute that the Government is liable to Moda under Section 1342.

2. In the Alternative, the Government Breached an Implied-in-Fact Contract with Moda by Refusing to Make Full Risk Corridors Payments

Though the Court could rest on its statutory entitlement ruling, the facts just as strongly indicate that the Government breached an implied-in-fact contract when it failed to pay Moda. Therefore, the Court finds in the alternative that Moda is entitled to summary judgment on that basis.

The elements of an implied-in-fact contract are identical to those of an express contract. *See Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997). So, to establish liability on a breach of contract claim, the plaintiff seeking summary judgment must show that there is no genuine dispute as to four elements: (1) mutuality of intent to contract, (2) consideration, (3) "lack of ambiguity in offer and acceptance," and (4) that the "[G]overnment representative whose conduct is relied upon [has] actual authority to bind the [G]overnment in contract." *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995) (citation omitted).

a. There was Mutuality of Intent to Contract

Clearly, the Government does not intend to bind itself in contract whenever it creates a statutory or regulatory incentive program. *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985). Therefore, "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." *Id.* (citation omitted). Courts should "proceed cautiously both in identifying a contract within the language of a regulatory statute and in defining the contours of any contractual obligation." *Brooks v. Dunlop Mfg. Inc.*, 702 F.3d 624, 631 (Fed. Cir. 2012).

However, statutory or regulatory provisions that do bind the Government in contract have certain hallmarks. First, the provision must create a program that offers specified incentives in return for the voluntary performance of private parties. *See Radium Mines, Inc. v. United States*, 153 F. Supp. 403, 405-06 (Ct. Cl. 1957). This performance must be in the form of an actual undertaking; simply "fill[ing] in the blanks of a Government prepared form," such as an application, does not constitute acceptance by performance. *Cutler-Hammer, Inc. v. United States*, 441 F.2d 1179, 1183 (Ct. Cl. 1971). Second, the provision must be promissory; in other words, it must give the agency officials administering the program no discretion to decide whether or not to award incentives to parties who perform. *See Radium Mines*, 153 F.

Supp. at 406. In short, statutes or regulations show the Government's intent to contract if they have the following implicit structure: if you participate in this program and follow its rules, we promise you will receive a specific incentive.

For example, in *Radium Mines*, the Government created an incentive program in which an agency Circular promised payment at a "guaranteed minimum price" to private parties who had uranium and wished to sell it. *Id.* at 404-05. Further, the Government had restricted private uranium production to such an extent that private parties essentially produced uranium for sale to the Government only. *Id.* at 406. The Government argued that it did not intend to make an offer in its Circular, but merely an invitation to offer. *Id.* at 405. The Court of Claims rejected this argument, stating,

> It could surely not be urged that one who had complied in every respect with the terms of the Circular could have been told by the Government that it would pay only half the 'Guaranteed Minimum Price,' nor could he be told that the Government would not purchase his uranium at all."

Id. at 406. So, agency officials had no discretion to determine (1) whether they would purchase uranium offered to them, or (2) the price they would pay producers. Therefore, the Circular was an offer, and the Government had shown intent to contract. *Id.* at 405-06.

New York Airways also is instructive. In that case, as noted above, a statute authorized the Civil Aeronautics Board to set a monthly subsidy for

helicopter companies. 369 F.2d at 744. The statute further stated, "The Postmaster General shall make payments out of appropriations for the transportation of mail by aircraft of so much of the total compensation as is fixed and determined by the Board under this section. . . ." *Id.* at 745. Congress then failed to appropriate the necessary funds to pay the compensation the Board "fixed and determined," so the Postmaster General did not pay the helicopter companies. *Id.* at 745-46. While the Court of Claims found that helicopter companies could recover under the original statute (see above), it also ruled in the alternative that "[t]he Board's rate order was, in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer." *Id.* at 751. So, again, both of the required elements were present: (1) an incentive program that private parties could join voluntarily by performing services according to the program's rules, and (2) a firm Government promise to pay those parties a fixed amount if they performed the required services.

It is true that *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12 (2011), disagrees with this framework. In *ARRA Energy*, the court articulated a simpler test, namely, that the plaintiff "must point to specific language in [the statute] or to conduct on the part of the government that allows a reasonable inference that the government intended to enter into a contract." *Id.* at 27. The court took this statement quite literally, finding that Section 1603 of the American Recovery and Reinvestment Act of 2009 did not show the Government's intent to contract because

it did not specifically require the Government to enter into contracts. *Id.* at 27-28. The Court disagrees with *ARRA Energy*'s interpretation. Neither *Radium Mines* nor *New York Airways* turned on the invocation of the magic word "contract" in the statutes they examined. Rather, both cases examined the *structure* of a statutory program and determined whether the Government had expressed its intent to contract by using that structure.

The ACA meets the criteria set out in *Radium Mines* and *New York Airways*. First, it created an incentive program in the form of the Exchanges on which insurers could voluntarily sell QHPs. Insurers' performance went beyond filling out an application form; they needed to develop QHPs that would satisfy the ACA's requirements and then sell those QHPs to consumers. In return for insurers' participation, the Government promised risk corridors payments as a financial backstop for unprofitable insurers. Finally, as discussed in detail above, Section 1342 specifically directs the Secretary of HHS to make risk corridors payments in specific sums, and HHS has no discretion to pay more or less than those sums. Therefore, the Government intended to enter into contracts with insurers, and there was mutuality of intent to contract.

b. Moda Accepted the Government's Offer, and the Condition Precedent to Payment was Satisfied

Of course, because the ACA shows that the Government intended to enter into contracts with insurers, it is also an offer on the part of the

Government. Specifically, the Government offered to enter into a unilateral contract with insurers like Moda. In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral contract" as "[a] contract in which only one party makes a promise or undertakes a performance."); *see also Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize). Here, the Government has promised to make risk corridors payments in return for Moda's performance. Moda accepted this offer through performance. It sold QHPs on the health benefit exchanges while adhering to the ACA's requirements.

At oral argument, the Government claimed that Moda's reliance on the Government's promise to pay was immaterial to its contractual claim. *See* Oral Arg. Tr. at 14. Reliance may be immaterial to contract formation; however, Moda has not really made a reliance argument here. When the offeree fully performs under a unilateral contract in response to the offeror's promise of payment, then one does not say that the offeree performed "in reliance" on the offeror's promise. Rather, the offeree's performance constitutes an acceptance, and it means that the offeror's duty to pay has fully matured under the contract. *See, e.g.*, Restatement (Second) of Contracts § 53 (Acceptance by Performance); *cf. Winstar Corp. v. United States*, 64 F.3d 1531, 1545 (Fed. Cir. 1995) ("When the plaintiffs satisfied the conditions imposed on them by the contracts, the government's contractual obligations

became effective and required it to recognize and accept the purchase method of accounting . . . and the use of supervisory goodwill and capital credits as capital assets for regulatory capital requirements."), *aff'd and remanded*, 518 U.S. 839 (1996).

In addition, for the Government's payment obligation under the unilateral contract to mature, a condition precedent had to be satisfied: Moda's QHPs needed to be lossmaking. A condition precedent is an event that, if it does not occur, can discharge one party's duty to perform under the contract. *See* Restatement (Second) of Contracts § 224. If Moda's QHPs were profitable, then no risk corridors payments would have come due under Section 1342. Because the QHPs were unprofitable, the condition precedent was therefore satisfied.

c. There was Consideration

Consideration is a bargained-for performance or return promise. Restatement (Second) of Contracts § 71. Here, the Government offered consideration in the form of risk corridors payments under Section 1342. In return, Moda offered performance under the contract by providing QHPs to consumers on the Health Benefit Exchanges. Therefore, there was consideration.

d. The Secretary of HHS had Actual Authority to Contract on the Government's Behalf

"An agent's actual authority to bind the Government may be either express or implied." *Marchena v. United States*, 128 Fed. Cl. 326, 333 (2016) (citing *Salles v. United States*, 156 F.3d 1383,

1384 (Fed. Cir. 1998)). Authority is implied when it is "considered to be an integral part of the duties assigned to a government employee." *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989) (citation omitted). Here, Section 1342 states that the Secretary of HHS "shall establish" the risk corridors program and "shall pay" risk corridors payments. More generally, the Secretary is responsible for administering the ACA. *See* ACA §§ 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d). As discussed above, the ACA itself creates a contractual framework. Therefore, entering into contracts pursuant to the contractual structure of the risk corridors program is an integral part of the Secretary's duties in administering and implementing the ACA, and the Secretary had implied actual authority to contract.

The Government argues that the Anti-Deficiency Act, 31 U.S.C. § 1341(a)(1)(B), cabins the Secretary's authority to enter into contracts under the ACA. That Act provides that the Government "may not . . . involve [the] government in a contract or obligation for the payment of money before an appropriation is made unless authorized by law." The Court of Claims faced a similar statute in *New York Airways*, stating, "Since it has been found that the Board's action created a 'contract or obligation (which) is authorized by law', obviously the statute has no application to the present situation." 369 F.2d at 152. Similarly, the Secretary of HHS is explicitly authorized to make risk corridors payments in specific amounts under the ACA. Therefore, the secretary is "authorized by law" under the ACA to make risk corridors payments pursuant to implied-in-fact contracts with insurers, and the

implied-in-fact contract does not fall under the Anti-Deficiency Act.[17]

e. No Further Discovery is Necessary

Finally, the Government claims that further discovery is necessary before the Court can rule that an implied-in-fact contract exists between Moda and the Government. Def. Reply Br. at 30-31. The Court disagrees. As shown above, the Court finds as a matter of law that an implied-in-fact contract exists between Moda and the Government, and further discovery as to the parties' subjective intentions would not change the Court's conclusion. Furthermore, if the nonmovant on a summary judgment motion believes "it cannot present facts essential to justify its opposition," it is required to bring this belief to the Court's attention "by affidavit or declaration." RCFC 56(d). The Court highly doubts that the Government does not have access to the facts necessary to justify its opposition. Regardless, the Government has not submitted the necessary affidavit or declaration. Therefore, the Government's informal request for discovery is denied.

