No. 20-____

IN THE

Supreme Court of the United States

COMMON GROUND HEALTHCARE COOPERATIVE, ON BEHALF OF ITSELF AND ALL OTHERS SIMILARLY SITUATED,

Petitioners,

v.

UNITED STATES,

Respondent.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

May the United States invoke a non-statutory mitigation defense to avoid the unambiguous requirement of section 1402 of the Patient Protection and Affordable Care Act ("ACA") that the Government "shall make" cost-sharing reduction payments to insurers in set amounts?

PARTIES TO THE PROCEEDING BELOW

Common Ground Healthcare Cooperative was a plaintiff-appellee below.

The United States was a defendant-appellant below.

RULE 29.6 STATEMENT

Common Ground Healthcare Cooperative has no parent corporation, and no corporation owns more than 10% of its stock.

RELATED PROCEEDINGS

Common Ground Healthcare Cooperative v. United States, No. 20-1286 (Fed. Cir. order issued Sept. 30, 2020; order denying rehearing *en banc* issued Dec. 16, 2020; mandate issued Dec. 23, 2020).

Common Ground Healthcare Cooperative v. United States, No. 1:17-cv-00877 (Fed. Cl. judgment issued Oct. 22, 2019).

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INTRODUCTION

The Federal Circuit decision at issue here allows the Government to use a non-statutory mitigation defense to evade its obligation to make payments in amounts set by statute. That decision disregards the Court's instruction just last Term in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), conflicts with other precedents in multiple ways, and threatens to destabilize not only the healthcare system but also government contracts ranging far beyond this case. The decision thus warrants the Court's review.

The statute at issue, the Patient Protection and Affordable Care Act ("ACA"), states that the Government "shall make periodic and timely payments to the issuer equal to the value of [cost-sharing] reductions" that qualified health plan ("QHP") issuers are required to make under the ACA. 42 U.S.C. § 18071(c)(3)(A). The Government chose not to make those payments, on the theory that there was no appropriation for them. That is the same situation this Court addressed in *Maine Community*, where the Government refused to make "risk corridor" payments under the ACA. This Court held that the "shall pay" statutory language created both a right of action and a remedy in the form of "specific sums already calculated, past due." *Maine Community*, 140 S. Ct. at 1331.

In contrast, under the Federal Circuit decision below, the Government need never make payments "equal to the value of [cost-sharing] reductions," as required by the statute. Instead, the Government can subtract from the required amount *other* payments that the QHP issuers received—unless the QHP issuers can prove they would have received the other payments anyway, in a hypothetical world in which the Government had made the statutorily required cost-

sharing payments. This constitutes a radical rewriting of the statute with enormous consequences for the functioning of the healthcare system. It also reflects a change in basic principles of law, which would allow the Government to shirk its statutory payment obligations under countless statutes.

Common Ground Healthcare Cooperative ("Common Ground") is a QHP issuer that brought suit—on behalf of itself and class of 101 opt-in plaintiffs—against the Government under the Tucker Act for payment of the cost-sharing reduction ("CSR") reimbursements. The Court of Federal Claims granted summary judgment to Common Ground for payment of the full amount of the unpaid CSR reimbursements. The Federal Circuit addressed the same issue for other individual QHP issuers in *Community Health Choice, Inc. v. United States*, 970 F.3d 1364 (Fed. Cir. 2020) (Dyk, J., joined by Bryson and Taranto, JJ.), and correctly held that plaintiffs have a cause of action to enforce the statutory requirement that the Government "shall make" CSR reimbursements to QHP issuers. App. 57a. But it then erred in holding that the Government can invoke a defense of mitigation to pay less than what the statute requires. App. 74a. The Government's appeal of the Court of Federal Claims judgment for Common Ground had been stayed pending resolution of *Community Health Choice*. After that decision, the Federal Circuit (Reyna, Wallach, and Chen, JJ.) entered judgment consistent with *Community Health Choice*, permitting the Government to reduce required payments to the Common Ground class based on mitigation.

I. The Federal Circuit's decision in *Community Health Choice*, as adopted here, conflicts with the precedents of this Court and many courts of appeals. *Maine Community* confirmed the fundamental principle

that the Government can and should be held to its statutory obligations. 140 S. Ct. at 1331. The Federal Circuit defied that principle here, where the statutory language is materially identical to that in *Maine Community*, holding that the plaintiffs could not enforce the payment obligation as written in the ACA. More generally, the Federal Circuit's decision rests on three consequential and erroneous legal rulings.

First, the Federal Circuit's holding that the plaintiffs' claim is subject to mitigation as an ordinary damages claim, not a claim to the specific relief promised by the statute, conflicts with both *Maine Community* and *Bowen v. Massachusetts*, 487 U.S. 879 (1988), which held that a claim for money to which a person is statutorily entitled is a claim for specific relief, *id.* at 910. Common Ground is not asking for money in compensation for non-payment; it is simply asking for the Government to pay the amounts required by statute. Consistent with *Maine Community* and *Bowen*, several circuit courts recognize that such a claim for money statutorily required to be paid is one for specific relief.

Second, even assuming the claim were an ordinary claim for monetary damages, the Federal Circuit's holding that mitigation can reduce those damages conflicts with *Maine Community*, which held that the statute defines both the right and the remedy. Here, the Federal Circuit determined the remedy based not on the statute, but on background contract-law principles of mitigation. There is nothing in the statute to suggest that CSR payments can be reduced by mitigation, and *Maine Community* specifically held that "partial payment" does not suffice absent any indication in the ACA that the Government can lessen its obligation. 140 S. Ct. at 1321.

Third, even if the contract-law principle of mitigation were relevant, it does not apply to an absolute promise to pay, which includes the statutory language here. Every circuit to consider the issue has held that the remedy for the breach of a promise to pay a certain amount is the payment of that amount, and the defense of mitigation is inapposite. The Federal Circuit simply ignored this contrary case law.

II. These questions are of enormous importance. There are countless statutes requiring Government payments, and the Federal Circuit's decision will provide the Government a strong incentive not to pay in the hope of receiving a reduction through mitigation. The result is that a statute that requires a certain payment by the Government now is merely a suggestion, and if the Government declines that suggestion, then private parties are left with complex and uncertain litigation over damages. This would occur even if (as here) the statute provides no indication at all of any exception to full payment. In addition, given the Federal Circuit's role as the appellate court for the Court of Federal Claims, its decision will affect many, if not most, of the cases challenging Government nonpayment. Indeed, the effect in this case alone is staggering, as the Government has conceded that failure to make CSR payments will actually cost taxpayers *$194 billion more* over the next ten years, based on efforts to fix indirectly the lack of payments that Congress required. *See* Supplemental Brief for Appellant at 4, *Community Health*, No. 2019-1633, Dkt. 56 (Fed. Cir. Feb. 10, 2020). These problematic results, flowing from an unmoored decision that fails to confront contrary language from this Court, warrants this Court's review.

OPINION BELOW

The order of the U.S. Court of Appeals for the Federal Circuit is not reported, but is reproduced at App. 1a-2a.

JURISDICTION

The court of appeals issued its order and judgment on September 30, 2020. The court of appeals denied Common Ground's petition for rehearing *en banc* on December 16, 2020. This Court has jurisdiction under 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

The relevant statutory provisions are as follows:

> In the case of an eligible insured enrolled in a qualified health plan—
>
> (1) the Secretary shall notify the issuer of the plan of such eligibility; and
>
> (2) the issuer shall reduce the cost-sharing under the plan at the level and in the manner specified in subsection (c).

42 U.S.C. § 18071(a).

> An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and 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).

STATEMENT

A. Cost-Sharing Reductions Under The ACA

The ACA attempted to stabilize the health insurance market and decrease the cost of health insurance by helping offset certain costs consumers must pay: insurance premiums and out-of-pocket expenses. For low-income insureds, the ACA did so by, *inter alia*, establishing the Cost-Sharing Reduction ("CSR") program.

Section 1402 of the ACA requires QHP issuers to reduce out-of-pocket costs for eligible insureds (whose household income is below 250% of the poverty level) by making CSR payments. "Cost-sharing" is defined to include "deductibles, coinsurance, copayments, or similar charges." 42 U.S.C. § 18022(c)(3)(A)(i). QHP issuers must reduce cost sharing for eligible insureds who enroll in "silver plans" through the exchanges, *id.* § 18071(b)(1), and QHP issuers must offer at least one "silver" plan in order to participate in the exchanges, *id.* § 18021(a)(1)(C)(ii).

Section 1402 also requires the Secretaries of HHS and the Treasury to reimburse QHP issuers for these cost-sharing reductions: "An issuer of a qualified health plan making reductions under this subsection shall notify the Secretary of such reductions and the Secretary *shall make periodic and timely payments to the issuer equal to the value of the reductions.*" *Id.* § 18071(c)(3)(A) (emphasis added). The implementing regulations further provide that the Government make "advance" payments for the cost-sharing reductions QHP issuers must by law provide. *See* 45 C.F.R. § 156.430(b), (d), & (e).

B. The Government's Non-Payments For Cost-Sharing Reductions

Until October 2017, the Government made CSR reimbursements as required by the ACA. On October 11, 2017, however, then-Attorney General Sessions submitted a letter to the Department of Treasury and HHS advising that the appropriation in 31 U.S.C. § 1324 could not be used to fund CSR reimbursements. The next day, HHS announced that it would stop making CSR reimbursements: "In light of [Attorney General Session's] opinion—and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately. CSR payments are prohibited unless and until a valid appropriation exists." Oct., 12, 2017 Mem. from E. Hargan to S. Verma re Payments to Issuers for Cost-Sharing Reductions (CSRs). As of the date of this petition, Common Ground and the other members of the CSR class have not been reimbursed for any CSR payments they made from October 2017 through the present.

