No. _____

In the
Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,
Petitioner,

v.

UNITED STATES,
Respondent.

COMMUNITY HEALTH CHOICE, INC.,
Petitioner,

v.

UNITED STATES,
Respondent.

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

PETITION FOR WRIT OF CERTIORARI

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QUESTION PRESENTED

Just this past Term, this Court held in *Maine Community Health Options v. United States*, 140 S.Ct. 1308 (2020), that the government was obligated to make the risk corridor payments required by the unambiguous shall-pay command of §1342 of the Patient Protection and Affordable Care Act ("ACA"), and that insurers who performed in full could bring suit in the Court of Federal Claims to recover the amounts that the government "shall pay." In the decision below, the Federal Circuit recognized that under *Maine Community*, the government must make the cost-sharing reduction payments required by the equally unambiguous shall-pay language of §1402 of the ACA and not having appropriated funds did not simply vitiate the government's obligation. So far, so good; but it then went on to hold, based on a purported "analogy to contract law," that the remedy for the breach of the government's statutory shall-pay obligation is not an order to pay the statutory shall-pay amount, but only a far smaller amount (in the government's view, perhaps even zero). The decision below discounts the specific sums the government promised to pay for specific undertakings that insurers have performed in full to account for premium increases and related tax credits prompted by the government's breach.

The question presented is:

Whether the government is required to pay insurers the full amount of the cost-sharing reduction payments required by the unambiguous shall-pay language of §1402 of the ACA.

PARTIES TO THE PROCEEDING

Maine Community Health Options v. United States: Petitioner Maine Community Health Options was plaintiff in the Court of Federal Claims and appellee in the Federal Circuit. Respondent United States was defendant in the Court of Federal Claims and appellant in the Federal Circuit.

Community Health Choice, Inc. v. United States: Petitioner Community Health Choice, Inc. was plaintiff in the Court of Federal Claims and appellee in the Federal Circuit. Respondent United States was defendant in the Court of Federal Claims and appellant in the Federal Circuit.

CORPORATE DISCLOSURE STATEMENT

Petitioners Maine Community Health Options and Community Health Choice, Inc. have no parent corporations, and no publicly held company owns 10% or more of either petitioner's stock.

STATEMENT OF RELATED PROCEEDINGS

Maine Community Health Options v. United States, No. 19-2102 (Fed. Cir. opinion and judgment issued Aug. 14, 2020; order denying rehearing issued Nov. 10, 2020; mandate issued Nov. 17, 2020).

Maine Community Health Options v. United States, No. 1:17-cv-2057 (Fed. Cl. judgment issued June 11, 2019).

Community Health Choice, Inc. v. United States, No. 19-1633 (Fed. Cir. opinion and judgment issued Aug. 14, 2020; order denying rehearing issued Nov. 10, 2020; mandate issued Nov. 17, 2020).

Community Health Choice, Inc. v. United States, No. 1:18-cv-5 (Fed. Cl. judgment issued Mar. 7, 2019, and June 30, 2020).

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PETITION FOR WRIT OF CERTIORARI

The decision below is the latest chapter in the Federal Circuit's ongoing effort to excuse the federal government from honoring the statutory commitments Congress made to health insurers in the Patient Protection and Affordable Care Act ("ACA"). Just this past year, this Court reversed the Federal Circuit (nearly unanimously) and squarely held that the government must honor its statutory payment obligations in the specific context of the ACA. *Maine Community Health Options v. United States*, 140 S.Ct. 1308 (2020). This Court held that when Congress makes a clear shall-pay promise in a statute, and a private party performs, then the government shall pay the statutory amount and make good on its promise. That holding should have made this an easy case, as the ACA payment obligation at issue here is an equally unambiguous shall-pay commitment, and the government tried to escape it by pressing the exact same no-appropriation-no-obligation argument that *Maine Community* rejected. Indeed, the Federal Circuit agreed that the payment obligation here is enforceable under *Maine Community*. Yet it still refused to hold the government to the full extent of its statutory commitment. Instead, drawing a purported "analogy to contract law," App.13, it invented a novel and wholly unprecedented theory of "mitigation" to allow the government to pay far less than the statutory shall-pay amount, even though, just as in *Maine Community*, the insurers fully lived up to their end of the bargain.

That decision is every bit as wrong as the Federal Circuit's earlier effort to relieve the government of its

payment obligations in *Maine Community*. It is also every bit as consequential, implicating the government's ongoing obligations under §1402, billions of dollars in payments withheld from more than 100 insurers, and the government's reliability as a contracting partner across the board.

The statute at issue here, §1402 of the ACA, requires insurers to reduce the cost-sharing payments (such as deductibles and copayments) required of certain of their insureds. In turn, it unambiguously commits the United States to reimburse insurers for the full amount of those cost-sharing reductions, providing that the Secretary of Health and Human Services ("HHS") "shall make" payments to each insurer "equal to the value of the reductions." 42 U.S.C. §18071(c)(3)(A). Insurers responded to that clear promise in the precise manner Congress intended—namely, by reducing deductibles and co-payments based on the assurance that the government would honor its commitment to make payments equal to the amounts of the reductions. But despite the clear statutory language and insurers' equally clear reliance on it, in October 2017, HHS announced that it lacked sufficient appropriations and thus the United States would no longer honor its statutory commitment to reimburse insurers. The government's unilateral refusal to honor its financial commitments did not relieve insurers of their statutory obligation to reduce cost-sharing payments, but it did leave them on the hook for over $7 billion in unreimbursed costs over the next two years alone.

In the wake of *Maine Community*, the Federal Circuit correctly recognized that §1402 imposed an

unambiguous obligation on the government to make the promised cost-sharing payments, and that insurers could sue in the Court of Federal Claims to enforce that shall-pay obligation. So far, so good; but at that point the Federal Circuit lost the thread of *Maine Community* and returned to its errant ways by declining to order the remedy *Maine Community* contemplated—*i.e.*, a shall-pay remedy for a shall-pay violation. Instead, the court invoked misguided "mitigation" principles to reduce the government's obligation (in the government's view, perhaps to zero), despite the insurers' performance in full.