In sum, the ACA created an implied-in-fact contract with insurers like Moda under which the Government owed Moda risk corridors payments if (1) Moda sold QHPs on the Exchanges and (2) those QHPs were lossmaking. Moda sold QHPs and suffered

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[17] Furthermore, just as Congress did not modify its statutory obligation through the appropriations riders, it also did not modify its contractual obligation. *See, e.g., Salazar*, 132 S. Ct. at 2189 ("[T]he Government is responsible to the contractor for the full amount due under the contract, even if the agency exhausts the appropriation in service of other permissible ends.").

losses. The Government has breached the contract by failing to make full risk corridors payments as promised. Therefore, there is no genuine dispute that the Government is liable to Moda under the implied-in-fact contract, and Moda also is entitled to partial summary judgment on that basis.

CONCLUSION

There is no genuine dispute that the Government is liable to Moda. Whether under statute or contract, the Court finds that the Government made a promise in the risk corridors program that it has yet to fulfill. Today, the Court directs the Government to fulfill that promise. After all, "to say to [Moda], 'The joke is on you. You shouldn't have trusted us,' is hardly worthy of our great government." *Brandt v. Hickel*, 427 F.2d 53, 57 (9th Cir. 1970). Moda's cross-motion for partial summary judgment is GRANTED. The Government's motion to dismiss is DENIED.

The Court requests that counsel for the parties submit a joint status report on or before March 1, 2017, indicating the proposed steps and schedule for completing the resolution of this action.

IT IS SO ORDERED.

s/Thomas C. Wheeler
THOMAS C. WHEELER
Judge

Appendix E

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

No. 16-651C

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA.,

Plaintiff,

v.

UNITED STATES,

Defendant.

Filed: April 18, 2017

MEMORANDUM OPINION AND ORDER

GRIGGSBY, Judge.

I. INTRODUCTION

Plaintiff, Blue Cross and Blue Shield of North Carolina ("Blue Cross"), brings this action alleging statutory, breach of contract and takings claims against the United States to recover certain payments allegedly due under the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010) (the "ACA"). *See generally* Compl. The government has moved to dismiss this action for lack of subject-matter jurisdiction and for failure to state a claim upon which relief can be granted, pursuant to Rules 12(b)(1) and 12(b)(6) of the Rules of the United States Court of Federal Claims ("RCFC").

See generally Def. Mot. For the reasons discussed below, the Court GRANTS-IN-PART and DENIES-IN-PART the government's motion to dismiss.

II. FACTUAL AND PROCEDURAL BACKGROUND

A. Factual Background[1]

1. Overview

Plaintiff, Blue Cross, brings this action alleging statutory, breach of contract and takings claims against the government to recover certain payments allegedly due under the ACA's Risk Corridors Program. *See generally* Compl. The Risk Corridors Program is a three-year, temporary premium stabilization program, in which the government and Qualified Health Plans ("QHPs"), like Blue Cross, "share in the risk associated with the new marketplace's uncertainty for each of the temporary program's three years: 2014, 2015 and 2016" (the "Risk Corridors Program"). *Id.* at ¶¶ 6; *see also id.* at 33; 42 U.S.C. § 18062. Blue Cross participated in the Risk Corridors Program during 2014, 2015 and 2016. *Id.* at ¶¶ 34-44. Under the Risk Corridors Program, Blue Cross and other QHPs may receive money from the United States Department of Health and Human Services ("HHS") to help reduce financial uncertainty during the initial years of the ACA. Compl. at ¶ 21. To date, Blue Cross has received only a portion of such

[1] The facts recited herein are taken from the complaint ("Compl."); the government's motion to dismiss ("Def. Mot."); the appendix to the government's motion to dismiss ("Def. App."); plaintiffs response thereto ("Pl. Opp."); and the government's reply brief ("Def. Reply"). Unless otherwise stated herein, the facts are undisputed.

payments for 2014 (the "Risk Corridors Program Payments").[2] Compl. at ¶¶ 135-36.

Blue Cross asserts five claims in the complaint to recover the full amount of its 2014 Risk Corridors Program Payments. First, Blue Cross alleges that the government violated Section 1342 of the ACA and its implementing regulations, 45 C.F.R. § 153.510, by failing to make full, annual Risk Corridors Program Payments to Blue Cross. *Id.* at ¶¶ 154-65. Second, Blue Cross alleges that the government also breached its QHP Agreement with the government by failing to make these payments in full, upon an annual basis. *Id.* at ¶¶ 166-79. Third, Blue Cross contends that the government also breached implied-in-fact contracts with Blue Cross to make full, annual Risk Corridors Program Payments. *Id.* at ¶¶ 180-98.

In addition, Blue Cross contends that the government breached the covenant of good faith and fair dealing implied in its alleged express and implied contracts with the government, by failing to make these payments. *Id.* at ¶¶ 199-210. Lastly, Blue Cross alleges that the government has improperly taken its

[2] Plaintiffs Risk Corridors Program Payments and the governments pro-rated payment amounts for calendar · year 2014 are as follows:

Plaintiff	State/ Market	Risk Corridor Amount	Prorated Amount	Percent Pro Rata
BCBSNC	NC/ Individual	$147,421,876.38	$18,601,495.60	12.6%
BCBSNC	NC/Small Group	$53,091.97	$6,699.07	12.6%

Compl. at ¶ 135.

property interest in a statutory, regulatory and contractual right to receive full, annual Risk Corridors Program Payments, in violation of the Fifth Amendment of the United States Constitution. *Id*. at ¶¶ 211-18. Blue Cross also requests that the Court declare that the government must make full, annual Risk Corridors Program Payments for calendar years 2015 and 2016. Compl. at Prayer for Relief.

2. The Affordable Care Act

As background, Congress enacted the Patient Protection and Affordable Care Act in 2010. *See* Pub. L. No. 111-148. The goal of the ACA is to increase access to affordable, quality health insurance coverage for all Americans. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

The ACA contains three key reforms to the health insurance system: (1) to prohibit health insurance companies from denying coverage or setting premiums based upon health status or medical history; (2) to require individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service; and (3) to provide federal insurance subsidies in the form of premium tax credits and cost sharing reductions to make insurance more affordable to eligible consumers. *Id*. at 2486-87 (citing 42 U.S.C. §§ 300gg, 300gg–1(a), 18081-82, 18091 (2016); 26 U.S.C. §§ 36B, 5000A (2016)); *see also* 42 U.S.C. § 18071 (2016). To implement the aforementioned reforms, the ACA creates American Health Benefit Exchanges ("Exchanges"), which are virtual marketplaces in each state where individuals and small groups can purchase health insurance coverage. 42 U.S.C. §§ 18031-41 (2016). The Exchanges provide,

among other things, a centralized location for consumers to enroll in qualified health plans and competitive marketplaces for insurers to compete for business. *Id.*

All plans offered through the Exchanges must be QHPs, meaning that such a plan must provide "essential health benefits" and comply with other regulatory parameters such as provider network requirements, benefit design rules, and cost sharing limitations. *See* 42 U.S.C. § 18021; 45 C.F.R. §§ 155-56. As part of the process to ensure that issuers that participate in the Exchanges comply with the ACA's requirements, HHS requires issuers to, among other things, execute an agreement known as a "Qualified Health Plan Certification Agreement and Privacy and Security Agreement" (the "QHP Agreement"). 45 C.F.R. § 155.260(b)(2). In the QHP Agreement, QHP issuers agree to, among other things, adhere to certain privacy and security standards when conducting transactions on the federally-facilitated Exchanges. *Id.*; *see e.g.*, Compl. at Exs. 2-4.

3. The Risk Corridors Program

Because the ACA introduced millions of previously uninsured individuals into the insurance markets, pricing uncertainties arose from the unknown health status of these additional enrollees and the fact that insurers could no longer charge higher premiums or deny coverage based upon an enrollee's health. *See* 42 U.S.C. §§ 300gg, 300gg-1; 45 C.F.R. §§ 147.104-147.110; 78 Fed. Reg. 13406-01, 13432-33, 2013 WL 685066 (Feb. 27, 2013); Compl. at ¶¶ 4-5. To mitigate the pricing risk and incentives for adverse selection arising from these changes, the ACA

establishes three premium stabilization programs (the "3Rs") that have been modeled upon similar programs established under the Medicare Program. *See* Compl. at ¶¶ 5, 7, 21. The 3Rs began in 2014 and consist of the reinsurance, risk adjustment, and risk corridors programs. *See generally* 42 U.S.C. §§ 18061-63. The reinsurance and risk corridors programs expire after the third year of the new ACA Marketplace. Pl. Opp. at 7.

Specifically relevant to this case, the Risk Corridors Program is authorized under Section 1342 of the ACA, which directs the Secretary of Health and Human Services (the "Secretary") to establish and administer the program under which qualifying health plans either pay money to, or receive money from, HHS based upon the ratio of insurance premiums to claims costs. 42 U.S.C. § 18062. This program seeks to reduce financial uncertainty for QHP issuers during the initial years of the ACA. *See* Compl. at ¶ 21.

Section 1342 provides, in pertinent part, that:

> (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.].

42 U.S.C. § 18062(a) (brackets in original). With respect to the methodology for making the Risk Corridors Program Payments, Section 1342 also provides that:

> (b) Payment methodology
>
> (1) Payments out
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (2) Payments in
>
> The Secretary shall provide under the program established under subsection (a) that if—

> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062(b). Under the payment methodology set forth in Section 1342, if a QHP issuer's allowable costs exceed the target amount by more than three percent, the issuer will receive a percentage of the difference in the form of a payment from HHS. 42 U.S.C. § 18062(b)(1). Conversely, if a QHP issuer's allowable costs are less than the target amount by more than three percent, an issuer must pay a percentage of the difference in the form of a payment to HHS. 42 U.S.C. § 18062(b)(2).

HHS has also promulgated regulations to implement the Risk Corridors Program. With regards to the Risk Corridors Program Payments made to QHP issuers, these regulations provide that:

> **§ 153.510 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.