C. The Suit At Issue

In 2017, Common Ground filed suit alleging that, pursuant to the Tucker Act, the United States owes QHP issuers back payments under the CSR provision of the ACA. On April 17, 2018, the Court of Federal Claims granted Common Ground's motion to certify a class of QHP issuers that were owed CSR reimbursements for the 2017 and/or 2018 benefit years. *Common Ground Healthcare Coop. v. United States*, 137 Fed. Cl. 630, 645 (2018). Ultimately, 101 plaintiffs chose to opt in to the *Common Ground* CSR class action, making this the largest CSR-related Tucker Act case in the Nation. *See Common Ground*, No. 1:17-cv-00877-MMS (Fed. Cl.), Dkt. Nos. 38, 60, 67, 69.

On February 15, 2019, the Court of Federal Claims granted Common Ground's motion for summary judgment. *Common Ground*, 142 Fed. Cl. 38, 53 (2019). The court held that Section 1402 was "a money-mandating statute for Tucker Act purposes." App. 31a (citations omitted). The court also rejected the Government's argument that the claims were barred because the class would receive a "double recovery" if they received CSR payments, since they also received premium tax credits:

> [U]nder the statutory scheme as it exists, even if the government were making the required cost-sharing reduction payments, insurers could (to the extent permitted by their state insurance regulators) increase their silver-level plan premiums; in such circumstances, it could not credibly be argued that the insurers were obtaining a double recovery of cost-sharing reduction payments. While the premium tax credit and cost-sharing reduction provisions were enacted to reduce an individual's health-care-related costs (to obtain insurance and to obtain health care, respectively), they are not substitutes for each other.

App. 26a.

The United States appealed, and on January 28, 2020, the Federal Circuit stayed the appeal pending the court's disposition in *Sanford Health Plan v. United States*, No. 2019-1290 (Fed. Cir.), and *Community Health*. Order, Dkt. 12 at 2. On March 17, 2020, Common Ground filed an *amicus* brief in *Community Health*, arguing (*inter alia*) that plaintiffs' claim was for specific relief and that, even if it were for monetary

damages, the doctrine of mitigation did not apply. *See* No. 2019-1633 (Fed. Cir.), Dkt. 64.

On August 14, 2020, the Federal Circuit issued opinions in *Sanford* and *Community Health*. In *Sanford*, the court held that section 1402 of the ACA "imposes an unambiguous obligation on the Government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims under the Tucker Act." *Sanford Health Plan v. United States*, 969 F.3d 1370, 1372-73 (Fed. Cir. 2020). In *Community Health*, the court held that the claim was for monetary damages, not specific relief, because "the type of relief that the insurers are seeking is best characterized as 'specific sums, already calculated, past due, and designed to compensate for completed labors,'" App. 62a n.6 (quoting *Maine Community*, 140 S. Ct. at 1330-31), and because "the Court of Claims has no general power to grant equitable relief," *id.* (quotation marks and brackets omitted). The court also held that the principle of mitigation applies, based on common law and contract principles. App. 62a-74a. Thus, according to the Federal Circuit, if (and to the extent that) state insurance regulators approved increased premiums for silver-level plans ("silver loading") *because of* the non-payment of CSR reimbursements, those increases should be used to offset the plaintiffs' damages. App. 74a-78a. And in the Federal Circuit's view, plaintiffs have the burden of proving that in the "hypothetical 'but for' world" in which the Government had met its obligation, the silver loading would have occurred nonetheless. App. 78a (quotations omitted).

With the consent of the Government, Common Ground moved for entry of judgment, and on September 30, 2020, the Federal Circuit entered judgment in this

case consistent with *Community Health*. App. 1a-2a. The Federal Circuit "acknowledge[d] Common Ground's statement that its motion should not be understood as 'necessarily' agreeing 'with the opinion in *Community Health*,' but rather 'simply reflects the overlapping issues' between the appeals, and that 'the United States agrees with this proposal for entry of judgment without prejudice to any challenges the parties may bring in the future.'" App. 2a n.* (citations omitted).

On December 16, 2020, the Federal Circuit denied Common Ground's petition for rehearing *en banc*.

REASONS FOR GRANTING THE WRIT

I. THE FEDERAL CIRCUIT'S DECISION CONFLICTS WITH THIS COURT'S AND OTHER CIRCUITS' PRECEDENTS IN HOLDING THAT A NONSTATUTORY MITIGATION DEFENSE CAN REDUCE PAYMENTS THE GOVERNMENT "SHALL MAKE"

In *Maine Community*, this Court held that the Government must pay the amount the ACA requires it to pay. *Maine Community* concerned the Risk Corridors provision of the ACA, which stated that the Government "shall pay" specified amounts to eligible unprofitable healthcare plans. 140 S. Ct. at 1316. This Court concluded that this statutory provision "created an obligation neither contingent on nor limited by the availability of appropriations or other funds." *Id.* at 1323. It then explained precisely what remedy the plaintiffs had when the Government failed to comply with this obligation: Plaintiffs "seek specific sums already calculated, past due, and designed to compensate for completed labors. The Risk Corridors statute and Tucker Act allow them that remedy." *Id.* at 1331.

Moreover, *Maine Community* expressly held that the specific payment amount required by the statute could not be reduced:

> Nor does the text suggest that the Secretary's payments to unprofitable plans pivoted on profitable plans' payments to the Secretary, or that a partial payment would satisfy the Government's whole obligation. Thus, without 'any indication' that § 1342 allows the Government to lessen its obligation, we must 'give effect to [Section 1342's] plain command.'

140 S. Ct. at 1321 (citation omitted) (alteration in original). Simply put, "the statute meant what it said: The Government 'shall pay' the sum that § 1342 prescribes." *Id.*

The statutory provision at issue here was also enacted as part of the ACA and contains virtually identical "shall pay" language. A QHP issuer "making reductions under this subsection shall notify the Secretary of such [cost-sharing] reductions and 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) (emphases added). Thus, just as in *Maine Community*, the Government has an obligation to make the required payments, and the remedy for non-payment is a suit under the Tucker Act for the specific amount owed.

The Federal Circuit held, to the contrary, that the plaintiffs' remedy was not the unreceived payments, but the damage to the plaintiffs as compared to the "hypothetical 'but for' world" in which the payments had been made. App. 78a. In reaching this conclusion, the court ignored the language in *Maine Community* quoted above. Instead, the court held that "[t]he

available remedy is defined by analogy to contract law where the statute does not provide its own remedies for government breach." App. 62a. However, *Maine Community* never analogized the claim or remedy to those provided under contract law. In short, the Federal Circuit defied the pertinent language in *Maine Community* and undermined its fundamental principle that the Government can be held to its full statutory payment obligations. This conflict alone warrants certiorari, given the importance of the issue, as discussed *infra* Part II.

More generally, the importation of a mitigation-based contract law principle to reduce the payments required by statute conflicts with well-established law in three ways: (a) the claim is properly considered one for specific relief under the statute, not monetary damages subject to mitigation; (b) even if considered monetary damages, those damages are defined by the statute itself; and (c) mitigation does not apply to an absolute obligation to pay.

A. The Decision Below Conflicts With Precedents That Statutory Payment Requirements Are Claims For Specific Relief

1. This Court has held that a statute requiring a payment by the Government creates both the right to the money at issue and a Tucker Act remedy for specific relief in the form of that same money. As noted, that was the essential holding of *Maine Community*. It is also consistent with what this Court held in *Bowen v. Massachusetts*, 487 U.S. 879 (1988). There, the plaintiffs sued to enforce section 1396b(a) of the Medicaid Act, which provides that the Secretary "shall pay" certain amounts for appropriate Medicaid services. *Id.* at 900. *Bowen* held that this "is not a suit

seeking money in *compensation* for the damage sustained by the failure of the Federal Government to pay as mandated; rather, it is a suit seeking to enforce the statutory mandate itself, which happens to be one for the payment of money." *Id.* (emphasis in original). This Court explained the distinction: "Damages are given to the plaintiff to substitute for a suffered loss, whereas specific remedies are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled." *Id.* at 895 (quotation marks omitted). Thus, where (as in *Bowen*) the plaintiff "is seeking funds to which a statute allegedly entitles it, rather than money in compensation for the losses . . . suffered by virtue of the withholding of these funds," "the nature of the relief sought" is "specific relief, not relief in the form of damages." *Id.* at 901 (quotation marks omitted).