That effort to give lip service to *Maine Community* on the merits, while ignoring its remedial holding and potentially leaving insurers who fully performed with pennies on the dollar, cannot stand. It is unsupported by contract law, which makes clear that when a party fully performs based on a specific promise to pay, there is no role for mitigation and no excuse for the breaching party not to make full payment for full performance. Worse still, the decision threatens to unsettle well-settled principles of government contracting law and invites the government to concoct creative theories about how parties who took the government at its word are actually better off for the government's breach. Finally, the decision contradicts the simple principle that this Court set forth in *Maine Community*: When the government violates a clear statutory shall-pay obligation, the party who performed in full is entitled to a statutory shall-pay remedy. This Court should grant review and clarify that *Maine Community* meant what it said when it held that the government must pay "the full amount" of its statutory obligations. 140 S.Ct. at 1319.

OPINIONS BELOW

The Federal Circuit's opinion is reported at 970 F.3d 1364 and reproduced at App.1-34. The Court of Federal Claims' opinion in *Community Health* is reported at 141 Fed. Cl. 744 and reproduced at App.39-94, and its opinion in *Maine Community* is reported at 143 Fed. Cl. 381 and reproduced at App.95-148.

JURISDICTION

The Federal Circuit issued its opinion on August 14, 2020, and denied rehearing on November 10, 2020. This Court has jurisdiction under 28 U.S.C. §1254(1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the appendix.

STATEMENT OF THE CASE

A. Factual and Statutory Background

1. The ACA aimed to extend affordable health insurance to millions of uninsured and underinsured Americans. To that end, the ACA established new "health benefit exchanges" on which individuals and small groups could purchase "qualified health plans" from participating insurers. 42 U.S.C. §18031(b)(1). These exchanges are intended to provide uninsured or underinsured individuals with easy access to health insurance plans that will provide them with adequate healthcare coverage at affordable prices.

To ensure adequate coverage, the ACA requires qualified health plans offered on the exchanges to provide a minimum level of "essential health benefits." *See* 42 U.S.C. §18022(b). The ACA defines four levels

of coverage—bronze, silver, gold, and platinum—based on the percentage of the cost of essential health benefits that the insurer pays under each plan. *Id.* §18022(d)(1); *see* App.3. Under a bronze plan, the insurer pays 60% of the full actuarial value of the healthcare benefits covered under the plan (and the insured person is responsible for the other 40%); under a silver plan, the insurer pays 70%; under a gold plan, the insurer pays 80%; and under a platinum plan, the insurer pays 90%. 42 U.S.C. §18022(d)(1); *see* App.3. Every insurer who offers plans on an ACA exchange must offer at least one silver plan and at least one gold plan on that exchange. 42 U.S.C. §18021(a)(1)(C)(ii).

2. The ACA includes several provisions designed to reduce the costs of healthcare coverage for individuals buying insurance on the exchanges. This Court already confronted one of those provisions, the risk-corridors payments set forth in §1342 of the ACA, in *Maine Community*. This case involves another, the cost-sharing reduction provision in §1402, codified at 42 U.S.C. §18071. Unlike the temporary risk-corridor payments in §1342, which applied only in the first three years of the exchanges, the cost-sharing provisions of §1402 are a permanent feature of the ACA. Section 1402 seeks to reduce the cost of medical care for eligible insured individuals by reducing their "cost-sharing" payments—out-of-pocket costs such as "deductibles, coinsurance, copayments, or similar charges." *Id.* §18022(c)(3)(A). To that end, §1402 requires insurers to reduce cost-sharing payments for eligible individuals insured under ACA silver plans, and commits the government to reimburse insurers for those reductions. *See id.* §18071.

Specifically, §1402 requires insurers to reduce the cost-sharing payments owed by "eligible insureds," defined as any person whose household income is between 100% and 400% of the poverty line and who is enrolled in a silver-level qualified health plan. *Id.* §18071(b). The Secretary "shall notify" the insurer of each eligible insured covered by that insurer, at which point the insurer "shall reduce" the cost-sharing obligations for that insured based on the insured's household income level. *Id.* §18071(a), (c). Depending on the insured's income level, those reductions require the insurer to cover up to 94% of the insured's costs (as opposed to 70% for a silver plan without cost-sharing reductions). *Id.* §18071(c)(1)(B), (c)(2).

Critically, while §1402 unambiguously requires insurers to make those reductions, it does not leave the resulting financial burden on the insurers. Instead, §1402 provides in unambiguously mandatory language that the Secretary "shall make periodic and timely payments to the [insurer] equal to the value of the reductions." *Id.* §18071(c)(3)(A). That statutory commitment ensures that as long as the insurers hold up their end of the bargain and reduce the cost-sharing payments of eligible insureds, the government will reimburse insurers for those reductions. *See Sanford Health Plan v. United States*, 969 F.3d 1370, 1373 (Fed. Cir. 2020).

3. The ACA also includes a separate "premium tax credit" provision—§1401, codified at 26 U.S.C. §36B—that aims to lower the premiums that low-income individuals must pay to obtain coverage on the exchanges, by providing a federal subsidy for those

premiums in the form of a refundable tax credit. *See* App.4; *Sanford*, 969 F.3d at 1374.

Section 1401 defines an "applicable taxpayer" eligible for a premium tax credit as any taxpayer whose household income is between 100% and 400% of the poverty line, the same thresholds used to define an "eligible insured" under §1402. *Compare* 26 U.S.C. §36B(c)(1), *with* 42 U.S.C. §18071(b)(2). But unlike the cost-sharing reductions in §1402, which are available only to persons who purchase silver plans, the premium tax credit is available to any eligible taxpayer who purchases any qualified health plan on an ACA exchange, whether bronze, silver, gold or platinum. *Compare* 26 U.S.C. §36B(c)(1), *with* 42 U.S.C. §18071(b)(1); *see Sanford*, 969 F.3d at 1374-75. The amount of each taxpayer's premium tax credit is set by a statutory formula that depends on (1) the taxpayer's household income and (2) the premiums for the second-lowest-cost silver plan offered on the taxpayer's local ACA exchange, regardless of whether the taxpayer actually enrolls in that plan. 26 U.S.C. §36B(b)(2)(B), (3); *see Sanford*, 969 F.3d at 1375.

The government pays these tax credits directly to insurers, who apply the payments toward the insured's monthly premiums, so that "the amount of the premiums charged by the insurers to the insured is effectively reduced," and the amount the insured pays in premiums is, in fact, reduced. App.4; *see* 26 U.S.C. §36B(f); 42 U.S.C. §18082(a)(3). The payment formula ensures that an insurer cannot simply pocket the amount of the premium tax credit payments itself by increasing its own premiums an equivalent amount, because, *inter alia*, the payments are keyed

to the premiums for the second-lowest-cost silver plan in the market, not on what the insurer actually charges. Moreover, while both §§1401 and 1402 are tied (in different ways) to silver plans, nothing in either section provides for adjustments in the amount of §1402 reimbursements to account for §1401 tax credits or vice-versa.