45 C.F.R. § 153.510(a)-(b). Under these regulations, QHP issuers must compile and submit premium and cost data and other information underlying their risk corridors calculations to HHS after the close of each benefit year, and no later than July 31 of the next calendar year. 45 C.F.R. § 153.530(a)-(d). HHS uses the data provided to calculate the charges and payments due to, and from, each issuer for the

preceding benefit year under the Risk Corridors Program. *See* 45 C.F.R. § 153.530(a)-(c); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410-01, 15,473-74, 2013 WL 865946 (Mar. 11, 2013). Although HHS's regulations provide that QHP issuers must submit the Risk Corridors Program Payments to HHS within 30 days of HHS's announcement of final charge amounts, neither Section 1342 nor its implementing regulations provide a specific deadline for HHS to make the Risk Corridors Program Payments to QHP issuers. *See generally* 42 U.S.C. § 18062; 45 C.F.R. § 153.510.

4. HHS's Rulemaking On The Risk Corridors Program Payments

Congress did not include an appropriation or an authorization of funding for the Risk Corridors Program in the ACA. Def. Mot. at 8; Def. Reply at 13 (citation omitted); *see also* 42 U.S.C. § 18062; United States Government Accountability Office, Opinion Letter on Department of Health & Human Services-Risk Corridors Program to former Senator Jeff Sessions and Congressman Fred Upton, 2014 WL 4825237, at *2 (Sept. 30, 2014) ("Section 1342, by its terms, did not enact an appropriation to make the payments specified in section 1342(b)(1)."). And so, HHS has addressed funding for the program through rulemaking. *See, e.g.*, *Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 76 Fed. Reg. 41,930-01, 2011 WL 2728043 (proposed July 15, 2011); *Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 77 Fed. Reg. 17,220-01, 2012 WL 959270 (Mar. 23, 2012); *HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed.

Reg. 15,410-01, 2013 WL 865946 (Mar. 11, 2013); *HHS Notice of Benefit and Payment Parameters for 2015*, 79 Fed. Reg. 13,744-01, 13,787, 2014 WL 909454 (Mar. 11, 2014); *Exchange and Insurance Market Standards for 2015 and Beyond Final Rule*, 79 Fed. Reg. 30,240-01, 30,260, 2014 WL 2171429 (May 27, 2014); *HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. 10,750-01, 10,779, 2015 WL 799390 (Feb. 27, 2015).

In this regard, the Secretary has interpreted Section 1342 to not require that HHS make full Risk Corridors Program Payments until the end of the three-year Risk Corridors Program. Def. Mot. at 17. Specifically, in July 2011, HHS published a proposed rule observing that the Congressional Budget Office ("CBO") "assumed [risk corridors] collections would equal payments to plans in the aggregate," when the CBO performed a cost estimate contemporaneously with ACA's passage. *Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 76 Fed. Reg. at 41,948. In the same proposed rule, HHS considered establishing deadlines for the Risk Corridors Program Payments made to issuers, as well as for the payments made to HHS. *Id.* at 41,943. But, in a final rule published on March 11, 2013, HHS established a 30-day deadline for only the Risk Corridors Program Payments that QHP issuers make to HHS. *See HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. 15410-01, 15,531, 2013 WL 865946 (Mar. 11, 2013) (codified at 45 C.F.R. § 153.510(d)).

HHS has also issued rulemaking on how to address the circumstance where payments owed by

HHS exceed the collections received under the Risk Corridors Program. As background, in February 2014, the CBO issued a report providing that: "[i]n contrast [to the reinsurance and risk adjustment programs], payments and collections under the risk corridors program will not necessarily equal one another . . . ." CBO, The Budget and Economic Outlook: 2014 to 2024, at 59 (Feb. 2014), *available at* https://www.cbo.gov/sites/default/files/113thcongress-2013-2014/reports/45010-outlook2014feb0.pdf. While the CBO projected that the Risk Corridors Program would result in $8 billion in net gain to the government, the CBO's report also acknowledged that "[i]f insurers' costs exceed their expectations, on average, the risk corridor program will impose costs on the federal budget . . . ." *Id.* at 110.

On March 11, 2014, HHS issued a final rule stating that "[w]e intend to implement th[e] [risk corridors] program in a budget neutral manner, and may make future adjustments, either upward or downward to this program . . . to the extent necessary to achieve this goal." *HHS Notice of Benefit and Payment Parameters for 2015 Final Rule*, 79 Fed. Reg. at 13,787; *see also id.* at 13,829 ("HHS intends to implement this program in a budget neutral manner."); *Exchange and Insurance Market Standards for 2015 and Beyond Proposed Rule*, 79 Fed. Reg. 15,808-01, 15,822, 2014 WL 1091600 (proposed Mar. 21, 2014) (same). And so, HHS issued guidance explaining that it would make the Risk Corridors Program Payments to QHP issuers to the extent that these payments could be satisfied by the collections under the Risk Corridors Program. Compl. at Ex. 20; *see also Exchange and Insurance Market*

Standards for 2015 and Beyond, 79 Fed. Reg. at 30,260; *HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. at 10,779. On April 11, 2014, HHS also advised that any shortfall in payments would result in a pro-rata reduction of all the Risk Corridors Program Payments to QHP issuers. Compl. at Ex. 20.

5. Relevant Appropriations Legislation

In September 2014, the United States Government Accountability Office ("GAO") responded to an inquiry from former Senator Jeff Sessions and Representative Fred Upton regarding the availability of appropriations to make the Risk Corridors Program Payments. United States Government Accountability Office, Opinion Letter on Department of Health & Human Services-Risk Corridors Program to former Senator Jeff Sessions and Congressman Fred Upton, 2014 WL 4825237, at *1 (Sept. 30, 2014). The GAO's response to this inquiry provided that "the CMS [Program Management] appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1)." *Id.* at *3.

On December 9, 2014, Congress enacted the Consolidated and Further Continuing Appropriations Act, 2015 (the "2015 Appropriations Act"), which addressed the budget authority for the Risk Corridors Program. Pub. L. No. 113-235, div. G, title II (2014). The 2015 Appropriations Act expressly limited the availability of Program Management funds for the Risk Corridors Program, as follows:

> None of the funds made available by this Act from [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).

Id. at § 227. On December 18, 2015, Congress enacted an identical funding limitation with respect to the Risk Corridors Program in the Consolidated and Further Continuing Appropriations Act, 2016 (the "2016 Appropriations Act"). *See* Pub. L. No. 114-113, div. H, title II, § 225 (2015).

6. Pro-Rata Reduction Of The Risk Corridors Program Payments

Due to the spending limitations imposed by Congress, HHS reduced the amount of its Risk Corridors Program Payments to QHP issuers. Specifically, on October 1, 2015, HHS announced that collections under the Risk Corridors Program for 2014 were expected to total $362 million, while payments calculated for the program totaled $2.87 billion. Def. Mot. at 13 (citing *Centers for Medicare & Medicaid Services, Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015)). Because the amount of payments exceeded the collections, HHS also announced that the government would pay 12.6% of the Risk Corridors Program Payments during the 2015 payment cycle. *Id.* In late 2015, HHS also issued a guidance explaining that HHS would make pro-rata Risk Corridors Program Payments, with "[t]he remaining 2014 risk corridors payments . . . made from 2015 risk corridors collections [in 2016], and if necessary, 2016 collections [in 2017]." Def. Mot. at 13 (citing *Centers for Medicare*

& Medicaid Services, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015)); Compl. at Ex. 17

In November 2015, HHS began collecting the Risk Corridors Program Payments from QHP issuers for the 2014 benefit year. Def. Mot. at 13. In December 2015, HHS began remitting its pro-rata Risk Corridors Program Payments to QHP issuers, including Blue Cross. *Id.* at 13-14.

Although HHS is currently making pro-rata payments to QHP issuers under the Risk Corridors Program, HHS appears to have interpreted Section 1342 to require that full payments must be made. *See* 45 C.F.R. § 153.510(b) ("QHP issuers *will* receive payment from HHS. . . .") (emphasis supplied); *Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. at 30,260 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); Compl. at Ex. 17 (same). And so, HHS has committed to using funding sources other than the risk corridors collections to satisfy these outstanding payments, subject to the availability of appropriations at the conclusion of the program. Def. Mot. at 9-10; s*ee also HHS Notice of Benefit and Payment Parameters for 2016*, 80 Fed. Reg. at 10,779; *Exchange and Insurance Market Standards for 2015 and Beyond*, 79 Fed. Reg. at 30,260; *HHS Notice of Benefit and Payment Parameters for 2014*, 78 Fed. Reg. at 15,473. To that end, on September 9, 2016, HHS announced that:

> As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability

> of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.

Def. App. at A248; *id*. at A144.

7. Blue Cross's Risk Corridors Program Payments

To date, Blue Cross has received approximately $25 million of the Risk Corridors Program Payments that it is owed for 2014. Compl. at ¶¶ 135-38. Blue Cross submitted its calendar year 2014 risk corridors data to the Centers for Medicare and Medicaid Services ("CMS") in July 2015, and this data reflects that the government owes Blue Cross more than $140 million in Risk Corridors Program Payments for 2014. Pl. Opp. at 12. On November 2, 2015, Kevin J. Counihan, Director of CMS's Center for Consumer Information & Insurance Oversight and Chief Executive Officer of the ACA Marketplace, sent a letter to Blue Cross stating that, because the $362 million in risk corridors collections could not match the payment requests of $2.87 billion:

> [T]he remaining 2014 risk corridors claims will be paid out of 2015 risk corridors collections, and if necessary, 2016 collections. . . . . [W]e will not know the total loss or gain for the program until the fall of 2017 when the data from all three years of the

> program can be analyzed and verified. In the event of a shortfall for the 2016 program year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

Compl. at Ex. 18. Mr. Counihan also stated that HHS "recognizes that the [ACA] requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligations of the United States government for which full payment is required." *Id.*

B. Relevant Procedural Background

Plaintiff commenced this action on June 2, 2016. *See generally* Compl. On September 30, 2016, the government moved to dismiss the complaint for lack of subject-matter jurisdiction, pursuant to RCFC 12(b)(1) or, in the alternative, for failure to state a claim upon which relief can be granted, pursuant to RCFC 12(b)(6). *See generally* Def. Mot.