To be sure, *Maine Community* distinguished *Bowen* in finding a Tucker Act remedy appropriate, 140 S. Ct. at 1330-31, but its holding is fully consistent with *Bowen*'s characterization of a statutory "shall-pay" obligation as lending itself to a claim for specific relief for the amount specified in the statute, as opposed to a damages claim subject to mitigation. This Court held that the "remedy" that the ACA and Tucker Act allow are "specific sums already calculated." 140 S. Ct. at 1331. In addition, *Maine Community* referred to the remedy in terms of enforcing the obligation to make the required payments: "[D]id §1342 of the Affordable Care Act *obligate the Government to pay participating insurers the full amount* calculated by that statute? . . . [M]ay petitioners sue the Government under the Tucker Act to *recover on that obligation*? Because our answer to each is yes, we reverse." 140 S. Ct. at 1319 (emphases added); *see also id.* at 1331 ("Congress . . . requir[ed] the Federal Government to

make payments under § 1342's formula. . . . [P]etitioners may seek to collect payment through a damages action in the Court of Federal Claims."). An action to enforce the obligation to pay and to "collect payment" of "specific sums" is the very definition of specific relief.[1]

The Federal Circuit's opinion conflicts with these precedents. Plaintiffs are entitled to unpaid CSR reimbursements under the ACA's plain terms. The language "shall make periodic and timely payments" of set amounts, 42 U.S.C. § 18071(c)(3)(A), is materially identical to the language at issue in *Maine Community* ("the Secretary shall pay to the plan an amount equal to" a certain calculated amount, 42 U.S.C. § 18062(b)) and in *Bowen* ("the Secretary . . . shall pay to each State which has a plan approved" the amounts specified, 42 U.S.C. § 1396b(a)). Moreover, *Bowen*'s reasoning is directly on point: Plaintiffs here do not seek a substitute for the unmade CSR reimbursements, but rather for the Government to meet its obligation to make the payments themselves. That is the "very thing to which [Plaintiffs were] entitled," which constitutes a claim for specific relief. *See Bowen*, 487 U.S. at 895 (quotation marks omitted).

The Federal Circuit provided little explanation for refusing to recognize that a claim to enforce a statutory "shall pay" obligation is one for the specific relief

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[1] While *Maine Community* referred to the claim as one for "damages," it did so in the context of holding Tucker Act jurisdiction existed because the case was a "damages action in the Court of Federal Claims." 140 S. Ct. at 1331. As discussed *infra* at 15-16, that jurisdictional holding is controlling here, but it does not imply that the remedy is for anything other than the specific sums required to be paid under the statute. And this Court did not suggest that it was considering "damages" in opposition to specific relief.

required by the statute. The opinion did not address whether the money sought is a substitute for or the very thing to which Plaintiffs are entitled. Instead, the Federal Circuit's reasoning was based on a misreading of *Maine Community*. According to the Federal Circuit, "the Supreme Court made clear that the type of relief that the insurers are seeking is best characterized as 'specific sums, already calculated, past due, and designed to compensate for completed labors.'" App. 62a n.6 (quoting *Maine Community*, 140 S. Ct. at 1330-31). However, as noted above, a claim for "specific sums" is a claim for "specific relief." The Federal Circuit seemed to suggest that, because *Maine Community* mentions "compensat[ion]," it must mean monetary damages. But the *Maine Community* language mirrors the language *Bowen* used when describing specific relief—and distinguishing monetary damages. *See Bowen*, 487 U.S. at 900 n.31 ("The jurisdiction of the Claims Court, however, is not expressly limited to actions for 'money damages,'" but include "statutes that provide compensation for specific instances of past injuries or labors . . . ."). Indeed, there is a critical distinction between a statute that requires specific payments as compensation for past labors (which gives rise to a claim for specific relief), and a plaintiff seeking compensation not specifically required by statute as a substitute for the Government's failure to meet its obligations. The Federal Circuit missed this distinction in treating this Court's use of the word "compensation" as precluding specific relief in *Maine Community*.

The Federal Circuit's only other explanation for denying that the claim here is for specific relief is that this supposedly would preclude Tucker Act jurisdiction, App. 62a n.6, but that holding also conflicts with this Court's precedents. According to the Federal Circuit, the claim here cannot be for specific relief because

"'the Court of Claims has no [general] power to grant equitable relief.'" *Id.* (quoting *Bowen*, 487 U.S. at 905) (brackets in original). It is a mistake, however, to equate "equitable relief" and "specific relief": "*Bowen*'s interpretation . . . hinged on the distinction between specific relief and substitute relief, not between equitable and nonequitable categories of remedies." *Dep't of the Army v. Blue Fox, Inc.*, 525 U.S. 255, 261-62 (1999). Moreover, *Bowen* refutes any suggestion that the Court of Federal Claims has jurisdiction only for claims for monetary damages: "The jurisdiction of the Claims Court . . . is not expressly limited to actions for 'money damages,'" and applies to "statutes that provide compensation for specific instances of past injuries or labors." 487 U.S. at 900 n.31; *see also id.* at 904 n.39. In any event, *Maine Community* expressly held that there is Tucker Act jurisdiction in circumstances materially identical to those here. *See* 140 S. Ct. at 1329-31. The Federal Circuit ignored this holding in *Maine Community*.

Finally, the specific-relief issue is dispositive here because the Government has not disputed—nor could it—that there is no legal basis for using a contract-based mitigation theory to reduce a claim for specific relief. *See, e.g.*, *Mobil Oil Expl. & Producing Se., Inc. v. United States*, 530 U.S. 604, 623-24 (2000) (holding in a Tucker Act case arising out of the Federal Circuit that where a party is not seeking damages, but rather restitution of payments, the plaintiff is entitled to the payments owed regardless of whether it may have profited from the breach); *Amber Res. Co. v. United States*, 538 F.3d 1358, 1376 (Fed. Cir. 2008) (similar). Indeed, the Federal Circuit's entire approach of determining what would have happened had the payments been made, to determine compensation for the harm of

not being paid, is irrelevant to a claim for specific relief.

2. The Federal Circuit's decision deepens an existing split among the circuits on the specific-relief issue. The Second, Third, and D.C. Circuits have held that a plaintiff's claim to a statutory entitlement to certain funds is a claim for specific relief. *See Linea Area Nacional de Chile S.A. v. Meissner*, 65 F.3d 1034, 1042-43 (2d Cir. 1995) (holding that a claim for refund of detention expenses of excludable aliens was for specific relief based on 8 U.S.C. § 1356(h)(2)(A) (1994), which directed that the "Secretary of the Treasury shall refund" the relevant funds); *Zellous v. Broadhead Assocs.*, 906 F.2d 94, 98 (3d Cir. 1990) (holding that a claim for reimbursement of excess rent from HUD was for specific relief because "the tenants seek only that to which they were entitled under the Brooke Amendment"); *Md. Dep't of Human Res. v. HHS*, 763 F.2d 1441, 1444, 1446 (D.C. Cir. 1985) (quoted in *Bowen* and holding that a claim was for specific relief because "Maryland is seeking funds to which a statute allegedly entitles it" under 42 U.S.C. § 1397a(b)(2), which provided that "[t]he Secretary shall then pay to the State" various funds).

Moreover, there is significant confusion in the circuits regarding whether a claim is for specific relief where it seeks money statutorily required to be paid but without a specific appropriation. For instance, in a 2-1 decision, the Tenth Circuit held that a claim is not for specific relief unless there is a specific appropriation for it. *See Modoc Lassen Indian Hous. Auth. v. U.S. Dep't of Hous. & Urban Dev.*, 881 F.3d 1181, 1198 (10th Cir. 2017) ("[T]o the extent the district court ordered HUD to repay the Tribes 'from all available sources,' we hold that those orders

constitute awards of money damages unless HUD has at its disposal sufficient funds from the relevant yearly appropriations") (internal citation omitted). The Second Circuit has also held that a specific appropriation is necessary. *See Cty. of Suffolk v. Sebelius*, 605 F.3d 135, 141 (2d Cir. 2010) ("[I]n cases challenging an agency's expenditure of funds, the res at issue is identified by reference to the congressional appropriation that authorized the agency's challenged expenditure. To seek funds from another source is to seek compensation rather than the specific property the plaintiff aims to recover."). The principal case on which the Second Circuit relied was *City of Houston, Tex. v. Dep't of Hous. & Urban Dev.*, 24 F.3d 1421, 1428 (D.C. Cir. 1994). But the D.C. Circuit later held that a plaintiff's "claim represents specific relief . . . not consequential damages compensating for an injury" even where "the [agency] no longer possesses the precise funds." *Am.'s Cmty. Bankers v. F.D.I.C.*, 200 F.3d 822, 829-30 (D.C. Cir. 2000); *see also id.* at 830 (distinguishing *City of Houston* because, "[u]nlike Houston, [plaintiff here] is not seeking compensation for economic losses suffered by the government's alleged wrongdoing; Bankers wants the FDIC to return that which rightfully belonged to Bankers's member institutions in the first place").

The requirement of a specific appropriation to determine whether a claim is for specific relief has no basis in this Court's precedents. This Court has always considered only the nature of the relief, not the source of the appropriation, in deciding whether a claim is for specific relief. *See Bowen*, 487 U.S. at 919 n.3 (Scalia, J., dissenting) ("Respondent seeks fungible funds, not any particular notes in the United States Treasury."); *Modoc Lassen*, 881 F.3d at 1201 (Matheson, J., concurring in part and dissenting in part) ("[U]nder the Supreme Court's cases, the distinction between

specific and substitutionary relief turns on the nature of the relief, not on the source of funds."). Indeed, in *Modoc*, the Government told this Court that the Tenth Circuit's reasoning was limited to relief that concerned payment from funds appropriated for use in future years, and that (in contrast) "[a]n order that required [the agency] to pay to petitioners the particular funding that [the agency] wrongfully withheld . . . would constitute specific relief." Brief in Opposition at 12, *Fort Peck Housing Auth. v. Dep't of Housing & Urban Development*, No. 17-1353 (July 2018) (quotation marks and brackets omitted).

B. The Decision Below Conflicts With Precedents That The Statute Rather Than Background Contract Law Defines The Remedy For Failure To Pay

1. Regardless of whether the claim is deemed one for specific relief, the statute defines the remedy as the CSR reimbursements themselves. As discussed above, *Maine Community* held that, where a statute requires the Government to pay a certain amount, it must pay that amount absent "any indication that [the statute] allows the Government to lessen its obligation." 140 S. Ct. at 1321 (quotation marks omitted). This is simple statutory construction: where Congress states that the Government "shall pay" a certain amount, it must pay that amount, not some lesser amount depending on the circumstances. It also "reflect[s] a principle as old as the Nation itself: The Government should honor its obligations." *Id.* at 1331.