4. The first open enrollment period on the exchanges began in October 2013, allowing customers to purchase health coverage for the 2014 calendar year. In January 2014, as soon as coverage was first provided via the exchanges, insurers were obligated to make cost-sharing reductions for eligible insureds, and the government began making its own cost-sharing reduction reimbursement payments to insurers as required by §1402 and its implementing regulations. *See Sanford*, 969 F.3d at 1377. The government likewise provided the requisite premium tax credit payments to the insurers under §1401. The government continued to make those payments for the next three and a half years. *Id.*

In October 2017, however, the Secretary unilaterally "announced that the government would cease payment of cost-sharing reduction reimbursements," asserting (contrary to HHS's position for the previous three and a half years) that it was under no binding obligation to make the payments because Congress had failed to appropriate funds to make them. App.6; *see Sanford*, 969 F.3d at 1377. That announcement, three-quarters of the way through the 2017 plan year, did nothing to relieve insurers of their obligation under §1402 to continue offering cost-sharing reductions to their eligible silver-

plan customers during the 2017 plan year or subsequent plan years. App.6; *see* 42 U.S.C. §18071(a), (c). Instead, it left the insurers with a non-negotiable obligation to provide cost-sharing reductions while the federal government reneged on its statutory obligation to reimburse those costs. The situation continued in subsequent years, with insurers statutorily obligated to provide cost-sharing reductions and the government refusing to honor its obligation to reimburse those reductions, despite an unambiguous statutory command to do so, on the simple ground that the funds had not been appropriated. Put differently, the insurers performed their statutory obligations in full, while the government's arrears mounted. *See CHC* C.A.Dkt.16 at 13 (admitting to "approximately $433 million in unmade cost-sharing payments during the last quarter of 2017 and approximately $6.7 billion in unmade advance cost-sharing payments during the 2018 calendar year").

The government's announcement that it would no longer comply with the unambiguous mandate of §1402 placed insurers in a bind and caused many insurers to seek permission from state regulators to increase their premiums for 2018 (and subsequent years). App.7-8. Those increased premiums, unsurprisingly, fell most heavily on silver plans—*i.e.*, the plans for which insurers remained statutorily obligated to provide cost-sharing reductions on an ongoing basis. *Id.*; 42 U.S.C. §18071(b)(1). Those premium increases applied not only to individuals who bought and paid for their own insurance through an exchange, but also to some individuals who were eligible for premium tax credits under §1401. Because

those tax credits are calculated based on premiums for the second-lowest-cost silver plan in the market (but not each insurer's own premiums), any increase in an insurer's premiums did not necessarily result in a corresponding increase in the premium tax credit payments it received under §1401. Nevertheless, many insurers did receive some additional payments under §1401 as a result of the state-approved premium increases. *See* App.7-8.

B. Proceedings Below

1. Petitioners Maine Community Health Options and Community Health Choice, Inc. ("CHC") are health insurance providers that sell qualified health plans on ACA exchanges in Maine and Texas, respectively. App.8. As required by §1402, both petitioners provided cost-sharing reductions to eligible insureds on their silver-level plans. App.9. The amounts of those reductions were considerable, as eligible insureds constituted a substantial portion of both petitioners' customer bases. In 2017, for instance, CHC provided cost-sharing reductions to more than 80,000 eligible insureds—about 58% of its total insured population. App.56. But while petitioners extended their insureds the cost reductions required by §1402, the government has not upheld its end of the bargain and has defaulted on its unambiguous obligation to make payments to reimburse petitioners for those cost reductions. In fact, petitioners (like all other insurers) have not received a penny in reimbursement from the federal government since October 2017, leaving petitioners saddled with tens of millions of dollars in unreimbursed costs. *CHC* Cl.Ct.Dkt.35 (calculating

that CHC is owed more than $70 million for 2017 and 2018 alone). As in *Maine Community*, the federal government claimed the absence of appropriations to make the required payments obviated the payment obligation altogether.

Petitioners had little choice but to file suit against the United States in the Court of Federal Claims, seeking to recover the cost-sharing reduction reimbursements they were owed under §1402. App.9. In lengthy and detailed opinions, the Court of Federal Claims (Sweeney, J.) ruled for both petitioners, holding that the government could not renege on its statutory commitment to reimburse insurers for their cost-sharing reductions after petitioners had performed in full. App.58-77, 81-93; 116-47. The court squarely rejected the government's primary argument that it had no obligation to make payments under §1402 unless and until Congress appropriated funds for those payments, explaining that the government's unambiguous statutory commitment in §1402 was not conditioned on future appropriations. App.58-71; 115-28.

The court likewise rejected the government's alternative argument that Congress intended insurers bilked by the federal government to raise premiums rather than sue to recover statutorily required payments improperly withheld. In the government's view, Congress must not have intended to allow insurers to sue because insurers could recoup their losses from the government's refusal to meet its cost-sharing obligations by increasing the premiums they charged all their customers in future years (and, in some instances, obtaining increased premium tax

credit payments under §1401 as a result). App.66, 77; 122-23, 134. The court found that argument wholly unsupported, explaining that the government could not identify "any statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation," or any evidence in the ACA's legislative history suggesting that Congress intended to authorize that approach. App.66, 125.

The court also rejected the government's theory that holding the government to its statutory commitment under §1402 would afford insurers a "double recovery" or an "unwarranted windfall." App.67, 78, 124, 134. As it explained, any amounts the government owed insurers in premium tax credits were the result of the government's independent statutory obligations under §1401, and even if the amount of those credits increased because of the government's default, that did not excuse the government from complying with its separate statutory cost-sharing obligations under §1402. *See* App.67, 124 (explaining that §1401 and §1402 "are not substitutes for each other"). Notably, the government did not argue that its payments under §1401 should reduce its damages for violating §1402; it argued only that insurers could not sue the government *at all* for breaching its §1402 commitment. *See* App.67, 93, 125, 147.

Four other cases were brought before the Court of Federal Claims by various insurers seeking to recover unpaid cost-sharing payments under §1402, including a class action involving more than 100 insurers and seeking some $1.5 billion in unpaid 2018 payments.