On October 31, 2016, plaintiff filed an opposition to the government's motion to dismiss. *See generally* Pl. Opp. The government filed a reply in support of its motion to dismiss on November 22, 2016. *See generally* Def. Reply. On December 6, 2016 plaintiff, filed a sur-reply in support of its opposition to the government's motion to dismiss. *See generally* Pl. Sur-Reply.

On February 13, 2017, the Court directed the parties to file supplemental briefs on the following issues: (1) whether the purpose of the Risk Corridors

Program may only be fulfilled by the full, annual payment of the Risk Corridors Program Payments; (2) whether HHS's proposed rule dated March 23, 2012, 77 Fed. Reg. 17220-01, 17238, 2012 WL 959270 (Mar. 23, 2012), requires that HHS provide full, annual payment of the Risk Corridors Program Payments; (3) whether the Court should dismiss Count I of the complaint pursuant to RCFC 12(b)(6), if the Court concludes that plaintiff is not entitled to "presently due money damages" under Section 1342; and (4) whether the Court should dismiss Counts II-IV of the complaint, pursuant to RCFC 12(b)(6), if the Court concludes that plaintiff is not entitled to "presently due money damages" under Section 1342.[3] *See generally* Scheduling Order, Feb. 13, 2017.

On March 3, 2017, Blue Cross and the government filed their respective initial supplemental briefs. Pl. Supp. Br.; Def. Supp. Br. On March 17, 2017, Blue Cross and the government filed their respective responsive supplemental briefs. Pl. Supp. Resp.; Def. Supp. Resp. The Court held oral argument on the government's motion to dismiss on April 11, 2017.

The aforementioned matter having been fully briefed, the Court resolves the pending motion to dismiss.

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[3] HHS's rule dated March 23, 2012, is a final rule. *See Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, 77 Fed. Reg. 17220-01, 17238, 2012 WL 959270 (Mar. 23, 2012).

III. LEGAL STANDARDS

A. Jurisdiction And RCFC 12(b)(1)

When deciding a motion to dismiss upon the ground that the Court does not possess subject-matter jurisdiction pursuant to RCFC 12(b)(1), this Court must assume that all undisputed facts alleged in the complaint are true and must draw all reasonable inferences in the non-movant's favor. *Erickson v. Pardus*, 551 U.S. 89, 94 (2007); *see also* RCFC 12(b)(1). But, plaintiff bears the burden of establishing subject-matter jurisdiction, and plaintiff must do so by a preponderance of the evidence. *Reynolds v. Army & Air Force Exch. Serv.*, 846 F.2d 746, 748 (Fed. Cir. 1988). And so, should the Court determine that "it lacks jurisdiction over the subject matter, it must dismiss the claim." *Matthews v. United States*, 72 Fed. Cl. 274, 278 (2006) (citations omitted); *see also* RCFC 12(h)(3).

In this regard, the United States Court of Federal Claims is a court of limited jurisdiction and "possess[es] only that power authorized by Constitution and statute . . . ." *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994). The Tucker Act grants the Court jurisdiction over:

> [A]ny claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort.

28 U.S.C. § 1491(a)(1). The Tucker Act, however, is a "jurisdictional statute; it does not create any

substantive right enforceable against the United States for money damages. . . . [T]he Act merely confers jurisdiction upon [the United States Court of Federal Claims] whenever the substantive right exists." *United States v. Testan*, 424 U.S. 392, 398 (1976) (citation omitted). And so, to pursue a claim against the United States under the Tucker Act, a plaintiff must identify and plead a money-mandating constitutional provision, statute, or regulation; an express or implied contract with the United States; or an illegal exaction of money by the United States. *Cabral v. United States*, 317 F. App'x 979, 981 (Fed. Cir. 2008) (citing *Fisher v. United States*, 402 F.3d 1167, 1172 (Fed. Cir. 2005)); *Norman v. United States*, 429 F.3d 1081, 1095 (Fed. Cir. 2005). "[A] statute or regulation is money-mandating for jurisdictional purposes if it 'can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s].'" *Fisher*, 402 F.3d at 1173 (quoting *United States v. Mitchell*, 463 U.S. 206, 217 (1983)) (brackets in original).

B. Ripeness

Even when the Court's jurisdiction over a claim has been established, the Court may not adjudicate a claim if the claim is not ripe for judicial review. *See, e.g.*, *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 772 (2017); *Morris v. United States*, 392 F.3d 1372, 1375 (Fed. Cir. 2004) (citing *Howard W. Heck & Assocs., Inc. v. United States*, 134 F.3d 1468 (Fed. Cir. 1998)). To that end, "[r]ipeness is a justiciability doctrine that prevents the courts, through avoidance of premature adjudication, from entangling themselves in abstract disagreements."

Shinnecock Indian Nation v. United States, 782 F.3d 1345, 1348 (Fed. Cir. 2015) (citations and internal punctuation omitted). This Court has also recognized that, while the ripeness doctrine has been developed through Article III courts, the doctrine's principles are equally applicable in this Court. *See CW Gov't Travel, Inc. v. United States*, 46 Fed. Cl. 554, 557-58 (2000). And so,

> [a] court should dismiss a case for lack of ripeness when the case is abstract or hypothetical. . . . A case is generally ripe if any remaining questions are purely legal ones; conversely, a case is not ripe if further factual development is required.

Rothe Dev. Corp. v. DOD, 413 F.3d 1327, 1335 (Fed. Cir. 2005) (quoting *Monk v. Houston*, 340 F.3d 279, 282 (5th Cir. 2003)) (ellipsis existing).

In determining whether a dispute is ripe for review, the Court must evaluate two factors: "(1) the 'fitness' of the disputed issues for judicial resolution; and (2) 'the hardship to the parties of withholding court consideration.'" *Shinnecock*, 782 F.3d at 1348 (citing *Abbott Labs. v. Gardner*, 387 U.S. 136, 149 (1967), *abrogated on other grounds by Califano v. Sanders*, 430 U.S. 99 (1977); *Sys. Application & Techs., Inc. v. United States*, 691 F.3d 1374, 1383-84 (Fed. Cir. 2012)). Under the first prong, "an action is fit for judicial review where further factual development would not 'significantly advance [a court's] ability to deal with the legal issues presented.'" *Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc.*, 527 F.3d 1278, 1295 (Fed. Cir. 2008) (citing *Nat'l Park Hospitality Ass'n v. Dep't of Interior*, 538 U.S.

803, 812 (2003)) (bracket existing). Under the second prong, "withholding court consideration of an action causes hardship to the plaintiff where the complained-of conduct has an 'immediate and substantial impact' on the plaintiff." *Id*. (citing *Gardner v. Toilet Goods Ass'n*, 387 U.S. 167, 171 (1967)).

C. RCFC 12(b)(6)

When deciding a motion to dismiss based upon failure to state a claim upon which relief can be granted pursuant to RCFC 12(b)(6), this Court must assume that all undisputed facts alleged in the complaint are true and draw all reasonable inferences in the non-movant's favor. *Erickson*, 551 U.S. at 94; *see also* RCFC 12(b)(6). To survive a motion to dismiss pursuant to RCFC 12(b)(6), a complaint must contain facts sufficient to "state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007); *see also Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citation omitted). And so, when the complaint fails to "state a claim to relief that is plausible on its face," the Court must dismiss the complaint. *Iqbal*, 556 U.S. at 678 (citation omitted). On the other hand, "[w]hen there are well-pleaded factual allegations, a court should assume their veracity" and determine whether it is plausible, based upon these facts, to find against defendant. *Id*. at 679.

D. Statutory Interpretation

When interpreting a statute, the Court must "start[] with the plain language." *Barela v. Shinseki*, 584 F.3d 1379, 1382-83 (Fed. Cir. 2009) (citation omitted). Statutes are not, however, interpreted in a vacuum and the Court "must consider not only the bare meaning of each word but also the placement and

purpose of the language within the statutory scheme." *Id.* at 1383 (citation omitted). And so, a statute's meaning, regardless of whether the language is "plain or not, thus depends on context." *Id.* (citation omitted)

Generally, this Court must defer to an agency's interpretation of ambiguous statutory provisions, provided that the interpretation is reasonable. *Chevron U.S.A., Inc. v. Natural Res. Defense Council, Inc.*, 467 U.S. 837, 842-43 (1984). When the Court reviews an agency's construction of a statute which it administers, the Court is confronted with two questions. First, the Court examines "whether Congress has directly spoken to the precise question at issue." *Id*. at 842. If so, the Court "must give effect to the unambiguously expressed intent of Congress." *Id*. at 842-43; *see also Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1362 (Fed. Cir. 2005). If the statute is ambiguous, the Court must proceed to step two and examine "whether the agency responsible for filling a gap in the statute has rendered an interpretation that is based on a permissible construction of the statute." *Doe v. United States*, 372 F.3d 1347, 1358 (Fed. Cir. 2004) (citations omitted); *see also Cathedral Candle Co.*, 400 F.3d at 1364-65. And so, this standard of deference should apply, where "Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co.,* 400 F.3d at 1361 (quoting *United States v. Mead Corp*., 533 U.S. 218, 229 (2001)).

In addition, courts generally accord *Chevron* deference when Congress has authorized an administrative agency to engage in rulemaking or adjudication that produces regulations or rulings for which the deference is claimed. *Chevron*, 467 U.S. at 1361. And so, in this instance, an agency's interpretation of its own regulations is also entitled to broad deference from the Court. *Id*. at 1363-64.