The opinion below conflicts with *Maine Community* in holding that full payment is not required and that the Government's obligation can be reduced for reasons not mentioned in the statute. The Federal Circuit did not discuss the relevant language in *Maine Community*,

instead asserting that *Maine Community* did not "resolve[] this question." App. 58a. Nor did the Federal Circuit look to the statute itself as a source for its suggestion that the required payments could be reduced. The ACA here is just as unequivocal as it was in *Maine Community* about the requirement to pay and the amount of those payments: 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) (emphases added). The nature of the potential offset here is impossible to reconcile with the statute. That is because the potential deduction is based solely on an amount that the statute requires to be paid *in addition to* CSR reimbursements. The ACA states that, entirely apart from the CSR reimbursements, QHP issuers are entitled to a "[r]efundable [tax] credit for coverage under a qualified health plan." 26 U.S.C. § 36B. Thus, the statute requires *both* CSR reimbursements and premium tax credits, not remotely suggesting that the latter can offset the former.

Rather than relying on the statute, the Federal Circuit's decision rests on the assumption that the statute includes an implied contract-law defense of mitigation. However, as explained in *Maine Community*, the statute itself creates the remedy and defines the remedy. And in countless cases dealing with Government payments over the course of centuries, there is *no precedent* for allowing generic contract-law principles to reduce the Government's statutorily required payments.[2] There is accordingly no reason to believe

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[2] The Federal Circuit relied only on a few Court of Federal Claims cases supposedly "limit[ing] damages in suits against the government under the Back Pay Act, 5 U.S.C. § 5596." App. 62a. But as the Federal Circuit itself recognized (App. 63a n.8), the Back Pay Act has an express provision for offset—unlike the

that Congress intended for courts to imply a mitigation-based reduction to CSR reimbursements.

When Congress wants to allow for reductions in payments based on such principles, it does so expressly. *See, e.g.*, 42 U.S.C. § 2000e-5(g)(1) (for back pay under Title VII of the Civil Rights Act, the statute requires the court deduct "interim earnings or amounts earnable with reasonable diligence by the person or person discriminated against" from the award of damages). Congress chose not to do so here. To uphold the Federal Circuit would require this Court to rewrite the clear statutory command that the Government "shall make periodic and timely payments to the issuer equal to the value of the reductions," 42 U.S.C. § 18071(c)(3)(A), and provide instead that the Government "shall see what happens, and if it turns out the QHP issuers are doing well enough without the payments, the Government does not have to make the payments." But there is no indication of any congressional intent for such a radical and substantial rewriting of the statute. *See, e.g.*, *Cherokee Nation of Okla. v. Leavitt*,

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statute here. *See* 5 U.S.C. § 5596(b)(1) (An employee "(A) is entitled, on correction of the personnel action, to receive . . . — (i) an amount equal to all or any part of the pay, allowances, or differentials, . . . less any amounts earned by the employee . . . ."). The cases the Federal Circuit cites are unique to the military back pay situation, given the "principle that the Government is entitled to the complete services and undivided attention of its employee during working hours." *Craft v. United States*, 589 F.2d 1057, 1068 (Ct. Cl. 1978). In other words, a military employee cannot as a matter of law obtain both military pay and outside earnings (unless specifically exempted). *See id.*; *Silver v. United States*, 551 F.2d 295, 297 (Ct. Cl. 1977). In any event, *Craft* recognized it was not applying "setoff . . . or even mitigation of damages in the traditional sense," 589 F.2d at 1068, and provides no basis for the Government's attempt to apply mitigation here.

543 U.S. 631, 640 (2005) (rejecting the Government's argument that it could evade the statutory requirement to pay certain "contract support costs" because "we have found no indication that Congress believed or accepted the Government's current claim that . . . tribes, not the Government, should bear the risk that an unrestricted lump-sum appropriation would prove insufficient to pay all contractors") (emphasis removed).

Finally, the Federal Circuit erred (App. 60a-61a) in relying on *Barnes v. Gorman*, 536 U.S. 181 (2002), and *Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274 (1998), for the proposition that contract-law rules are generally applicable to statutory payment provisions. In *Barnes*, this Court expressly stated that "we have been careful not to imply that all contract-law rules apply to Spending Clause legislation," and the only one it applied there was the rule that "a recipient may be held liable to third-party beneficiaries for intentional conduct that violates the clear terms of the relevant statute." 536 U.S. at 186-87 (emphasis removed). In *Gebser*, the Court likewise held only that a recipient of federal funds could be held liable for violating the statutory conditions for receipt of those funds. 524 U.S. at 287. And even in applying this contract principle, the Court determined liability based not on general principles of constructive notice or respondeat superior, but on actual notice of misconduct because that was more consistent with the statute. *Id.* at 288-89. In short, a statute may be analogous to a contract in certain respects, but contract principles apply only to the extent they are consistent with the statute. Thus, the question is ultimately one of the statutory language, which here suggests no mitigation exception to the Government's payment requirement.

2. The Federal Circuit's holding that contractual defenses should be inferred to reduce the remedy for non-payment of the Government's statutory obligations also creates a circuit conflict. Several circuits have held that contractual rules do not apply in this statutory context. For instance, the Tenth Circuit held that "the rules that traditionally govern contractual relationships don't necessarily apply in the context of federal grant programs." *Modoc*, 881 F.3d at 1194. The Ninth Circuit similarly rejected as "problematic" "the whole notion of importing contract doctrines into an area that is a complex statutory and regulatory scheme" because "[u]pon joining the Medicare program . . . the hospitals received a statutory entitlement, not a contractual right." *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014) (quotation marks omitted); *see also Md. Dep't of Human Res. v. Dep't of Health & Human Servs.*, 762 F.2d 406, 409 (4th Cir. 1985) (rejecting argument to apply "contractual principles" of impossibility of performance to federal grant program, which is instead "governed by the applicable statute[s] and implementing regulations").

The Federal Circuit's attempt (App. 61-62a n.5) to distinguish these precedents is unavailing. In particular, the Federal Circuit concluded that contract-law principles apply only where the statute "impose[s] an affirmative obligation or condition in exchange for federal funding." App. 59a (quotation marks and brackets omitted). However, all of the cases cited above imposed obligations or eligibility criteria for the payments at issue. *See Modoc*, 881 F.3d at 1186; *PAMC*, 747 F.3d at 1217-18; *Md. Dep't of Human Res.*, 762 F.2d at 407. Regardless, the question is whether the Government intended to limit *its* obligations, and the Federal Circuit's holding that it did so implicitly based on mitigation marks an entirely new rule of law.

C. The Decision Below Conflicts With Precedents That Mitigation Does Not Apply To An Unrestricted Payment Obligation

Even assuming contract law principles could be implied in the statute, the principle of mitigation cannot reduce damages for breach of an absolute obligation to pay. This Court has long held that, for an "agreement to pay . . . , a recovery may be had as soon as there is a breach of the contract, and the measure of the damages is the full amount agreed to be paid." *Wicker v. Hoppock*, 73 U.S. (6 Wall.) 94, 99 (1867).

Moreover, every circuit court to consider the issue has held that the common law doctrine of mitigation for contractual damages does not apply to an absolute promise to pay. For instance, the Seventh Circuit has held that, where a "plaintiff simply claims the amount . . . owed to it under the contract," the breaching party's "obligation to pay these [amounts] would in no way be affected by the amount of income [plaintiff] was able to produce from other sources." *Publishers Res., Inc. v. Walker-Davis Publ'ns, Inc.*, 762 F.2d 557, 560 (7th Cir. 1985) (holding plaintiff "did not have any duty to mitigate"). Similarly, the Tenth Circuit has held that there is "no duty to mitigate" where "under the contract plaintiff's right to severance pay was absolute." *McBride v. Mkt. St. Mortg.*, 381 F. App'x 758, 773 n.21 (10th Cir. 2010) (quotation marks omitted); *see also Rice's Lucky Clover Honey, LLC v. Hawley*, 700 F. App'x 852, 863 (10th Cir. 2017) ("[T]here is no duty to make a deduction [of the amount avoided through mitigation] when the contract specifies the amount owed to the injured party."). The Eighth and Eleventh Circuits are in accord. *See Branch Banking & Tr. Co. v. Lichty Bros. Constr.*, 488 F. App'x 430, 434 (11th Cir.

2012) ("Where the [contracts in question] contain absolute promises to pay, there is no duty to mitigate damages."); *Ross v. Garner Printing Co.*, 285 F.3d 1106, 1113-14 (8th Cir. 2002) (recognizing no duty to mitigate exists where contract entitled plaintiff to "payment of all compensation remaining under the terms of employment").

The Federal Circuit's decision here conflicts with this case law. The statute here, by its plain terms, provides an absolute obligation to pay: the Government "shall make . . . payments," and those payments must be "equal to the value of the reductions, " without any caveats or exceptions. 42 U.S.C. § 18071(c)(3)(A). Thus, because QHP issuers are entitled to CSR reimbursements under the absolute terms of the ACA, those payments may not be reduced by future benefits QHP issuers receive.