Those four cases were assigned to three different judges (including Judge Sweeney), all of whom issued detailed opinions unanimously agreeing that the government is liable for the full amount of its unmet cost-sharing obligations. *See Common Ground Healthcare Coop. v. United States*, 142 Fed. Cl. 38 (2019) (Sweeney, J.); *Local Initiative Health Auth. for L.A. Cnty. v. United States*, 142 Fed. Cl. 1 (2019) (Wheeler, J.); *Sanford Health Plan v. United States*, 139 Fed. Cl. 701 (2018) (Kaplan, J.); *Mont. Health Co-op v. United States*, 139 Fed. Cl. 213 (2018) (Kaplan, J.).

2. The government appealed in each case. While those appeals were pending, this Court decided *Maine Community*. In *Maine Community*, the Court considered the government's refusal to make statutorily required payments to insurers under the risk corridors program in ACA §1342. In §1342, Congress provided that the Secretary of HHS "shall pay" insurers a portion of any losses above a certain threshold that insurers incurred on the exchanges in their first three years of operation. 140 S.Ct. at 1316. But when those payments came due, the government refused to make them, arguing that it had no obligation to pay because Congress had failed to appropriate the necessary funds and that in any event Congress did not intend to allow insurers to sue for damages to recover those payments. *Id.* at 1319-31.

This Court rejected both arguments. It held that the unambiguous "shall pay" language of §1342 "created an obligation neither contingent on nor limited by the availability of appropriations," and that Congress did not repeal that government obligation by

failing to appropriate money to pay it. *Id.* at 1319-27. Put simply, "the statute meant what it said: The Government 'shall pay' the sum that §1342 prescribes." *Id.* at 1321.

The Court also held that the insurers could sue the government for that sum in the Court of Federal Claims. *Id.* at 1327-31. By instructing that the government "shall pay" the amount specified by the statutory formula, §1342 "falls comfortably within the class of money-mandating statutes that permit recovery of money damages in the Court of Federal Claims." *Id.* at 1329. The explicit statutory language was bolstered by the statute's "focus on compensating insurers for past conduct," which used "a backwards-looking formula to compensate insurers for losses incurred." *Id.* The statute also did not create any alternative "comparable remedial scheme" with "its own judicial remedies" that would displace the default remedy under the Tucker Act of suing the United States for the amount owed in the Court of Federal Claims. *Id.* at 1329-30. On the contrary, the insurers' suit for "specific sums already calculated, past due, and designed to compensate for completed labors" was "in the Tucker Act's heartland." *Id.* at 1331. Simply put, the statutory shall-pay obligation gave rise to an equally clear shall-pay remedy under the Tucker Act.

3. In light of *Maine Community*, the government abandoned its argument below that Congress' purported failure to appropriate funds eliminated the government's cost-sharing obligations under §1402. However, the government continued to maintain that §1402 was not money-mandating, and that insurers

had no right to sue the government for the amounts it had refused to pay.

In addition, the government argued for the first time on appeal—in a cursory two-page section tacked onto the end of its opening brief—that petitioners had "no Article III injury," and should receive no damages, to the extent they received increased premium tax credit payments under §1401 after the government stopped making cost-sharing payments under §1402. *CHC* C.A.Dkt.16 at 40-41. The government expanded on this theory in a supplemental brief filed at the Federal Circuit's request, arguing that petitioners had "mitigated" their damages by raising their premiums after the government stopped making cost-sharing payments, and that any additional premium tax credit payments petitioners received under §1401 should be deducted from the amount the government owed under §1402—meaning, according to the government, that it owed petitioners nothing at all. *CHC* C.A.Dkt.56.

4. The Federal Circuit affirmed as to liability, but reversed and remanded as to damages. App.2. The panel agreed with the Court of Federal Claims that §1402 "imposes an unambiguous obligation on the government" to make cost-sharing reduction payments. App.11; *see Sanford*, 969 F.3d at 1372-73, 1381. It likewise agreed that because §1402 was money-mandating, petitioners could enforce that unambiguous obligation by suing the government for damages under the Tucker Act. App.11; *see Sanford*, 969 F.3d at 1381-83. And it agreed that for 2017—the first year in which the government failed to make those payments—the government owed petitioners

the full amount Congress had promised but HHS had failed to pay. App.11-12.

As to the cost-sharing reduction payments the government owed for 2018, however, the panel reached a very different result. Rather than requiring the government to make the full payments Congress mandated, the panel held that the government could reduce the payments it owed for 2018 by claiming "mitigation" based on "an analogy to contract law." App.12-13. In the panel's view, insurers had "mitigated the effects of the government's breach" by increasing their premiums, which in turn led some insurers to receive "additional premium tax credits" under §1401. App.23. The panel deemed those payments "a direct consequence of [insurers'] mitigation efforts following the government's nonpayment of 2018 cost-sharing reduction reimbursements." App.29. Accordingly, it held, the Court of Federal Claims should have "credit[ed] the government with such tax credit payments in determining damages." App.29.

The panel remanded for the Court of Federal Claims to undertake the "fact-intensive task" of determining "the amount of premium increases (and resultant premium tax credits) attributable to the government's failure to make cost-sharing reduction payments," rather than "other factors, such as market forces or increased medical costs." App.30.

REASONS FOR GRANTING THE PETITION

This Court's decision in *Maine Community* should have made this a simple case. The government raised the exact same no-appropriation-no-obligation arguments here that this Court rejected in *Maine*

Community. Thus, once this Court squarely rejected those arguments in *Maine Community*, there should have been one—and only one—thing left for the lower courts to do here: order the same clear shall-pay remedy this Court adopted in *Maine Community*. Once the government has defaulted on a money-mandating obligation under a statute, the remedy is quite simply to mandate the government to pay the money. The statute, *Maine Community*, and common sense require nothing less. But the Federal Circuit in the decision below provided far less. That decision conflicts with both *Maine Community* and well-established common-law principles and allows the government to escape billions of dollars in binding commitments.