E. Contract Claims Against The Government

To bring a valid contract claim against the United States in this Court, the underlying contract must be either express or implied-in-fact. *Aboo v. United States*, 86 Fed. Cl. 618, 626- 27 (2009). In addition, plaintiff bears the burden of proving the existence of a contract with the United States, and a plaintiff must show that there is "something more than a cloud of evidence that could be consistent with a contract to prove a contract and enforceable contract rights." *D & N Bank v. United States*, 331 F.3d 1374, 1377 (Fed. Cir. 2003). To establish the existence of either an express or implied-in-fact contract with the United States, a plaintiff must show: (1) mutuality of intent; (2) consideration; (3) lack of ambiguity in the offer and acceptance; and (4) actual authority to bind the government in contract on the part of the government official whose conduct is relied upon. *Kam-Almaz v. United States*, 682 F.3d 1364, 1368 (Fed. Cir. 2012); *see also Trauma Serv. Grp. v. United States*, 104 F.3d 1321, 1325 (Fed. Cir. 1997). A government official's authority to bind the United States must be express or implied. *Roy v. United States*, 38 Fed. Cl. 184, 188-89, *dismissed*, 124 F.3d 224 (Fed. Cir. 1997). And so, "the

[g]overnment, unlike private parties, cannot be bound by the apparent authority of its agents." *Id.* at 187.

In this regard, a government official possesses express actual authority to bind the United States in contract "only when the Constitution, a statute, or a regulation grants it to that agent in unambiguous terms." *Jumah v. United States*, 90 Fed. Cl. 603, 612 (2009) *aff'd*, 385 F. App'x 987 (Fed. Cir. 2010) (internal citations omitted); *see also City of El Centro v. United States*, 922 F.2d 816, 820 (Fed. Cir. 1990) (citation omitted). On the other hand, a government official possesses implied actual authority to bind the United States in contract "when the employee cannot perform his assigned tasks without such authority and when the relevant agency's regulations do not grant the authority to other agency employees." *SGS-92-X003 v. United States*, 74 Fed. Cl. 637, 652 (2007) (citations omitted); *see also Aboo*, 86 Fed. Cl. at 627 (implied actual authority "is restricted to situations where 'such authority is considered to be an integral part of the duties assigned to a [g]overnment employee.'") (quoting *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989)). In addition, when a government agent does not possess express or implied actual authority to bind the United States in contract, the government can still be bound by contract if the contract was ratified by an official with the necessary authority. *Janowsky v. United States*, 133 F.3d 888, 891-92 (Fed. Cir. 1998).[4]

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[4] Ratification may take place at the individual or institutional level. *SGS-92-X003*, 74 Fed. Cl. at 653-54. Individual ratification occurs when a supervisor: (1) possesses the actual authority to contract; (2) fully knew the material facts surrounding the

F. Takings Claims

Lastly, this Court may consider takings claims under the Fifth Amendment of the United States Constitution. *See* 28 U.S.C. § 1491; U.S. Const. amend. V; *Morris v. United States*, 392 F.3d 1372, 1375 (Fed. Cir. 2004) ("[T]he Tucker Act provides the Court of Federal Claims exclusive jurisdiction over takings claims for amounts greater than $10,000."); *see also Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1304 (Fed. Cir. 2008) (citing *E. Enters. v. Apfel*, 524 U.S. 498, 520 (1998)). The Takings Clause of the Fifth Amendment guarantees just compensation whenever private property is "taken" for public use. U.S. Const. amend. V. And so, the purpose of the Fifth Amendment is to prevent the "[g]overnment from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." *Penn Central Transp. Co. v. City of New York*, 438 U.S. 104, 123 (1978) (quoting *Armstrong v. United States*, 364 U.S. 40, 49 (1960)); *see also Florida Rock Indus., Inc. v. United States*, 18 F.3d 1560, 1571 (Fed. Cir. 1994).

To have a cause of action for a Fifth Amendment takings, a plaintiff must point to a protectable property interest that is asserted to be the subject of

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unauthorized action of his or her subordinate; and (3) knowingly confirmed, adopted, or acquiesced to the unauthorized action of the subordinate. *Id.* at 654 (quoting *Leonardo v. United States*, 63 Fed. Cl. 552, 560 (2005)). In contrast, institutional ratification occurs when the government "seeks and receives the benefits from an otherwise unauthorized contract." *SGS- 92-X003*, 74 Fed. Cl. at 654; *see also Janowsky v. United States*, 133 F.3d 888, 891-92 (Fed. Cir. 1998).

the takings. *See Phillips v. Wash. Legal Found.*, 524 U.S. 156, 164 (1998) ("Because the Constitution protects rather than creates property interests, the existence of a property interest is determined by reference to 'existing rules or understandings that stem from an independent source such as state law.'") (citation omitted). In this regard, contract rights can be the subject of a takings action. *See e.g.*, *Lynch v. United States*, 292 U.S. 571, 579 (1934) ("Valid contracts are property, whether the obligor be a private individual, a municipality, a state, or the United States."); *see also United States v. Petty Motor Co.*, 327 U.S. 372, 380-81 (1946) (holding that plaintiff was entitled to compensation for government's takings of an option to renew a lease).

IV. LEGAL ANALYSIS

The government has moved to dismiss this matter for several reasons. First, the government argues that the Court should dismiss Blue Cross's claim based upon Section 1342 and its implementing regulations upon the ground that Blue Cross has no right to "presently due" money damages under these provisions, pursuant to RCFC 12(b)(1) or, alternatively, pursuant to RCFC 12(b)(6). Def. Mot. at 14-31; Def. Supp. Br. at 5-8. Second, the government argues that the Court should dismiss Blue Cross's statutory, breach of contract and takings claims upon the ground that these claims are not ripe, because HHS has not yet determined the total amount of the Risk Corridors Program Payments that Blue Cross will receive. Def. Mot. at 21-22.

In addition, the government has moved to dismiss Blue Cross's statutory claim for failure to state a claim

upon which relief can be granted, because Section 1342 does not mandate the Risk Corridors Program Payments in excess of amounts collected, or impose a contractual obligation upon the government. *Id*. at 22-31; Def. Supp. Br. at 5-8. The government has also moved to dismiss Blue Cross's contract and takings claims for failure state a claim upon which relief can be granted, because: (1) HHS has no contractual obligation to make the Risk Corridors Program Payments and (2) Blue Cross has no vested property right to full, annual Risk Corridors Program Payments. Def. Mot. at 32-44. Lastly, the government also seeks the dismissal of Blue Cross's request for declaratory relief in this matter, because such relief would not be collateral or incidental to a money judgment in this action. *Id*. at 44.

For the reasons discussed below, the Court possess subject-matter jurisdiction to entertain Blue Cross's statutory, contract and takings claims. But, Blue Cross fails to state plausible claims for relief with respect to these claims. And so, the Court must dismiss these claims pursuant to RCFC 12(b)(6).

In addition, the Court must dismiss Blue Cross's request for declaratory relief because the relief that Blue Cross seeks is neither incidental nor collateral to any judgment for monetary relief in this matter. RCFC 12(b)(1). And so, the Court GRANTS-IN-PART and DENIES-IN-PART the government's motion to dismiss.

A. The Court Possesses Jurisdiction To Consider Plaintiff's Claims

1. The Court May Consider Blue Cross's Statutory Claim

As an initial matter, the Court possesses jurisdiction to consider Blue Cross's claim alleging a violation of Section 1342 and its implementing regulations. *See generally* Compl. at ¶¶ 154-165. In the complaint, Blue Cross alleges that HHS has violated Section 1342 and its implementing regulations, by failing to make full, annual Risk Corridors Program Payments. *Id.*; 42 U.S.C. § 1342; 45 C.F.R. § 153.510. Because Section 1342 and its implementing regulations are money-mandating sources of law, the Court possesses jurisdiction to consider Blue Cross's claim.

It is well established that to pursue a claim for monetary relief against the government, Blue Cross must plead a money-mandating source of law. *See Cabral v. United States*, 317 F. App'x 979, 981 (Fed. Cir. 2008) (citing *Fisher*, 402 F.3d at 1172). A source is moneymandating when it "can fairly be interpreted as mandating compensation by the [government]." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472 (2003) (citing *Mitchell*, 463 U.S. at 217). And so, a source is money-mandating if it is "reasonably amenable to the reading that it mandates a right of recovery in damages." *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 19 (2011) (quoting *White Mountain Apache Tribe*, 537 U.S. at 473). In contrast, a source is not money-mandating when it provides the government with "complete discretion" regarding whether it will make payments. *Doe v. United States*,

463 F.3d 1314, 1324 (Fed. Cir. 2006) (citations omitted); *see ARRA Energy Co. I*, 97 Fed. Cl. at 19 (noting that the determination of whether a source is money-mandating "generally turns on whether the government has discretion to refuse to make payments under that [source].").

In this case, Section 1342 provides that if "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." 42 U.S.C. § 18062(b)(1) (emphasis supplied). This statute further provides that if "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." *Id.* (emphasis supplied).

Section 1342's implementing regulations also provide that "[w]hen 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 that "[w]hen 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." 45 C.F.R. § 153.510(b) (emphasis supplied).

The aforementioned provisions are plainly money-mandating. Indeed, the Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Agwia v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003) (citing *McBryde v. United States*, 299 F.3d 1357, 1361 (Fed. Cir. 2002); *Huston v. United States*, 956 F.2d 259, 261- 62 (Fed. Cir. 1992); *Grav v. United States*, 886 F.2d 1305, 1307 (Fed. Cir. 1989)); *see also Lummi Tribe of the Lummi Reservation v. United States*, 99 Fed. Cl. 584, 594 (2011). Because Section 1342 and its implementing regulations provide that the government "shall pay" and "will pay" the Risk Corridors Program Payments, these provisions mandate compensation by the government. 42 U.S.C. § 18062(b)(1); 45 C.F.R. § 153.510(b). And so, Section 1342 and its implementing regulations are money-mandating sources of law upon which Blue Cross may rely to establish jurisdiction.

The Court is also not persuaded by the government's argument that that the Court should dismiss plaintiff's statutory claim for lack of subject-matter jurisdiction, because Blue Cross has no right to "presently due money damages" under Section 1342 and its implementing regulations. Def. Mot. at 15-20. As the government correctly states in its motion to dismiss, the Supreme Court held in *United States v. King*, that this Court's predecessor did not possess jurisdiction to consider a claim for declaratory relief because such a claim was not limited to "actual, presently due money damages from the United States." 395 U.S. 1, 3 (1969). But, *King* is distinguishable from this case because *King* involved

a claim for equitable, rather than monetary, relief. *King*, 395 U.S. at 2-3; Compl. at ¶¶ 154-218.