The cases the Federal Circuit cites (App. 71a) regarding the general duty to mitigate do *not* involve breaches of contractual obligations to pay specific amounts, as is the case here. *See Kansas Gas & Elec. Co. v. United States*, 685 F.3d 1361, 1364-66 (Fed. Cir. 2012) (damages for costs to deal with nuclear waste based on Government's breach of obligation to dispose of it); *LaSalle Talman Bank, F.S.B. v. United States*, 317 F.3d 1363, 1371 (Fed. Cir. 2003) (damages for projected profits lost from Government's breach based on forced sale of bank). These cases establish only that outside the context of payments, mitigation is considered in measuring damages. But for payments, no such measurement need occur because the lack of payment itself is the damage. Indeed, the damages for breach of contract are not a measure of everything that would be different in the but-for world, absent the breach. It is a measure of the damages *under the*

contract, and where the damages are the lack of payment, the payment itself comprises the damages. *See Publishers Res.*, 762 F.2d at 560 ("[P]laintiff simply claims the amount of commissions owed to it under the contract; [the defendant's] obligation to pay these commissions would in no way be affected by the amount of income [the plaintiff] was able to produce from other sources."). Thus, because Plaintiffs are entitled to CSR reimbursements under the absolute terms of the ACA, those payments may not be reduced by future benefits Plaintiffs may receive.

II. THE ISSUE IS EXTRAORDINARILY IMPORTANT AND WARRANTS THIS COURT'S REVIEW

The Federal Circuit's new rule, whereby the Government need not pay its full statutory obligations, has enormous and troubling consequences for the Nation's healthcare system and in countless future cases affecting government contractors far beyond the healthcare context here.

1. The Federal Circuit's approach distorts the proper functioning of the ACA, as Congress intended and expressly stated. There is no question that the statute requires Government payment of CSR reimbursements and that there was no provision allowing for the non-payment of those obligations. While the Federal Circuit posits that silver loading has offset some of the harm to QHP issuers, the result for the healthcare system as a whole is catastrophic. According to the Government itself, if it continues non-payment in defiance of section 1402's mandate, taxpayers will pay *$194 billion more* over the next ten years than if the Government had simply made the payments it was required to make. *See* Supplemental Brief for Appellant at 4, *Community Health*, No. 2019-1633, Dkt. 56 (Fed.

Cir. Feb. 10, 2020) ("The CBO also projected that federal spending would increase by $194 billion between 2017 and 2026 if cost-sharing reductions were not paid directly."). In litigation over the CSR program, the House of Representatives also noted that a failure to make payments in a way that provided certainty about the "existence and amount of payments" would be "inefficient and destabilizing," and "would also inevitably lead to increased premiums—and correspondingly greater federal expenditures," even if Congress ultimately appropriated funds for the payments. Brief for Defendants at 23, *United States House of Representatives v. Burwell*, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (No. 1:14-cv-01967), ECF No. 55-1. The severity of the consequences for taxpayers—without any plausible statutory basis—warrants this Court's review.[3]

2. Furthermore, the Federal Circuit's creation of a novel rule whereby the Government now can pay less than the amount required by statute has substantial and troubling implications outside the context of this case.

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[3] The Federal Circuit focuses (App. 65a) on the supposed windfall to QHP issuers if they are allowed to recover the required payments from the Government, but this is factually incorrect. The ACA prevents QHP issuers from enjoying excessive profits for any benefit year. Specifically, the statute establishes a regime around an issuer's medical loss ratio ("MLR"), wherein QHP issuers must provide a rebate to enrollees if they spend less than 80% of their premiums on incurred claims and medical costs in a benefit year. 45 C.F.R. § 158.210(c). CSR payments must be deducted from the issuer's incurred claims, *id.* § 158.140(b)(1)(iii), so if QHP issuers' collections in these cases lower their MLR for 2017 or 2018, insurers may be required by law to provide a rebate to their insureds. *Id.* Thus, it is *insureds* that will enjoy any supposed "windfall" from these cases. Regardless, the bottom line is that the statute itself requires the CSR reimbursements.

There are an enormous number of statutes with language similar to the statutory provision here. *See Bowen*, 487 U.S. at 900 n.31 ("There are, of course, many statutory actions over which the Claims Court has jurisdiction that enforce a statutory mandate for the payment of money rather than obtain compensation for the Government's failure to so pay."); *Maine Community*, 140 S. Ct. at 1333 (Alito, J., dissenting) ("[T]he phrase the 'Secretary shall pay'—the language that the Court construes as creating a cause of action—appears in many other federal statutes."). While *Maine Community* questioned how common such statutes were without an appropriation, *see id.* at 1329, there is no question that such statutes are common with an appropriation, *see id.* at 1322 n.7. And here, the question regarding the remedy does not depend on the presence or absence of an appropriation provision. Rather, the question whether the Government is entitled to pay less than statutorily required based on a defense of mitigation can arise for any statutory provision that requires the Government to make certain payments. And the opinion here would seemingly apply to any claim for payment based on a statute because the Federal Circuit's reasoning is not limited to any peculiarities of the ACA.

Furthermore, the Federal Circuit's ruling provides the Government with enormous incentives not to make required statutory payments. Under the Federal Circuit's approach, the Government can simply refuse to pay what a statute says it "shall pay," in the hope that mitigation will allow it to pay less in the future. That incentive is especially strong because of the extreme nature of the mitigation defense that the Federal Circuit endorsed. Under the Federal Circuit's view, the burden is on the party that did not receive the payment to prove the position it would have

occupied in the hypothetical, but-for world where the payment had been made. App. 76a. As the Federal Circuit recognizes, this is "necessarily a fact-intensive task." App. 74a. Moreover, the Federal Circuit's theory of mitigation includes effects from the actions of third parties (here, silver loading based on actions of state insurance regulators). App. 75a-76a. The result is that proving damages will be an onerous task, where many plaintiffs will inevitably struggle to prove precisely how the but-for world would have evolved and therefore what payment they are entitled to, despite the statute's direction that they are entitled to full payment.

The consequences of such a scheme are problematic and harmful. *First*, it defies the statutes themselves. Rather than paying the amount stated by Congress, the Government pays less, even in the absence of any such congressional intent. *Second*, it undermines private parties' ability to rely on the Government to meet its statutory obligations. There is now no guarantee that the Government will pay, and when it fails to do so, recovery will be uncertain at best. *Third*, it creates complex and prolonged litigation in countless cases because, as noted above, disproving mitigation will be an intensively fact-specific task. *Fourth*, it allows the executive branch to subvert congressionally enacted statutory programs. In particular, any statutory scheme that depends on Government payments now can be thwarted by the simple expedient of refusing to pay. Even if the party entitled to that payment brings suit, that litigation often will take years and may never allow for full recovery.

In addition, all of these results are exacerbated by the outsized role of the Federal Circuit in enforcing Government obligations. Because the Federal Circuit hears all appeals from the Court of Federal Claims, its

new rule will govern in many, if not most, of the cases raising this issue. And given that the Federal Circuit already received (and ignored) this Court's guidance on the remedy issue in *Maine Community*, further percolation is pointless. This case (along with *Community Health*, No. 20-1162 (petition for certiorari filed Feb. 19, 2021)) squarely raises the issue and is an ideal vehicle to resolve the question presented.

In short, as this Court recognized in *Maine Community*, the proper functioning of the Government requires that the Government be held to its obligations. The Federal Circuit's ruling undermines that fundamental principle and thus warrants this Court's review.

3. Finally, the particular legal issues on which the Federal Circuit departed from precedents of this Court and other circuits also have wide-ranging implications.

First, whether a statute stating that the Government "shall pay" certain amounts gives rise to a claim for specific relief under the statute is of extraordinary importance. As noted above, this "shall pay" language is commonly found in many statutes. The appropriate remedy for a breach of the statutory obligation that language creates thus has substantial importance, and the Federal Circuit's conclusion that a request for money that the Government "shall pay" is not for specific relief under the statute would be a substantial departure from the current state of the law.

Second, the issue of whether contractual damages principles should be incorporated into the remedies for non-payment of statutory obligations has broad applicability. Allowing common law principles for enforcement of contracts to be imported wholesale into statutory schemes would mark a substantial change in the law. And it would raise serious questions about

whether other contract-law principles (*e.g.*, reliance damages, election of remedies, etc.) are also implicitly incorporated into every statutory payment provision.

Third, the holding that mitigation applies to an absolute obligation to pay would have troubling consequences in numerous cases. The Federal Circuit held that this was a general rule of contract law, and as such, it would seemingly apply to any contract. The result (in conflict with every other circuit to consider the issue) is that a contractual promise to pay becomes contingent on future events—even when the contract included no such contingency. And just as for the Government in the statutory context, this result threatens to undermine contractual obligations and the well-established legal principle that a party must pay what a contract requires him or her to pay.

CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted,

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February 24, 2021

APPENDIX

APPENDIX A

NOTE: This order is nonprecedential.

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

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2020-1286

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COMMON GROUND HEALTHCARE COOPERATIVE, on behalf of itself and all others similarly situated,

Plaintiff-Appellee

v.

UNITED STATES,

Defendant-Appellant

———

Appeal from the United States Court of Federal Claims in No. 1:17-cv-00877-MMS, Chief Judge Margaret M. Sweeney.

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ON MOTION

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ORDER

Before REYNA, WALLACH, and CHEN, *Circuit Judges.*

REYNA, *Circuit Judge*.

Common Ground Healthcare Cooperative moves unopposed to lift the stay of proceedings and to enter judgment in this appeal consistent with *Community*

Health Choice, Inc. v. United States, Nos. 2019-1633, -2102, 2020 WL 4723757 (Fed. Cir. Aug. 14, 2020).*

Upon consideration thereof,

IT IS ORDERED THAT:

(1) The motion is granted to the extent that the judgment of the United States Court of Federal Claims is affirmed in part, reversed in part, and remanded in part consistent with the court's decision in *Community Health*.