First, the decision below runs headlong into *Maine Community* itself. As that decision made clear, when Congress directs that the United States "shall pay" private parties that undertake specified actions, then the government must honor its shall-pay obligation whether or not a subsequent Congress appropriates sufficient funds. And the remedy for failing to honor such a statutory obligation is equally clear: as long as the plaintiff has performed in full, the government must pay the full amount of its shall-pay obligation under the statute. That should have been the end of the matter here, for there is no dispute either that petitioners abided by their cost-sharing reduction obligations under §1402, or that §1402 requires the government to reimburse petitioners for those reductions in full. If anything, the statutory obligations of both insurers and the government were even clearer under the cost-reduction provisions of §1402 than under the risk-corridors provisions of

§1342. Unlike with the risk-corridor provisions, nothing in the discounting obligations of insurers or the reimbursement obligations of the government even arguably turned on future contingencies like whether payments-out outstripped payments-in. Insurers are under an absolute statutory obligation to reduce the deductibles and co-payments of eligible insureds, and the government is under an absolute statutory obligation to reimburse those amounts. Thus, when the federal government announced in 2017 that it lacked sufficient appropriations and would stop providing timely reimbursements, there was never any suggestion by the federal government or anyone else that insurers were thereby relieved of their statutory obligation to provide the cost-reductions. Insurers accordingly held up their end of the bargain and performed in full. The proper remedy under *Maine Community*, plain text, and common sense is that the government must pay in full just as if it had never repudiated its obligation to make timely reimbursement payments.

The Federal Circuit's invocation of mitigation principles to reduce (or, according to the government, eliminate) the government's payment obligations not only contradicts *Maine Community*, but finds no support in the statute and bears no resemblance to any doctrine known to the common law. As to the statute, Congress clearly understood that §§1401 and 1402 both key certain government payments to silver plans offered on exchanges (albeit in different ways). If Congress intended that payments under one section would reduce the government's obligations under the other, it would have said so. Instead, the statute plainly imposes two independent payment obligations.

As to the common law, mitigation is relevant only when one party's breach effectively *relieves* the other party of its obligation to perform. Under those circumstances, if the party spends the time and resources it would have otherwise spent upholding its end of the bargain in a manner that limits its losses, the damages calculation accounts for that activity. But petitioners are aware of no case that has ever applied common-law mitigation principles to reduce a plaintiff's recovery when the plaintiff performed its contractual obligations in full, and the defendant simply refused to pay the sum certain that it had agreed to pay for that performance. That presumably explains why the government never even attempted to raise any such mitigation argument before the Court of Federal Claims (or in *Maine Community*, where it would have been equally applicable).

Indeed, even the Federal Circuit seemed to recognize that the novel form of mitigation it crafted has no grounding in common law (or anything else) by refusing to embrace the untenable consequences of applying mitigation principles in this context. Under the common law, mitigation entails not just a damages offset when mitigation happens, but a *duty* to mitigate (or more precisely, an offset for any mitigation that should have occurred but did not). Thus, if mitigation principles really applied here, it would mean that all insurers were required (at their own peril) to raise their premiums to offset the losses attributable to the government's refusal to abide by its payment obligations under §1402. Not even the Federal Circuit could embrace that absurd consequence, as it would impose a duty that ran directly contrary to the whole thrust of the ACA, which is designed to make health

insurance affordable, not to require premium increases. But the absurdity of fully applying mitigation principles here underscores that those principles are a complete misfit when a party performs in full and the counterparty simply refuses to pay the sum certain it promised in advance. In those circumstances, the common-law remedy and the statutory remedy are the same: pay up. Full performance merits full payment of the amount promised in advance, full stop.

The decision below is not only seriously flawed, but also exceptionally important. The stakes here rival the stakes in *Maine Community*, as the government has defaulted on billions of dollars in clearly promised statutory payments based on the same flawed no-appropriation-no-obligation theory repudiated by this Court. As in *Maine Community*, a misguided Federal Circuit precedent threatens to excuse the government from living up to its end of the bargain after insurers have performed in full. But the consequences of the Federal Circuit's decision go beyond the billions of dollars at stake here. Unlike §1342, which involved only retrospective payment obligations for a three-year program that had run its course, §1402 imposes continuing obligations on both insurers and the government. Nonetheless, the decision below threatens to immunize the government from any consequence of disregarding its ongoing statutory reimbursement obligation. Moreover, by purporting to draw on general contract-law principles, the Federal Circuit's misguided "mitigation" analysis not only dilutes clear statutory shall-pay obligations but will apply broadly in government-contract litigation and risks diluting the government's

incentives and obligations to perform in a wide variety of contexts. In short, the decision here is every bit as flawed and consequential as the decision in the first *Maine Community* case. This Court should grant certiorari and correct the Federal Circuit once again.

I. The Federal Circuit's Decision Cannot Be Reconciled With This Court's Decision In *Maine Community*.

It has been less than a year since this Court decided *Maine Community*—and yet the Federal Circuit is already at it again. As *Maine Community* made abundantly clear, when Congress enacts a statute that squarely and unambiguously obligates the government to make payments, the United States must comply with that statutory shall-pay obligation—and if it fails to do so, it is liable for the full amount the statute directs that the government shall pay. The Federal Circuit's latest attempt to evade that now-settled principle and relieve the government of its statutory payment obligations once again warrants this Court's review.

1. The parallels between this case and *Maine Community* are striking—and make the Federal Circuit's evisceration of that binding precedent all the more inexplicable. Like *Maine Community*, this case involves an ACA provision that aims to reduce healthcare costs for low-income individuals by committing the government to reimburse insurers for their efforts to keep premiums and co-payments to a minimum. *Compare* 140 S.Ct. at 1315, *with* App.3-4. Here as in *Maine Community*, Congress "create[d] an obligation directly through statutory language" that unambiguously promised that the government shall

make the promised payments if insurers lived up to their end of the bargain. 140 S.Ct. at 1320; *compare* 42 U.S.C. §18062(b)(1) ("the Secretary shall pay"), *with* 42 U.S.C. §18071(c)(3)(A) ("the Secretary shall make periodic and timely payments"). In both cases, the amount of the payment obligation was set by a "precise statutory formula." 140 S.Ct. at 1320-21; *compare* 42 U.S.C. §18062(b)(1), *with* 42 U.S.C. §18071(c)(1)-(2), (c)(3)(A). Indeed, if anything, the government's statutory shall-pay obligation is even clearer under §1402, because the government's shall-pay obligation is not contingent on the balance of payments in and out; as long as an insurer provides the required cost reductions, the government's reimbursement obligation is clear and unconditional.