In addition, as this Court recently recognized in *Land of Lincoln Mut. Health Ins. Co. v. United States*, the Federal Circuit's decisions in *Todd* and *Annuity Transfers* similarly do not support dismissal of Blue Cross's statutory claim for want of jurisdiction. *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 97-98 (2016); *see also Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (holding the Court has jurisdiction under the Tucker Act only when the money damages are "actual" and "presently due") (citing *Testan*, 424 U.S. at 398); *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 173, 179 (2009) (holding the Court has jurisdiction under the Tucker Act only if the settlement agreement upon which plaintiff's claim rests seeks "actual, presently due money damages from the United States") (citation omitted). *Todd* and *Annuity Transfers* both involve claims against the United States based upon contracts, rather than money-mandating statutes or regulations. *See Todd*, 386 F.3d at 1093-94; *Annuity Transfers, Ltd.*, 86 Fed. Cl. at 179.[5] And so, the Court does not read these cases to

[5] In *Todd*, the appellants sought back pay based upon alleged breaches of a collective bargaining agreement and memorandum of understanding. *Todd v. United States*, 386 U.S. 1091, 1093 (Fed. Cir. 2004). Similarly, in *Annuity Transfers*, the plaintiff alleged a breach of a settlement agreement with the government. *Annuity Transfers, Ltd. v. United States*, 86 Fed. Cl. 163, 179 (2009) (finding jurisdiction lacking under "presently due money damages" because the plaintiff brought suit to recover a lump-sum payment instead of periodic payments as provided for in the agreement with the government); *see also United States v.*

require that Blue Cross establish a right to actual, presently due money damages with respect to its claim pursuant to Section 1342 and its implementing regulations to establish jurisdiction.

Because Blue Cross has identified a money-mandating statute and money-mandating regulations to support its claim here, Blue Cross has no further obligation to establish jurisdiction. And so, the Court denies the government's motion to dismiss plaintiff's statutory claim for lack of subject-matter jurisdiction. RCFC 12(b)(1).

2. The Court May Consider Blue Cross's Contract And Takings Claims

The Court may also consider Blue Cross's contract and takings claims. Indeed, to the extent that Blue Cross asserts non-frivolous allegations of an express or implied-in-fact contract with the government, the Court may entertain these claims so long as the claims are for "actual, presently due money damages." *Speed v. United States*, 97 Fed. Cl. 58, 66 (2011) (quoting *King*, 395 U.S. at 3).[6]

In Count II of the complaint Blue Cross alleges that it "entered into a valid written QHP agreement with CMS" regarding the Risk Corridors Program

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Testan, 424 U.S. 392 (1976) (holding that the plaintiffs were not entitled to "presently due money damages" absent first obtaining equitable relief in the form of a retroactive classification to a higher pay grade).

[6] Unlike plaintiff's statutory claim, plaintiff's contract claims require a showing of presently due money damages to establish jurisdiction. *See Speed v. United States*, 97 Fed. Cl. 58, 66 (2011).

Payments. Compl. at ¶ 167. Blue Cross further alleges that it has implied-in fact contracts with the government regarding the Risk Corridors Program Payments, and that the government is "in breach of an implied covenant of good faith and fair dealing" under its express and implied-in-fact contracts, in Counts III and IV of the complaint. *Id.* at ¶¶ 183, 202. It is well established that the Court possesses jurisdiction to consider such claims under the Tucker Act. 28 U.S.C. § 1491(a)(1) (The Tucker Act grants this Court jurisdiction to consider claims based "upon any express or implied contract with the United States."); *Aboo*, 86 Fed. Cl. at 626-27.

The Court may similarly entertain Blue Cross's claim that the government's failure to make full, annual Risk Corridors Program Payments "constitutes a deprivation and taking of Plaintiff's property interests." Compl. at ¶ 217; s*ee* 28 U.S.C. § 1491(a)(1); *Morris v. United States*, 392 F.3d 1372, 1375 (Fed. Cir. 2004) ("[T]he Tucker Act provides the Court of Federal Claims exclusive jurisdiction over takings claims for amounts greater than $10,000.") (citation omitted); *see also Jan's Helicopter Serv., Inc.*, 525 F.3d at 1304 (citing *Eastern Enters.*, 524 U.S. at 520). And so, the Court denies the government's motion to dismiss Blue Cross's contract and takings claims for lack of subject-matter jurisdiction.

B. Plaintiff's Claims Are Also Ripe

While Blue Cross has established that the Court possesses jurisdiction to consider its statutory, contract and takings claims, the Court may not adjudicate any of these claims if the claims are not ripe for judicial review. *See, e.g.*, *Health Republic Ins.*

Co. v. United States, 129 Fed. Cl. 757, 772 (2017). The government argues in its motion to dismiss that Blue Cross's claims are unripe, because no money is presently due to Blue Cross under Section 1342 and because HHS has not yet completed the data analysis for the 2015 and 2016 Risk Corridors Program Payments. Def. Mot. at 21-22. Similar to its arguments with respect to jurisdiction, the government's ripeness arguments are unavailing.

It is well established that in determining whether a dispute is ripe for review, the Court must evaluate two factors: "(1) the 'fitness' of the disputed issues for judicial resolution; and (2) 'the hardship to the parties of withholding court consideration.'" *Shinnecock*, 782 F.3d at 1348 (citing *Abbott Labs.*, 387 U.S. at 149; *Sys. Application & Techs., Inc.*, 691 F.3d at 1383-84); *Caraco Pharm. Labs., Ltd.*, 527 F.3d at 1295 ("[A]n action is fit for judicial review where further factual development would not 'significantly advance [a court's] ability to deal with the legal issues presented.'") (citing *Nat'l Park Hospitality Ass'n v. DOI*, 538 U.S. 803, 812 (2003)). In this case, Blue Cross seeks to recover all of its Risk Corridors Program Payments for calendar year 2014. Compl. at Prayer for Relief. There is no dispute that HHS has completed the data analysis for the Risk Corridors Program Payments owed to Blue Cross for that year. Compl. at ¶¶ 135-38; Def. Mot. at 22. It is also without dispute that HHS has already made a portion of the payments owed to Blue Cross for 2014. Def. Mot. at 13-14; Compl. at ¶¶ 135-36. Given this, plaintiff's claims seeking to recover the full amount of the 2014 Risk Corridors Program Payments are neither hypothetical

nor in need of further factual development. And so, this matter is fit for judicial review.

Withholding the Court's consideration of Blue Cross's claims would also cause a hardship to Blue Cross. As Blue Cross argues in its opposition to the government's motion to dismiss, Blue Cross is owed almost $130 million in Risk Corridors Program Payments for calendar year 2014. Pl. Opp. at 27. This outstanding sum certainly imposes an immediate financial hardship on Blue Cross. *See Caraco Pharm. Labs.*, 527 F.3d at 1295 (citing *Gardner*, 387 U.S. at 171) (A hardship exists where the complained-of conduct has an "immediate and substantial impact" on a party.). And so, Blue Cross's claims are ripe and appropriate for judicial review.

C. Blue Cross Fails To State Plausible Claims

1. Blue Cross Fails To State A Plausible Statutory Claim

While ripe for judicial review, Blue Cross's claim pursuant to Section 1342 and its implementing regulations fails to state a plausible claim for relief. In the complaint, Blue Cross alleges that it is "entitled under Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b) to recover full and timely mandated risk corridor payments from the Government for CY 2014." Compl. at ¶ 160. During oral argument, Blue Cross further clarified that it maintains that the deadline for this payment was December 2015. Tr. 37:14-18. And so, Blue Cross argues that "[t]he Government's failure to make full and timely risk corridor payments [by this deadline] . . . constitutes a violation and breach of the Government's mandatory payment obligations" under

Section 1342(b)(1) and its implementing regulations. *Id*. at ¶ 164; *see also* Pl. Opp. at 21-23.

The Government argues in its motion to dismiss that the Court should dismiss Blue Cross's statutory claim pursuant to RCFC 12(b)(6), because Section 1342 and its implementing regulations do not impose "a deadline for HHS to tender full risk corridor payments to [qualified health plain issuers]." Def. Mot. at 16; 22-31. The Court agrees that neither Section 1342 nor its implementing regulations impose an annual deadline for making the Risk Corridors Program Payments in full. And so, the Court dismisses this claim pursuant to RCFC 12(b)(6).

A plain reading of Section 1342 demonstrates that Congress has not directly addressed the question of the timing of the Risk Corridors Program Payments in this statute. Specifically, Section 1342(a) provides, in relevant part, that:

> 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 [Medicare Part D, 42 U.S.C. 1395w–101, *et seq*.].

42 U.S.C. § 18062(a). Section 1342 also provides with respect to the payment methodology under the statute that:

> 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.

Id. § 18062(b)(1). The above provisions demonstrate that Section 1342 neither addresses, nor establishes, a deadline for the payment of the Risk Corridors Program Payments. And so, this statute is silent and, thus, ambiguous with respect to the timing of the Risk Corridors Program Payments.

When it enacted the ACA, Congress delegated authority to HHS to implement Section 1342. 42 U.S.C. § 18041 ("The Secretary shall, as soon as practicable after March 23, 2010, issue regulations

setting standards for meeting the requirements under this title. . . ."). And so, HHS has filled the gap in Section 1342 regarding the timing of the Risk Corridors Program Payments through agency regulations and policy. Specifically relevant to Blue Cross's claim here, HHS has promulgated regulations to implement the government's obligation to make the Risk Corridors Program Payments to issuers. 45 C.F.R. § 153.510. These regulations provide, in relevant part, that:

> **§ 153.510 Risk corridors establishment and payment methodology.**
>
> (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.