(2) Each side shall bear its own costs.

FOR THE COURT.

September 30, 2020
Date

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

* The court acknowledges Common Ground's statement that its motion should not be understood as "necessarily" agreeing "with the opinion in *Community Health*," but rather "simply reflects the overlapping issues" between the appeals, ECF No. 13 at 3, and that "the United States agrees with this proposal for entry of judgment without prejudice to any challenges the parties may bring in the future," *id.* at 4.

APPENDIX B

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

No. 17-877C

COMMON GROUND HEALTHCARE COOPERATIVE,

Plaintiff,

v.

THE UNITED STATES,

Defendant.

Affordable Care Act; Cost-Sharing Reduction Payments; 42 U.S.C. § 18071; Motion for Summary Judgment, RCFC 56; Motion to Dismiss, RCFC 12(b)(6)

Filed: February 15, 2019

Stephen Swedlow, Chicago, IL, for plaintiff.

Christopher J. Carney, United States Department of Justice, Washington, DC, for defendant.

OPINION AND ORDER

SWEENEY, Chief Judge

Plaintiff Common Ground Healthcare Cooperative contends, for itself and on behalf of those similarly situated, that the federal government ceased making the cost-sharing reduction payments to which it and

other insurers are entitled under the Patient Protection and Affordable Care Act ("Affordable Care Act"), Pub. L. No. 111-148, 124 Stat. 119 (2010), and its implementing regulations. Currently before the court are plaintiff's motion for summary judgment and defendant's cross-motion to dismiss for failure to state a claim upon which relief can be granted. For the reasons set forth below, the court finds that plaintiff is entitled to recover the unpaid cost-sharing reduction reimbursements. Therefore, it grants plaintiff's motion and denies defendant's motion.

I. BACKGROUND

A. The Affordable Care Act

Congress enacted the Affordable Care Act as part of a comprehensive scheme of health insurance reform.[1] *See generally King v. Burwell*, 135 S. Ct. 2480 (2015). Specifically, the Act includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *Id.* at 2485. In conjunction with these reforms, the Act provided for the establishment of an American Health Benefit Exchange ("exchange") in each state by January 1, 2014, to facilitate the purchase of "qualified health plans" by individuals and small businesses. 42 U.S.C. §§ 18031, 18041 (2012); *accord King*, 135 S. Ct. at 2485 (describing an exchange as "a marketplace that allows people to compare and purchase insurance plans"). Qualified health plans can be offered at four levels (bronze, silver, gold, and platinum) that differ based on how

[1] Seven days after enacting the Affordable Care Act, Congress enacted the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, which included additional provisions related to health insurance reform.

much of a plan's benefits an insurer must cover under the plan.[2] 42 U.S.C. § 18022(d)(1).

Among the reforms included in the Affordable Care Act were two aimed at ensuring that individuals have access to affordable insurance coverage and health care: the premium tax credit enacted in section 1401 of the Act, 26 U.S.C. § 36B (2012), and the cost-sharing reduction program enacted in section 1402 of the Act, 42 U.S.C. § 18071. "The premium tax credits and the cost-sharing reductions work together: the tax credits help people obtain insurance, and the cost-sharing reductions help people get treatment once they have insurance." *California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017).

1. Premium Tax Credit

The first of these two reforms, the premium tax credit, is designed to reduce the insurance premiums paid by individuals whose household income is between 100% and 400% of the poverty line. *See* 26 U.S.C. § 36B(c)(1)(A); 42 U.S.C. § 18082(c)(2)(B)(i); *accord* 26 C.F.R. § 1.36B-2(a) to (b) (2017); 45 C.F.R. § 156.460(a)(1) (2017). The Secretary of the Department of Health and Human Services ("Secretary of HHS") is required to determine whether individuals enrolling in qualified health plans on an exchange are eligible for the premium tax credit and, if so, to notify the Secretary of the United States Department of the Treasury ("Treasury Secretary") of that fact. 42 U.S.C. § 18082(c)(1). The Treasury Secretary, in turn, is

[2] For example, for a silver-level qualified health plan, insurers are required to provide coverage for 70% of the benefits offered under the plan. 42 U.S.C. § 18022(d)(1)(B). Insurers offering qualified health plans on an exchange must offer at least one silver-level plan and one gold-level plan. *Id*. § 18021(a)(1)(C)(ii).

required to make periodic advance payments of the premium tax credit to the insurers offering the qualified health plans in which the eligible individuals enrolled. *Id*. § 18082(c)(2)(A). The insurers are required to use these advance payments to reduce the premiums of the eligible individuals. *Id*. § 18082(c)(2)(B)(i); *see also* 26 U.S.C. § 36B(f) (describing the process for annually reconciling an individual's actual premium tax credit with the advance payments of the credit). To fund the premium tax credit, Congress amended a preexisting permanent appropriation to allow for the payment of refunds arising from the credit. *See* 31 U.S.C. § 1324 (2012) ("Necessary amounts are appropriated . . . for refunding internal revenue collections as provided by law . . . . Disbursements may be made from the appropriation made by this section only for . . . refunds due from credit provisions of [26 U.S.C. § 36B].").

2. Cost-Sharing Reductions

The other reform, cost-sharing reductions, is designed to reduce the out-of-pocket expenses (such as deductibles, copayments, and coinsurance[3]) paid by individuals whose household income is between 100% and 250% of the poverty line. *See* 42 U.S.C. §§ 18022(c)(3), 18071(c)(2); *accord* 45 C.F.R. §§ 155.305(g), 156.410(a). Insurers offering qualified health plans are required to reduce eligible individuals' cost-sharing obligations by specified amounts,[4] 42 U.S.C.

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[3] "The term 'cost-sharing' includes . . . deductibles, coinsurance, copayments, or similar charges," but not "premiums, balance billing amounts for non-network providers, or spending for non-covered services." 42 U.S.C. § 18022(c)(3).

[4] To be eligible for cost-sharing reductions, an individual must enroll in a silver-level qualified health plan. 42 U.S.C. § 18071(b)(1). Under a standard silver-level plan, insurers are required to

§ 18071(a), and the Secretary of HHS is required to reimburse the insurers for the cost-sharing reductions they make, *see id*. § 18071(c)(3)(A) ("[T]he Secretary [of HHS] shall make periodic and timely payments to the issuer equal to the value of the reductions.").

The Secretary of HHS is afforded some discretion in the timing of the reimbursements: once he determines which individuals are eligible for cost-sharing reductions, he must notify the Treasury Secretary "if an advance payment of the cost-sharing reductions . . . is to be made to the issuer of any qualified health plan" and, if so, the time and amount of such advance payment. *Id*. § 18082(c)(3). Pursuant to this authority, the Secretary of HHS established a reimbursement schedule by which the government "would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,486 (Mar. 11, 2013) (to be codified at 45 C.F.R. § 156.430); *see also* 45 C.F.R. § 156.430(b)(1) ("A [qualified health plan] issuer will receive periodic advance payments [for cost sharing reductions]."). The amount of the cost-sharing reduction payments owed to insurers is based on information provided to HHS by the insurers. *See* 45 C.F.R.

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provide coverage for 70% of the benefits offered under the plan. *Id*. § 18022(d)(1)(B). However, for eligible individuals, that percentage increases to 73% (when household income is between 200% and 250% of the poverty line), 87% (when household income is between 150% and 200% of the poverty line), or 94% (when household income is between 100% and 150% of the poverty line). *Id*. § 18071(c)(2).

§ 156.430(c) (requiring insurers to report to HHS, "for each policy, the total allowed costs for essential health benefits charged for the policy for the benefit year, broken down by . . . (i) [t]he amount the [insurer] paid[,] (ii) [t]he amount the enrollee(s) paid[, and] (iii) [t]he amount the enrollee(s) would have paid under the standard plan without cost-sharing reductions").

The Affordable Care Act did not include any language appropriating funds to make the cost-sharing reduction payments.

3. Requirements for Insurers

To offer a health insurance plan on an exchange in any given year—and become eligible to receive payments for the premium tax credit and cost-sharing reductions—an insurer must satisfy certain requirements established by the Secretary of HHS. *See*, *e.g.*, 42 U.S.C. § 18041(a)(1) (authorizing the Secretary of HHS to "issue regulations setting standards for meeting the requirements under [title I of the Affordable Care Act] with respect to—(A) the establishment and operation of Exchanges . . . ; (B) the offering of qualified health plans through such Exchanges; . . . and (D) such other requirements as the Secretary determines appropriate"). The requirements include (1) obtaining certification that any plan it intends to offer is a qualified health plan, *see*, *e.g.*, 45 C.F.R. §§ 155.1000, .1010, 156.200; and (2) submitting rate and benefit information before the open enrollment period for the applicable year, *see*, *e.g.*, *id.* §§ 155.1020, 156.210. In addition, in most circumstances, insurers must make their qualified health plans available on the exchanges for the entire year for which the plans were certified. 45 C.F.R. § 156.272(a).