The parallels do not end with the statutory language. Here as in *Maine Community*, despite the unambiguous terms of the governing statute, the government refused to honor its obligations on the ground that Congress had failed to provide the necessary appropriations. 140 S.Ct. at 1316-17; App.6. Here as in *Maine Community*, the insurers refused to accept that the absence of appropriated funds somehow made the government's obligation disappear and sued in the Court of Federal Claims to recover the payments the government unambiguously owed under the plain statutory text. 140 S.Ct. at 1318; App.9. In both cases, the insurers sought "specific sums already calculated, past due, and designed to compensate for completed labors." 140 S.Ct. at 1331; *see* App.9. And in both cases, the Federal Circuit responded by inventing an atextual and unsustainable rationale for eliminating the government's obligations—in *Maine Community*, by reading an

implied repeal into a later appropriations rider, and here, by devising a novel theory of "mitigation." 140 S.Ct. at 1318; App.12-29. The parallels should not end there: As in *Maine Community*, this Court should grant certiorari, reverse the Federal Circuit, and reaffirm once again that the government must honor its shall-pay obligations in full.

2. The Federal Circuit recognized that *Maine Community* required it to reject the government's no-appropriation-no-obligation theory and to hold that §1402 imposed an unambiguous money-mandating obligation on the government. App.11; *see Sanford*, 969 F.3d at 1378-83. And the court found "no merit to the government's argument" that petitioners' damages for the government's failure to make cost-sharing payments in 2017 should be reduced. App.12. But when it came to the government's equally clear failure to make the same statutorily mandated payments in 2018 based on the same misguided excuse, the Federal Circuit reached a startlingly different conclusion, finding that *Maine Community* did not "resolve[] this question" of whether the government is obligated to pay petitioners the amounts that §1402 directs that the government shall pay. App.12.

That conclusion is plainly incompatible with *Maine Community*, which repeatedly made clear that the government's shall-pay obligation extends to the entire amount that Congress mandates—not some judicially reduced subset of that amount. The dispute in *Maine Community*, the Court explained, was "whether the Government must pay the remaining deficit" it owed under §1342. 140 S.Ct. at 1318. And

the Court's answer to that question was unmistakable, explicitly "hold[ing]" that the insurers had "a damages remedy for the unpaid amounts," not some smaller amount based on complicated interactions with different statutory provisions or novel theories of mitigation. *Id.* at 1315. The straightforward remedy for a failure to honor a statutory shall-pay obligation is an order that the government shall pay "the unpaid amounts." *Id.*

That same simple and straightforward answer reappears throughout *Maine Community*. The decision explicitly holds that §1342 "created a Government obligation to pay insurers the full amount set out in §1342's formula." *Id.* at 1319. It recognized the government's obligation to pay "whatever amount the statutory formula provides." *Id.* at 1321. It explicitly rejected the government's view that "a partial payment would satisfy the Government's whole obligation," and instead held that the government was required to pay "the sum that [the statute] prescribes." *Id.* And it twice repeated Justice Scalia's pronouncement that "[a] statute commanding the payment of a specified amount of money by the United States implicitly authorizes (absent other indication) a claim for damages *in the defaulted amount*." *Id.* at 1328 n.12, 1329 (emphasis added) (quoting *Bowen v. Massachusetts*, 487 U.S. 879, 923 (1988) (Scalia, J., dissenting)).

None of this was just stray dictum or imprecise wording. To the contrary, the Court held that there was Tucker Act jurisdiction in the case precisely because §1342 was a "moneymandating statute." *Id.* at 1327-29. And given that Tucker Act jurisdiction

depends on the statute providing a clear mandate to pay "specific sums," the remedy for the statutory violation is equally clear: an order for the government to pay the "specific sums already calculated, past due, and designed to compensate for completed labors" that §1342 unambiguously required the government to pay. *Id.* at 1331. Nothing in the Court's opinion remotely suggested that the remedy for violating a money-mandating statute was anything other than the "specific sums" of money that Congress explicitly mandated the government to pay under the statutory formula.

That is not because the logic (or, more aptly, illogic) of the Federal Circuit's "mitigation" theory would not have applied there. At least some insurers responded to the government's refusal to make risk corridors payments under §1342 just as they did to its refusal to make cost-sharing reduction payments under §1402: Facing a shortfall based on the government's refusal to make promised payments, they sought and obtained premium increases to help keep them afloat. *See Moda Health Plan, Inc. v. United States*, 908 F.3d 738, 748 (Fed. Cir. 2018) (Wallach, J., dissenting) (noting that insurers responded to government's failure to pay under §1342 "by offering health plans at higher prices than before" (emphasis omitted)). And at least some of those increased premiums translated into the government providing greater tax credits. But neither the government nor this Court suggested that the government was obligated to pay anything less than the full amount of its shall-pay obligation under §1342. Given that the petitioners in *Maine Community* were not shy about emphasizing the

stakes of the dispute, and the government subsequently honored its obligations in full, that reticence would be nothing short of remarkable if there were anything to the Federal Circuit's convoluted mitigation theory.

Put simply, *Maine Community* set forth a clear rule reflecting "a principle as old as the Nation itself: The Government should honor its obligations." 140 S.Ct. at 1331. The decision below subverts that rule, choosing instead to treat the government's statutory shall-pay obligation as a starting point to be whittled down based on the reactions of the victims of the breach, the intervening decisions of state regulators, the market response to changes in insurance premiums, and complicated interactions with distinct statutory obligations. That convoluted theory is incompatible with this Court's simple message. The principle that is as old as the Nation is not that the government should honor its obligations unless it can show that the efforts of its defaulted obligees to stave off insolvency made them better off or caused the government to outlay funds under a different statute. The age-old principle is far simpler: the government should keep its word and pay its shall-pay obligations in full.

II. The Federal Circuit's Theory Of Mitigation Has No Grounding In The Statutory Text Or Any Known Common-Law Doctrine.

Even without the clear guidance of *Maine Community*, the decision below would be plainly wrong, as the Federal Circuit's novel mitigation theory cannot be reconciled with either the text of

§1402 or settled common-law principles governing contract damages.

1. The Federal Circuit erred by departing from the plain statutory text. *See, e.g.*, *Hughes Aircraft Co. v. Jacobson*, 525 U.S. 432, 438 (1999) (statutory construction "begins with the language of the statute" and "where the statutory language provides a clear answer, it ends there as well"). Section 1402 establishes an unambiguous obligation: If an insurer makes the required cost-sharing reductions (which petitioners undisputedly did), then the Secretary "shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. §18071(c)(3)(A). The amount or value of the reductions can be calculated down to the penny because they involve defined co-payment and deductible requirements. The unambiguous statutory language specifies that the government must make payments in an amount "equal to the value of the reductions." *Id.* That clear reimbursement obligation leaves no room for the government or the judiciary to decide that some different amount would be more appropriate.