45 C.F.R. § 153.510(b).

A plain reading of the above regulations makes clear that HHS did not establish an annual deadline for the payment of the Risk Corridors Program Payments to insurers. In fact, these regulations simply provide that HHS will make the Risk Corridors Program Payments to issuers if certain criteria are met regarding costs. 45 C.F.R. § 153.510(b). And so, like Section 1342, these regulations provide no deadline with respect to when HHS must make the Risk Corridors Program Payments to issuers.[7]

Although Section 1342 and its implementing regulations are silent with respect to the timing of Risk Corridors Program Payments owed to issuers, HHS has addressed this issue through other agency policy. In this regard, a Risk Corridors and Budget Neutrality Bulletin from HHS, dated April 11, 2014, addresses the methodology that HHS will employ to make the Risk Corridors Program Payments owed to issuers in the event that the Risk Corridors Program collects less money than it is required to pay out under the program. Compl. at Ex. 20; Def. Mot. at 18-19. This bulletin provides, in relevant part, that:

> [I]f risk corridors collections are insufficient to make risk corridors payments for a year,

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[7] It is also notable that although HHS has established a 30-day deadline for issuers to make Risk Corridors Program Payments to HHS, HHS declined to establish such a deadline for the Risk Corridors Program Payments that are owed to issuers. *See* 45 C.F.R. § 153.510(d) ("A QHP issuer must remit charges to HHS within 30 days after notification of such charges."). The absence of such a deadline with respect to the payments owed to issuers indicates that HHS did not intend to establish an annual deadline for its payment of the Risk Corridors Program Payments.

> all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments.

Compl. at Ex. 20. The bulletin also provides that:

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

Id. This policy allows HHS to make pro-rata Risk Corridors Program Payments to issuers during a particular program year. But, the policy also requires that the agency to make up any shortfall in those payments during the subsequent years of the program, as additional funds are collected.

Given Congress's express and broad delegation of authority to HHS to implement the Risk Corridors Program, HHS's policy regarding the timing of the Risk Corridors Program Payments is reasonable and consistent with Section 1342. 42 U.S.C §§ 18041, 18062. The policy affords HHS the full three years of

this temporary program to make up any shortfall in the Risk Corridors Program Payments as funds become available. Given the absence of a statutory deadline for making the Risk Corridors Program Payments to issuers—and the temporary nature of the Risk Corridors Program—HHS's policy is sound and consistent with Section 1342. *Chevron*, 467 U.S. at 842-43. And so, the Court concludes that HHS has no obligation under Section 1342 or its implementing regulations to pay the full amount of Blue Cross's 2014 Risk Corridors Program Payments until, at a minimum, the agency completes its calculations for payments due for the final year of the Risk Corridors Program. During oral argument, the parties acknowledged that this deadline will not occur until December 2017 or January 2018. Tr. 26: 19-25.

The Court is also not persuaded by Blue Cross's argument that the government's pro-rata Risk Corridors Program Payments pursuant to the aforementioned policy undermine the purpose of the Risk Corridors Program. Pl. Opp. at 21-23; Pl. Supp. Br. at 5-10. As the government argues in its reply brief, pro-rata Risk Corridors Program Payments satisfy the stated purpose and objectives of the Risk Corridors Program, by protecting issuers from uncertainties regarding the cost of health insurance claims during the first three years of the ACA's Exchanges. *See* Def. Reply at 9-10. In fact, Blue Cross acknowledges in the complaint that it decided to continue to participate in the Risk Corridors Program despite HHS's announcement that the government would provide only pro-rata Risk Corridors Program Payments if the collections for a particular year could

not satisfy the payments due. Compl. at ¶¶ 42-43; *see also* Compl. at Ex. 3-4.

Blue Cross's argument that Section 1342 and its implementing regulations require full, annual Risk Corridors Program Payments because Section 1342 is based upon Medicare Part D is equally unavailing. Compl. at ¶¶ 7, 30; Pl. Opp. at 21-22, 30. While there is no dispute that the Risk Corridors Program is based upon Medicare Part D, this fact, alone, does not demonstrate that Congress intended for HHS to pay the Risk Corridors Program Payments owed to issuers in full, upon an annual basis. In fact, the Court is not aware of—and plaintiff has not cited to—any requirement in Section 1342 or elsewhere in the ACA that HHS must administer the Risk Corridors Program in the same manner as the Medicare Part D risk corridors program.

In addition, the fact that HHS calculates the amount of Risk Corridors Program Payments due and owed for each year under the three-year Risk Corridors Program similarly fails to establish the existence of an obligation upon the part of HHS to make full Risk Corridors Program Payments upon an annual basis. Pl. Opp. at 22. Rather, as both parties acknowledged during oral argument, any deadline for making the Risk Corridors Program Payments to issuers could be no earlier than the December of the following year, because HHS must accommodate state-operated reinsurance and risk adjustment programs and include risk adjustment and reinsurance payments received in the calculation of risk corridors charges and payments. Tr. 14:16-24, 37:14-18; Def. Mot. at 17. And so, HHS has reasonably

exercised its discretion with respect to the timing of Risk Corridors Program Payments to issuers, by making a pro-rata payment and requiring that the government make up any outstanding payments owed during the subsequent years of the program.

In sum, the plain language of Section 1342 and its implementing regulations provides no deadline for HHS to make the Risk Corridors Program Payments to Blue Cross. Blue Cross conceded this point, as it must, during oral argument. Tr. 45:23-25, 46:1-2. Rather, HHS has acted reasonably and consistent with Section 1342 and its implementing regulations by making pro-rata Risk Corridors Program Payments and committing to make up any shortfall in those payments during subsequent program years. Given this, the Risk Corridors Program Payments owed to Blue Cross for calendar year 2014 are not "presently due." For this reason, the Court must dismiss Count I of the complaint. RCFC 12(b)(6).

2. Blue Cross Fails To State A Plausible Express Contract Claim

The Court must also dismiss Count II of the complaint, because Blue Cross fails to state a plausible express contract claim. In Count II of the complaint, Blue Cross alleges that its QHP Agreement with CMS requires that HHS make full, annual Risk Corridors Program Payments. Compl. at ¶¶ 166-79. But, a plain reading of the complaint and the QHP Agreement shows, that Blue Cross's express contract claim fails as a matter of law.

First, to the extent that Blue Cross alleges that the government is contractually obligated to make full, annual Risk Corridors Program Payments,

because Section 1342 and its implementing regulations have been incorporated into its QHP Agreement, this claim is not viable. As discussed above, neither Section 1342, nor its implementing regulations, require that HHS make full, annual Risk Corridors Program Payments.

In addition, the contractual provisions that Blue Cross relies upon to show that HHS is contractually obligated to make full, annual Risk Corridors Program Payments cannot be reasonably read to create such an obligation. Specifically, Blue Cross relies upon section II, paragraph d of its QHP Agreement, which pertains to the acceptance of standard rules of conduct for QHP issuers and provides in relevant part, that:

> CMS will undertake all reasonable efforts to implement systems and processes that will support QHPI functions. In the event of a major failure of CMS systems and processes, CMS will work with QHPI in good faith to mitigate any harm caused by such failure.

Compl. at Ex. 2 at § II, ¶ d. But, this provision plainly does not require that HHS make the Risk Corridors Program Payments.

Section V, paragraph g of the QHPI Agreement, upon which Blue Cross also relies, similarly fails to address, or to require full, annual Risk Corridors Program Payments. Rather, this provision pertains to governing law and provides, in relevant part, that:

> This Agreement will be governed by the laws and common law of the United States of America, including without limitation such regulations as may be promulgated from time to time by the Department of Health and

> Human Services or any of its constituent agencies, without regard to any conflict of laws statutes or rules.

Compl. at Ex. 2 at § V, ¶ g. Again, to the extent that this provision can be read to incorporate Section 1342 and its implementing regulations, these legal provisions do not require full, annual Risk Corridors Program Payments. And so, because no reasonable reading of the contractual provisions that Blue Cross cites would show a contractual obligation upon the part of HHS to make full, annual Risk Corridors Program Payments, the Court must dismiss Count II of the complaint. RCFC 12(b)(6).

3. Blue Cross Fails To State A Plausible Implied-In-Fact Contract Claim

Blue Cross similarly fails to state a viable implied-in-fact contract claim. In this regard, Blue Cross alleges that "the combination of [Section] 1342, 45 C.F.R. § 153.510, and the Government's conduct before and after Plaintiff agreed to become a QHP for CY 2014, all support a reasonable inference that the Government entered into implied-in-fact contracts obligating it to pay CY 2014 risk corridors payments in full by the end of CY 2015." Pl. Opp. at 46; *see also* Compl. at ¶¶ 180-98. And so, Blue Cross maintains that the government materially breached these implied-in-fact contracts by failing to make full, annual Risk Corridors Program Payments. *Id.* at ¶ 197. Blue Cross's implied-in-fact contract claim is not plausible.

As an initial matter, Blue Cross's implied-in-fact contract claim is based upon Section 1342, and Blue Cross cannot overcome the general presumption that

Congress did not intend for the statutory obligations set forth in Section 1342 to contractually bind the government. To allege a plausible implied-in-fact contract claim here, Blue Cross must show, among other things, mutual intent on the part of the parties to contract with respect to the Risk Corridors Program Payments. *Kam-Almaz*, 682 F.3d at 1368 (To establish the existence of either an express or implied-in-fact contract with the United States, a plaintiff must show: (1) mutuality of intent; (2) consideration; (3) lack of ambiguity in the offer and acceptance; and (4) actual authority to bind the government in contract on the part of the government official whose conduct is relied upon.).

This Court has also long recognized that "[t]here is a general presumption that statutes are not intended to create any vested contractual rights." *ARRA Energy Co. I*, 97 Fed. Cl. at 27 (2011). And so, to determine whether Blue Cross can overcome such a presumption here, the Court must look to the text of Section 1342 to determine whether this statute contains specific language that creates a contract. *Brooks v. Dunlop Mfg. Inc.*, 702 F.3d 624, 631 (Fed. Cir. 2012). If not, the Court may also look to whether the circumstances surrounding the passage of Section 1342 manifest such an intent to bind the government contractually. *Id.*

Neither Section 1342 nor its implementing regulations contain language that creates a contractual obligation with respect to the Risk Corridors Program Payments. Section 1342 and its implementing regulations do mandate the payment of the Risk Corridors Program Payments under the

ACA's Risk Corridors Program. But, these provisions do not contain any language to create a contractual obligation for HHS to make these payments. And so, the Court must look to the circumstances surrounding the enactment of the ACA to determine whether there is any evidence that Congress, nonetheless, intended to contractually bind the government with respect to the Risk Corridors Program Payments. *Id*.