B. Termination of Cost-Sharing Reduction Payments

On April 10, 2013, before the exchanges opened for business, President Barack H. Obama submitted to Congress his budget for fiscal year 2014. *See* Office of Mgmt. & Budget, Exec. Office of the President, *Fiscal Year 2014 Budget of the United States Government to Congress* (2013). The budget included a request for a line-item appropriation for cost-sharing reduction payments. *See id*. at App. 448; *accord* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *Fiscal Year 2014 Justification of Estimates for Appropriations Committees* 184 (2013). However, Congress did not provide the requested appropriation. *See* Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5; *see also* S. Rep. No. 113-71, at 123 (2013) ("The Committee recommendation does not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the [Affordable Care Act]."). In fact, it is undisputed by the parties that Congress has never specifically appropriated funds to reimburse insurers for their cost-sharing reductions.[5] It is further undisputed that Congress has never (1) expressly prevented—in an appropriations act or otherwise—the Secretary of HHS or the Treasury Secretary from expending funds to make cost-sharing reduction payments or (2)

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[5] Whether Congress will appropriate funds for cost-sharing reduction payments in the future is an open question. *Cf*. Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 283 (Jan. 24, 2019) ("The Administration supports a legislative solution that would appropriate [cost-sharing reduction] payments . . . .").

amended the Affordable Care Act to eliminate the cost-sharing reduction payment obligation.

Although Congress did not specifically appropriate funds for cost-sharing reduction payments, the Obama administration began making advance payments to insurers for cost-sharing reductions in January 2014. *See* Ctrs. for Medicare & Medicaid Servs., Dep't of Health & Human Servs., *Guidance Related to Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015* 27 (2016). It made the payments from "the same account from which the premium tax credit" advance payments were made—in other words, from the permanent appropriation described in 31 U.S.C. § 1324. Letter from Sylvia M. Burwell, Director of the Office of Mgmt. & Budget, to Ted Cruz and Michael S. Lee, U.S. Senators 4 (May 21, 2014), http://www.cruz.senate.gov/files/documents/Letters/20140521_Burwell_Response.pdf.

On November 21, 2014, the United States House of Representatives ("House") sued the Obama administration in the United States District Court for the District of Columbia ("D.C. district court") to stop the payment of cost-sharing reduction reimbursements to insurers. *See generally U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC (D.D.C. filed Nov. 21, 2014). The D.C. district court ruled for the House, holding:

> The Affordable Care Act unambiguously appropriates money for Section 1401 premium tax credits but not for Section 1402 reimbursements to insurers. Such an appropriation cannot be inferred. None of Secretaries' extra-textual arguments—whether based on economics, "unintended" results, or legis-

> lative history—is persuasive. The Court will enter judgment in favor of the House of Representatives and enjoin the use of unappropriated monies to fund reimbursements due to insurers under Section 1402. The Court will stay its injunction, however, pending appeal by either or both parties.

U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 168 (D.D.C. 2016). The Obama administration appealed the ruling. *See generally U.S. House of Representatives v. Azar* ("Azar"), No. 16-5202 (D.C. Cir. filed July 6, 2016). However, the United States Court of Appeals for the District of Columbia Circuit ("D.C. Circuit") stayed the appeal to allow President-elect Donald J. Trump and his future administration time to determine how to proceed. *See* Mot. Hold Briefing Abeyance 1-2, *Azar*, No. 16-5202 (Nov. 21, 2016); Order, *Azar*, No. 16-5202 (Nov. 21, 2016).

The Trump administration continued the previous administration's practice of making advance cost-sharing reduction payments to insurers. However, on October 11, 2017, the United States Attorney General sent a letter to the Treasury Secretary and the Acting Secretary of HHS advising that "the best interpretation of the law is that the permanent appropriation for 'refunding internal revenue collections,' 31 U.S.C. § 1324, cannot be used to fund the [cost-sharing reduction] payments to insurers authorized by 42 U.S.C. § 18071." Letter from Jefferson B. Sessions III, U.S. Attorney General, to Steven Mnuchin, Sec'y of the Treasury, and Don Wright, M.D., M.P.H., Acting Sec'y of HHS 1 (Oct. 11, 2017), http://www.hhs.gov/sites/default/files/ csr-payment-memo.pdf. Based on this guidance, the Acting Secretary of HHS directed, the following day, that "[cost-sharing reduction] payments

to issuers must stop, effective immediately," and that such "payments are prohibited unless and until a valid appropriation exists." Memorandum from Eric Hargan, Acting Sec'y of HHS,[6] to Seema Verma, Administrator of the Ctrs. for Medicare & Medicaid Servs. (Oct. 12, 2017), http://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

C. Reaction to the Termination of Cost-Sharing Reduction Payments

The Trump administration's termination of cost-sharing reduction payments did not come as a surprise to insurers:

> Anticipating that the Administration would terminate [cost-sharing reduction] payments, most states began working with the insurance companies to develop a plan for how to respond. Because the Affordable Care Act requires insurance companies to offer plans with cost-sharing reductions to customers, the federal government's failure to meet its [cost-sharing reduction] payment obligations meant the insurance companies would be losing that money. So most of the states set out to find ways for the insurance companies to increase premiums for 2018 (with open enrollment beginning in November 2017) in a fashion that would avoid harm to consumers. And the states came up with an idea: allow

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[6] Eric Hargan was named Acting Secretary of HHS on October 10, 2017. *See* Press Release, The White House, President Donald J. Trump Announces Intent to Nominate Personnel to Key Administration Posts (Oct. 10, 2017), https://www.whitehouse.gov/presidential-actions/president-donald-j-trump-announces-intent-nominate-personnel-key-administration-posts-22/.

> the insurers to make up the deficiency through premium increases for silver plans only. In other words, allow a relatively large premium increase for silver plans, but no increase for bronze, gold, or platinum plans.
>
> As a result, in these states, for everyone between 100% and 400% of the federal poverty level who wishes to purchase insurance on the exchanges, the available tax credits rise substantially. Not just for people who purchase the silver plans, but for people who purchase other plans too.

California, 267 F. Supp. 3d at 1134-35 (footnote omitted). In other words, by raising premiums for silver-level qualified health plans, the insurers would obtain more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments.[7] *Accord id*. at 1139 (agreeing with the states "that the widespread increase in silver plan premiums will qualify many people for higher tax credits, and that the increased federal expenditure for tax credits will be far more

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[7] Notably, increasing silver-level qualified health plan premiums would not harm most consumers who qualify for the premium tax credit because the credit increases as the premium increases. *See California*, 267 F. Supp. 3d at 1134 ("[T]he amount [of the premium tax credit] is based on the cost of the second-cheapest silver plan available on the exchange in your geographic area, and then adjusted based on your income (that is, based on where you fall on the spectrum between 100% and 400% of the federal poverty level). So, if premiums for the second-cheapest silver plan in your area go up, the amount of your tax credit will go up by a corresponding amount. *See* 26 U.S.C. § 36B."); *see also id*. at 1122 ("[M]ost state regulators have devised responses that give millions of lower-income people better health coverage options than they would otherwise have had.").

significant than the decreased federal expenditure for [cost-sharing reduction] payments"). This approach is commonly referred to as "silver loading," and many states appear to have endorsed it, *see id*. at 1137 ("Even before the Administration announced its decision, 38 states accounted for the possible termination of [cost-sharing reduction] payments in setting their 2018 premium rates. And now that the announcement has been made, even more states are adopting [the] strategy [of increasing silver-level plan premiums to obtain additional premium tax credit payments]." (footnote omitted)).

D. Other Litigation

While the states and insurers were working on ways to mitigate the loss of cost-sharing reduction payments, the parties in the case on appeal at the D.C. Circuit began discussing that case's disposition. Joint Status Report 1-2, *Azar*, No. 16-5202 (Nov. 30, 2017). Ultimately, at the request of the parties, the D.C. Circuit dismissed the appeal, Order, *Azar*, No. 16-5202 (May 16, 2018), and the D.C. district court vacated the portion of its ruling in which it provided that "reimbursements paid to issuers of qualified health plans for the cost-sharing reductions mandated by Section 1402 of the Affordable Care Act, Pub. L. 111-148, are ENJOINED pending an appropriation for such payments," Order, *Azar*, No. 1:14-cv-01967-RMC (May 18, 2018).

A separate lawsuit was filed by seventeen states and the District of Columbia in the United States District Court for the Northern District of California ("California district court") to compel the Trump administration to continue making the advance cost-sharing reduction payments to insurers. *See generally California v. Trump*, No. 3:17-cv-05895-VC (N.D. Cal.

filed Oct. 13, 2017). The California district court denied the states' motion for a preliminary injunction. *California*, 267 F. Supp. 3d at 1121-22, 1140. Eventually, the states requested a stay of the proceedings or, alternatively, dismissal of the suit without prejudice, explaining:

> [S]taying the proceedings is warranted to avoid disturbing the status quo given the general success of the practice commonly referred to as "silver-loading" which mostly curbed the harm caused by the federal government's unjustified cessation of cost-sharing reduction (CSR) subsidies mandated by Section 1402 of the Patient Protection and Affordable Care Act (ACA). At the same time, because of the real threat of the federal government taking action to prohibit silver-loading, the Court should retain jurisdiction, thus allowing the Plaintiff States to expeditiously seek appropriate remedies from this Court for the protection of their citizens. Alternatively, if the Court determines that a stay is not appropriate at this time, the Plaintiff States respectfully request that the Court dismiss the action without prejudice.

Mot. for Order Staying Proceedings or, in the Alternative, Dismissing Action Without Prejudice 2, *California*, No. 3:17-cv-05895-VC (July 16, 2018); *cf.* HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. at 283 ("The Administration supports a legislative solution that would appropriate CSR payments and end silver loading. In the absence of Congressional action, we seek comment on ways in which HHS might address silver loading, for potential action in future rulemaking applicable not sooner than

plan year 2021."). The California district court dismissed the case without prejudice on July 18, 2018. Order Dismissing Case Without Prejudice, *California*, No. 3:17-cv-05895-VC (July 18, 2018).