The statutory language certainly leaves no room for the novel form of "mitigation" the Federal Circuit invented. In a nutshell, the Federal Circuit reasoned that if the government's breach of its §1402 obligations ultimately resulted in the government spending more on tax credits under §1401, then the government should get a reduction of its §1402 obligations to reflect the increased tax credits it paid under §1401. There are multiple problems with that convoluted theory, starting with the statutory text. As the Court

of Federal Claims recognized, §1401 and §1402 "are not substitutes for each other," and nothing in their text "permits the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation." App.66-67, 123-24. Indeed, given that the two provisions lie side-by-side in the ACA, and both require the government to make some payments in conjunction with "silver plans" (though not the same payments for the same plans), it would have been simple enough for Congress to make clear that, in certain circumstances, the government's obligations under one provision reduced its obligations under the other. But the statutory text says no such thing and instead imposes independent and mandatory obligations on the government. Nor is there any evidence in the ACA's legislative history that Congress "intended to limit its liability to make cost-sharing reduction payments by increasing its premium tax credit payments." App.67, 123. Indeed, even the Federal Circuit recognized that nothing in *the ACA* empowers the government to reduce the amount it owes under §1402 by deducting other amounts it separately owed and paid under §1401. App.13.

That should have been the end of the matter, for whatever role common-law contract doctrines may have to play when it comes to interpreting and enforcing statutory payment obligations, that role is always "subject to the paramount authority of Congress." *City of Milwaukee v. Illinois*, 451 U.S. 304, 313 (1981). And "when Congress addresses a question" itself, "the need for such an unusual exercise of lawmaking by federal courts disappears." *Id.* at 314. Here, Congress directly and explicitly addressed

the question of what the government should pay insurers who provided cost-sharing reductions: an amount "equal to the value of the reductions." 42 U.S.C. §18071(c)(3)(A). It equally addressed the amounts of tax credits the government must pay without suggesting any two-for-one discount or other adjustment for the separate payment obligations, even though Congress knew better than anyone that both provisions were implicated to different degrees by "silver" policies. Those express statutory mandates foreclose invoking an "analogy to contract law" to revise the government's payment obligations by judicial fiat. *Contra* App.16.

2. Even if the Federal Circuit were free to look past *Maine Community* and the clear text of §§1401 and 1402 to the common law, it would not matter because its novel theory of "mitigation" finds no support there either. To be sure, the doctrine of mitigation can require a nonbreaching party to take reasonable steps to mitigate its damages, and can require courts to reduce the damages owed by any losses avoided or benefits received as a result of that mitigation. *See generally* 11 *Corbin on Contracts* §57.11 (2020); 24 *Williston on Contracts* §64:31 (4th ed. 2020); Restatement (Second) of Contracts §350 (1981). But the Federal Circuit overlooked a critical—and fatal—flaw in its "analogy to contract law": The doctrine of mitigation has no application when, as here, one party performed its contractual obligations in full, and the other party simply refused to pay the agreed-upon amount it owes in return.

This Court recognized as much well over a century ago in *Wicker v. Hoppock*, 73 U.S. (6 Wall.) 94, 100

(1867), explaining that once Wicker agreed to pay Hoppock for performance, then "[a]s soon as Hoppock performed, the promise of Wicker became absolute," and mitigation was no longer relevant. That is because mitigation has no role to play when the breach is a simple "failure or refusal to pay a liquidated sum of money when due." *Valle de Oro Bank v. Gamboa*, 32 Cal. Rptr. 2d 329, 333 (Cal. Ct. App. 1994) (quoting *Vitagraph, Inc. v. Liberty Theaters Co.*, 242 P. 709, 711 (Cal. 1925)); *see also Corbin on Contracts, supra*, §57.10; *Publishers Res., Inc. v. Walker-Davis Publ'ns*, 762 F.2d 557, 560 (7th Cir. 1985); *see, e.g.*, *Rice's Lucky Clover Honey, LLC v. Hawley*, 700 F.App'x 852, 863 (10th Cir. 2017); *Branch Banking & Trust Co. v. Lichty Bros. Constr., Inc.*, 488 F.App'x 430, 434 (11th Cir. 2012); *M&M Auto Outlet v. Hill Inv. Corp.*, 230 P.3d 1099, 1109 (Wyo. 2010); *Superior Woolen Co. Tailors v. M. Samuels & Co.*, 293 S.W. 1078, 1079 (Ky. 1927).

Mitigation is instead reserved for cases in which the defendant's breach effectively relieved the plaintiff of the obligation to perform, and the plaintiff seeks to recover as damages what it *would* have been owed if (contrary to fact) it *had* performed. To put it in concrete terms, if Smith hires Jones on a one-year contract for $25,000, payable in full at the end of the year, but then wrongfully fires him after the first day, Jones may have a duty to mitigate by trying to find a new job over the ensuing 364 days. Jones cannot simply sit idle for a year and expect to get paid as if he performed in full. But if, instead, Jones performs in full and works for Smith for 365 days, and Smith just refuses to pay Jones at the end of the year, Jones has no duty to "mitigate" his losses by trying to find a

second job and working nights. And if Jones does just that to avoid having his house foreclosed, that in no way relieves Smith of his obligation to pay the full promised amount for the work Jones actually performed in full. *See Corbin on Contracts*, *supra*, §57.10 (party that "saves no expense by reason of the [other party's] breach" is entitled to recover "the full value of the [other party's] promised performance"). Any other rule would create terrible incentives for both parties.