In this regard, Blue Cross does not identify any circumstances surrounding the enactment of the ACA that would manifest an intent upon the part of Congress to contractually bind the government. Rather, Blue Cross points to "the Government's conduct before and after [Blue Cross] agreed to become a QHP for CY 2014" to show that the parties entered into implied-in-fact contracts regarding the Risk Corridors Program Payments. Pl. Sur-Reply at 17.

When this Court has previously examined whether the circumstances surrounding a statute passage manifest an intent to contract, the Court has looked to the conduct of Congress and the President in enacting and signing that statute. For example, in *ARRA Energy*, the Court considered whether Congress's intent to contract could be inferred from the conduct of Congress and the President in enacting and signing the American Recovery and Reinvestment Act. *ARRA Energy Co. I*, 97 Fed. Cl. at 27. Similarly, in *Brooks*, the Federal Circuit looked to the legislative history and other evidence during the passage of the Leahy-Smith America Invents Act, Pub. L. 112-29, 125 Stat 284 (2011), to determine whether the circumstances surrounding the passage of that statute

manifested Congressional intent to contractually bind the government. *Brooks*, 702 F.3d at 631.

But, here, the alleged conduct and statements that Blue Cross relies upon to establish implied-in-fact contracts with the government occurred several years after the enactment of the ACA. Compl. at ¶¶ 89-105, 182; Pl. Opp. at 21-22. For example, Blue Cross alleges that the statements, letters and emails that it received from CMS in 2015 manifest Congressional intent to contractually bind the government. Compl. at ¶¶ 99-105, 182.[8]

More importantly, even if the Court were to accept Blue Cross's allegation that it has entered into implied-in-fact contracts with the government

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[8] The government also argues persuasively that Blue Cross's reliance upon the United States Claims Court's decision in *New York Airways v. United States* to support its implied-in-fact contract claim is misplaced. In *New York Airways*, our predecessor Court held that the actions of the parties in that case could support the existence of an implied-in-fact contract requiring the United States Federal Aviation Administration to make certain subsidy payments to compensate helicopter companies for the transport of U.S. mail. *New York Airways v. United States,* 369 F.2d 743, 751-52 (1966). The Claims Court also held that Congressional intent to contractually bind the government for these payments could be inferred from the Independent Offices Appropriation Act and the Second Supplemental Appropriation Act for fiscal year 1965. *Id*. at 752 ("That Congress recognized the contract nature of the subsidy payments is inferred by the title 'Payments to Air Carriers (Liquidation of Contract Authorization),' which was given to the subsidy appropriations in [the appropriations legislation]."). *New York Airways* is, however, factually distinguishable from this case, because the Risk Corridors Program Payments are made in connection with administering the Risk Corridors Program, rather than payments for particular goods or services.

regarding the Risk Corridors Program Payments as true, Blue Cross cannot show that the government breached such contracts in this case. As discussed above, neither Section 1342 nor its implementing regulations set an annual deadline for the Risk Corridors Program Payments. Given this, Blue Cross has not–and cannot–establish that the government breached an implied-in-fact contract based upon Section 1342 by failing to make full, annual 2014 Risk Corridors Program Payments. Def. Supp. Br. at 9; Tr. 62:18-25, 63: 1-2; RCFC 12(b)(6).

4. Blue Cross Fails To State A Plausible Implied Covenant Claim

Because the Court concludes that Blue Cross has not alleged plausible express or implied-in-fact contract claims in the complaint, the Court must also dismiss Blue Cross's claim for breach of the implied covenant of good faith and fair dealing. The Federal Circuit has recognized that every contract imposes upon the parties a duty of good faith and fair dealing and that the failure to fulfill that duty constitutes a breach of that contract. *Metcalf Constr. Co. v. United States,* 742 F.3d 984, 990. (Fed. Cir. 2014) (citations omitted). But, such an implied covenant cannot expand the parties' contractual duties beyond those existing in the contract, or create duties that are inconsistent with that contract. *Id*. at 991 (citation omitted).

Blue Cross alleges in Count IV of the complaint that "[b]y failing to make full and timely CY 2014 risk corridor payments to [Blue Cross], the United States . . . [is] in breach of an implied covenant of good faith and fair dealing" under its alleged express and

implied-in-fact contracts. Compl. at ¶ 202. But, the absence of either an express or implied contractual obligation upon the part of HHS to make the Risk Corridors Program Payments in full, upon an annual basis, precludes Blue Cross from establishing any right under an implied covenant of good faith and fair dealing. And so, the Court must also dismiss Count IV of the complaint. RCFC 12(b)(6).

5. Blue Cross Fails To State A Plausible Takings Claim

The Court must also dismiss Blue Cross's takings claim, because Blue Cross cannot demonstrate that it has a cognizable property interest in full, annual Risk Corridors Program Payments. In this regard, the Federal Circuit has long held that a plaintiff must have a cognizable property interest to state a viable Fifth Amendment takings claim. *Adams v. United States*, 391 F.3d 1212, 1218 (Fed. Cir. 2004) (In evaluating a takings claim, the Court first determines whether the claimant possessed a cognizable property interest in the subject of the alleged taking for purposes of the Fifth Amendment.) (citations omitted). While Blue Cross alleges that it "has a vested property interest in its contractual, statutory, and regulatory rights to receive" full, annual Risk Corridors Program Payments, neither Section 1342 nor its implementing regulations—nor any alleged contract by and between Blue Cross and the government—obligates the government to make full, annual Risk Corridors Program Payments. Compl. at ¶ 213. And so, Blue Cross simply cannot show that it has a cognizable contractual, statutory, or regulatory right to receive

full, annual Risk Corridors Program Payments. RCFC 12(b)(6).

D. The Court May Not Consider Blue Cross's Claim For Declaratory Relief

As a final matter, the Court must also dismiss Blue Cross's request "that the Court declare, as incidental to [a] monetary judgment, that based on the Court's legal determinations as to the Government's CY 2014 risk corridor payment obligations, the Government must make full and timely CY 2015 and CY 2016 risk corridor payments to Plaintiff if Plaintiff experiences losses during those years." Compl. at Prayer for Relief. Such relief is not incident of, or collateral to, any monetary judgment related to Blue Cross's 2014 Risk Corridors Program Payments.

This Court has long recognized that the Tucker Act provides the Court with jurisdiction to grant equitable or declaratory relief in limited circumstances. *See Annuity Transfers*, 86 Fed. Cl. at 181. Relevant to the present matter, the Court may "issue orders directing restoration to office or position, placement in appropriate duty or retirement status, and correction of applicable records" as an "incident of and collateral to" a monetary judgment. 28 U.S.C. § 1491(a)(2). But, the declaratory relief that Blue Cross seeks here is not incident of or collateral to a monetary judgment regarding its 2014 Risk Corridors Program Payments. Rather, such declaratory relief pertains to Risk Corridors Program Payments for 2015 and 2016, and those payments are not at issue in

this litigation.[9] In addition, the Court has determined that Blue Cross has no right to full, annual Risk Corridors Program Payments under Section 1342 and its implementing regulations. Given this, the declaratory relief that Blue Cross seeks is also unwarranted based upon the circumstances of this case. And so, the Court must also dismiss plaintiff's claim for declaratory relief.[10]

V. CONCLUSION

In sum, while the Court possesses jurisdiction to consider Blue Cross's statutory, contract and takings claims to recover the full amount of its Risk Corridors Program Payments for 2014 in this action, Blue Cross fails to state plausible claims for relief. As Blue Cross acknowledged during oral argument, there is no requirement in Section 1342 or its implementing

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[9] During oral argument, Blue Cross informed the Court that it withdraws its claim for declaratory relief with respect to the 2016 Risk Corridors Program Payments. Tr. 101:7-13. Blue Cross further advised that it would seek to amend the complaint with regards to plaintiff's request for declaratory relief regarding the 2015 Risk Corridors Program Payments. Tr. 101:13-18.

[10] Although the Court does not reach the question of whether the Risk Corridors Program Payments are an obligation to pay money under a statutory benefits program, the Federal Circuit has held that an obligation to pay money under a statutory benefit program does not create a cognizable property interest. *Adams v. United States*, 391 F.2d 1212, 1223-24 (Fed. Cir. 2004). Because the Court concludes that the government has no obligation to make full, annual Risk Corridors Program Payments under Section 1342 and its implementing regulations, and that HHS's policy with respect to the timing of those payments is reasonable and consistent with Section 1342, the Court does not reach the issue of whether Section 1342 mandates Risk Corridors Program Payments in excess of collections.

regulations that HHS make these payments in full by December 2015. As a result, Blue Cross fails to show that it is entitled to presently due money damages from the government.

In reaching the decision to dismiss this action, the Court concludes only that the government has no obligation to make full, annual Risk Corridors Program Payments and that the government may continue to make up any shortfall in plaintiff's 2014 Risk Corridors Program Payments until HHS completes its data calculations and collections for the final year of the Risk Corridors Program. And so, the Court does not reach the question of whether the government may, ultimately, limit such payments to the amount of collections under that program.

Because Blue Cross's claim for declaratory relief regarding its 2015 Risk Corridors Program Payments is not incidental of or collateral to plaintiff's claim for monetary relief in this action, the Court also dismisses this claim.

And so, for the foregoing reasons, the Court:

1. GRANTS-IN-PART and DENIES-IN-PART the government's motion to dismiss; and

2. DISMISSES the complaint.

The Clerk shall enter judgment accordingly.

The parties shall bear their own costs.

IT IS SO ORDERED.

s/ Lydia Kay Griggsby
LYDIA KAY GRIGGSBY
Judge

Appendix F

RELEVANT STATUTORY PROVISIONS

42 U.S.C. §18062

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

(2) Target amount

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

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014)

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

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015)

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

Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135, 543 (2016)

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).