Applying those settled principles, the common-law doctrine of mitigation would not apply here even if Congress had left any room for judicial revision of the government's obligations under §1402. There is no dispute that petitioners fully performed their obligations under §1402, complying with Congress' command to provide cost-sharing reductions to eligible insureds at all times. Even assuming the government's refusal to reimburse those expenses in a timely fashion caused some insurers to seek and obtain larger premium increases than they would have absent the government's breach, and that those rate increases indirectly caused the government to provide greater tax credits pursuant to a separate statutory formula, it would not excuse the government's obligation to uphold its end of the bargain. The cost reductions were real; the government's reimbursement obligation is clear; and the carry-on effects of the government's refusal to honor its reimbursement obligation are beside the point. Indeed, as far as petitioners are aware, in all the centuries of common-law contracts jurisprudence, no other case has *ever* found that mitigation has any role to play when, as here, the plaintiff performed in

full an obligation for which it was promised a sum certain. Notably, even the government never argued in the Claims Court that traditional mitigation principles supported reducing the damages it owed under §1402 by the payments it made under §1401, or that §1401 had any bearing on petitioners' contract claims at all. *See* App.93, 147. That is likely because nothing in the traditional doctrine of mitigation supports reducing the government's explicit statutory obligations here.[1]

3. One measure of the disconnect between the decision below and any valid common-law theory of mitigation is that even the Federal Circuit refused to accept the logical consequences of its theory. As the court acknowledged, when common-law mitigation *does* apply, "the non-breaching party is expected to take reasonable steps to mitigate his or her damages." App.20. Thus, if a "mitigation" offset for the effects of increasing premiums were appropriate (as the Federal

[1] Moreover, even if mitigation had any role to play when the plaintiff performed in full, the Federal Circuit's convoluted mitigation theory would still face insuperable obstacles. As the Federal Circuit acknowledged, any potential increases in premium tax credits "did not automatically flow from" either the government's refusal to make the cost-sharing payments it owed under §1402, or any individual insurer's decision to raise premiums. App.24. Indeed, because premium tax credits are based on premiums for the second-lowest-cost silver plan in each market, each insurer received additional payments only if *other* insurers raised their premiums. *See supra* pp.7-8, 9-10. That kind of highly attenuated "offset" is far too indirect to qualify as "mitigation." *See Kansas v. Utilicorp United, Inc.*, 497 U.S. 199 (1990); *S. Pac. Co. v. Darnell-Taenzer Lumber Co.*, 245 U.S. 531 (1918).

Circuit held), then under the common law insurers would equally have a "mitigation" obligation to raise their premiums (or have their damages reduced for failing to do so). *See* Restatement (Second) of Contracts §350(1); *Roehm v. Horst*, 178 U.S. 1, 11 (1900). But that was a bridge too far even for the Federal Circuit, which recognized that in enacting a statute designed to make health insurance affordable, Congress could not possibly have meant to impose a duty on insurers to increase their premiums just because the government frustrated the goal of providing affordable health care by withholding mandated payments. App.20-21. The Federal Circuit's unwillingness to embrace the logical consequences of its theory underscores that it has no grounding in any known common-law doctrine, but rather is a jerry-rigged doctrine purpose-built to permit the government to reduce its statutory shall-pay obligations.

4. To the extent the decision below was motivated by a belief that it was necessary to prevent insurers from receiving a windfall, that concern was misplaced both legally and factually. Courts have no license to invent new remedial principles that contradict precedent, text and the common law just to prevent perceived windfalls. In any event, there is no windfall here to prevent. Insurers could not raise premiums unilaterally, but only with the approval of state regulators. Moreover, the ACA itself includes other provisions protecting against windfalls by capping participating insurers' profits and requiring rebates of any excess to insureds. *See* 42 U.S.C. §300gg-18; 45 C.F.R. §158.210. That provision underscores that the job of preventing windfalls is one for Congress, not for

courts clouding otherwise clear statutory shall-pay obligations and shall-pay remedies with ill-suited common-law doctrines.

Finally, the notion that a company can recoup all its losses from a government failure to pay simply by raising its prices flunks Economics 101. When insurers increase their rates, they price some customers out of the market. While the analysis is surely complicated by state regulation and the various interlocking provisions of the ACA, none of those provisions made insurance companies immune from the laws of supply and demand. In reality, thousands of customers who were unable to pay those higher premiums changed or dropped their coverage. *See* App.8 (recognizing that insureds not entitled to tax credits "would be paying significantly more in premiums").

III. The Question Presented Is Exceptionally Important.

The decision below is not only clearly wrong, but enormously consequential. The stakes under §1402 alone are staggering, representing billions of dollars in broken statutory promises. But the stakes are higher still because, unlike §1342, §1402 imposes ongoing mutual obligations, and the Federal Circuit's misguided mitigation reasoning is not limited to §1402 or even the ACA.

1. The sheer volume of statutory obligations the government seeks to shirk here is eye-popping. The government's unilateral refusal to honor its reimbursement obligations while insisting on full compliance by the insurers has left insurers holding an enormous bill. Petitioners alone are on the hook

for tens of millions of dollars in unreimbursed costs, and for healthcare insurers generally the tally is measured in the billions. *See CHC* C.A.Dkt.16 at 13 (acknowledging "approximately $6.7 billion in unmade advance cost-sharing payments during the 2018 calendar year"). As in *Maine Community*, the prospect of the government pulling a multi-billion-dollar bait and switch alone fully justifies this Court's review.

And here, the problem is not just retrospective or limited to a three-year program. Section 1402 imposes ongoing obligations on insurers and the government. Not only has the government steadfastly refused to honor its statutory obligations under §1402 since 2017, but the Federal Circuit's decision provides a roadmap for the government never coming into compliance or paying its statutory debts.

2. The ramifications extend far beyond the healthcare context. Just like its decision in *Maine Community*, the Federal Circuit's decision here implicates "a principle as old as the Nation itself: The Government should honor its obligations." 140 S.Ct. at 1331. If the decision below stands, it will not just allow the government to shirk its unambiguous statutory commitment under §1402, it will create terrible incentives for the government in a wide variety of contexts. The lessons of *Maine Community* for the government should have been clear: The failure to appropriate the necessary funds does not make the government's commitments disappear and the government should keep its word. The decision below sends very nearly the opposite message: There is no need to timely honor unambiguous commitments

because the Federal Circuit may offer a discount later depending on how the defaulted party responds to the government's breach. Indeed, by (erroneously) grounding its decision on generally applicable common-law mitigation principles, the Federal Circuit virtually guaranteed that the government will invoke it in all manner of government-contracting disputes. And virtually all those disputes will fall within the Federal Circuit's exclusive jurisdiction. The distortion of the government's incentive to honor its commitments will be widespread and substantial.

As this Court underscored in *Maine Community*, the government's commitment to fulfilling its statutory and contractual obligations is "a cornerstone of fiscal policy." 140 S.Ct. at 1331. The Federal Circuit's decision here once again strikes at the heart of that fundamental commitment. This Court should not permit that profoundly misguided decision to stand.

CONCLUSION

For the foregoing reasons, this Court should grant the petition for certiorari.

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