E. Effect of Cost-Sharing Reduction Payment Termination on Plaintiff

Plaintiff is a nonprofit corporation that offers qualified health plans on Wisconsin's exchange.[8] It began offering qualified health plans on the exchange in January 2014, continued to offer such plans in 2015, 2016, 2017, and committed to offering such plans in 2018. Plaintiff began receiving monthly advance cost-sharing reduction payments in January 2014 and, as with every other insurer offering qualified health plans on the exchanges, stopped receiving these payments effective October 12, 2017. Plaintiff estimates that it is owed $12-13 million for 2017 and asserts that because approximately 65% of its insured population receives cost-sharing reductions, the unpaid amount will have a significant effect on its finances. In addition, plaintiff estimates that it will be owed cost-sharing reduction payments of approximately $60 million for 2018.

F. Procedural History

Plaintiff filed a complaint in this court on June 27, 2017, to recover, for itself and other insurers, unpaid risk corridors payments for 2016.[9] It then filed an

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[8] Aside from the estimated amounts of unpaid cost-sharing reduction reimbursements, it appears that the facts in this subsection, which are derived from the allegations in plaintiff's amended complaint, are undisputed.

[9] Proceedings on the risk corridors claim are currently stayed pending final, nonappealable judgments in *Moda Health Plan*,

amended complaint on November 22, 2017, to add a claim to recover, for itself and other insurers, the cost-sharing reduction payments that the government has not made for 2017 and 2018.[10] In the latter claim, plaintiff contends that the government violated the statutory and regulatory mandate to make cost-sharing reduction payments to insurers.

The court certified a cost-sharing reduction class on April 17, 2018. Thereafter, plaintiff moved for summary judgment on its cost-sharing reduction claim, and defendant cross-moved to dismiss that claim. The parties completed briefing, and after hearing argument on February 14, 2019, the court is prepared to rule.[11]

Inc. v. United States, No. 16-649C, and *Land of Lincoln Mutual Health Insurance Co. v. United States*, No. 16-744C.

[10] A number of other insurers have filed suit in this court seeking to recover unpaid cost-sharing reduction reimbursements. *See, e.g.*, *Local Initiative Health Auth. for L.A. Cty. v. United States*, No. 17-1542C (Judge Wheeler); *Me. Cmty. Health Options v. United States*, No. 17-2057C (Chief Judge Sweeney); *Cmty. Health Choice, Inc. v. United States*, No. 18-5C (Chief Judge Sweeney); *Sanford Health Plan v. United States*, No. 18-136C (Judge Kaplan); *Montana Health Co-op v. United States*, No. 18-143C (Judge Kaplan); *Molina Healthcare of Cal., Inc. v. United States*, No. 18-333C (Judge Wheeler); *Health Alliance Med. Plans, Inc. v. United States*, No. 18-334C (Judge Campbell-Smith); *Blue Cross & Blue Shield of Vt. v. United States*, No. 18-373C (Judge Horn); *Guidewell Mut. Holding Corp. v. United States*, No. 18-1791C (Judge Griggsby); *Harvard Pilgrim Health Care, Inc. v. United States*, No. 18-1820C (Judge Smith).

[11] The court has had the benefit of full briefing and oral argument in three cost-sharing reduction cases: *Common Ground Healthcare Cooperative v. United States*, No. 17-877C, *Maine Community Health Options v. United States*, No. 17-2057C, and *Community Health Choice, Inc. v. United States*, No. 18-5C. The plaintiffs in all three cases allege that the government violated

II. STANDARDS OF REVIEW

A. Motions for Summary Judgment

Plaintiff moves for summary judgment pursuant to Rule 56 of the Rules of the United States Court of Federal Claims ("RCFC"). Summary judgment is appropriate when there is no genuine issue of material fact and the moving party is entitled to a judgment as a matter of law. RCFC 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). A fact is material if it "might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). An issue is genuine if it "may reasonably be resolved in favor of either party." *Id.* at 250. Entry of summary judgment is mandated against a party who fails to establish "an element essential to that party's case, and on which that party will bear the burden of proof at trial." *Celotex Corp.*, 477 U.S. at 322. Statutory construction is a "question[] of law amenable to resolution through summary judgment." *Stathis v. United States*, 120 Fed. Cl. 552, 561 (2015); *accord Anderson v. United States*, 54 Fed. Cl. 620, 629 (2002) ("The plaintiff's entitlement . . . rests solely upon interpretation of the cited statute and is thus amenable to resolution by summary judgment."), *aff'd*, 70 F. App'x 572 (Fed. Cir. 2003) (unpublished opinion).

B. Motions to Dismiss for Failure to State a Claim Upon Which Relief Can Be Granted

Defendant cross-moves to dismiss plaintiff's cost-sharing reduction claim for failure to state a claim upon which relief can be granted pursuant to RCFC

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the cost-sharing reduction statutes and regulations. Thus, in ruling on the parties' motions in this case, the court has considered the parties' arguments in all three cases.

12(b)(6). To survive such a motion, a plaintiff must include in its complaint "enough facts to state a claim to relief that is plausible on its face." *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 570 (2007). In other words, a plaintiff must "plead[] factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (citing *Bell Atl. Corp.*, 550 U.S. at 556). Indeed, "[t]he issue is not whether a plaintiff will ultimately prevail but whether the claimant is entitled to offer evidence to support the claims." *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974), *overruled on other grounds by Harlow v. Fitzgerald*, 457 U.S. 800, 814-19 (1982).

III. DISCUSSION

In seeking to recover the cost-sharing reduction payments not made by the government, plaintiff contends that the government's failure to make the payments was a violation of the cost-sharing reduction provisions of the Affordable Care Act and its implementing regulations. Plaintiff further contends that Congress's failure to specifically appropriate funds for cost-sharing reduction payments does not suspend or terminate the government's obligation to make the payments. Defendant disagrees, arguing that Congress expressed its intent that cost-sharing reduction payments should not be made absent a specific appropriation for that purpose by not appropriating funds for cost-sharing reductions in the Affordable Care Act or thereafter. Consequently, defendant contends, monetary damages—payable from the Judgment Fund—are unavailable from this court.

A. The Government Is Obligated to Make Cost-Sharing Reduction Payments to Plaintiff Notwithstanding the Absence of a Specific Appropriation for That Purpose

To determine whether Congress intended the government to make cost-sharing reduction payments to insurers, the court first turns to the language of the Affordable Care Act. *See Lamie v. U.S. Tr.*, 540 U.S. 526, 534 (2004) ("The starting point in discerning congressional intent is the existing statutory text."); *see also Conn. Nat'l Bank v. Germain*, 503 U.S. 249, 253-54 (1992) ("[C]ourts must presume that a legislature says in a statute what it means and means in a statute what it says there."). In addition to evaluating the specific provision of the Affordable Care Act establishing the cost-sharing reduction program, the court must read that provision in the context of the Affordable Care Act as a whole. *See King v. St. Vincent's Hosp.*, 502 U.S. 215, 221 (1991) (following "the cardinal rule that a statute is to be read as a whole, since the meaning of statutory language, plain or not, depends on context" (citation omitted)); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its object and policy."); *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974) ("When 'interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give to it such a construction as will carry into execution the will of the Legislature . . . .'" (quoting *Brown v. Duchesne*, 60 U.S. 183, 194 (1856))); *see also Chevron, U.S.A., Inc. v. Nat.*

Res. Def. Council, Inc., 467 U.S. 837, 843 n.9 (1984) ("If a court, employing traditional tools of statutory construction, ascertains that Congress had an intention on the precise question at issue, that intention is the law and must be given effect."); *Kilpatrick v. Principi*, 327 F.3d 1375, 1384 (Fed. Cir. 2003) ("[I]n determining whether Congress has directly spoken to the point at issue, a court should attempt to discern congressional intent either from the plain language of the statute or, if necessary, by resort to the applicable tools of statutory construction[.]"). If congressional intent can be ascertained from evaluating the text of the Affordable Care Act, then the court's inquiry on this issue is complete. *See Conn. Nat'l Bank*, 503 U.S. at 254.

The statutory provision governing cost-sharing reductions sets forth an unambiguous mandate: "the Secretary [of HHS] shall make periodic and timely payments" to insurers "equal to the value of the reductions" made by the insurers. 42 U.S.C. § 18071(c)(3)(A); *accord Montana Health Co-op v. United States*, 139 Fed. Cl. 213, 218 (2018)[12] ("[T]he statutory language clearly and unambiguously imposes an obligation on the Secretary of HHS to make payments to health insurers that have implemented cost-sharing reductions on their covered plans as required by the [Affordable Care Act]."); *see also SAS Inst., Inc. v. Iancu*, 138 S. Ct. 1348, 1354 (2018) ("The word 'shall' generally imposes a nondiscretionary duty."); *Gilda Indus., Inc. v. United States*, 622 F.3d 1358, 1364 (Fed. Cir. 2010) ("When a statute directs that a certain consequence 'shall' follow from specified

[12] The judge who decided *Montana Health Co-op*—the Honorable Elaine D. Kaplan— subsequently issued a substantively identical ruling in another case. *See Samford Health Plan v. United States*, 139 Fed. Cl. 701 (2018).

contingencies, the provision is mandatory and leaves no room for discretion."); *cf. Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320 (2018) (concluding that similar language in section 1342 of the Affordable Care Act—indicating that the Secretary of HHS "shall establish" a risk corridors program pursuant to which the Secretary of HHS "shall pay" risk corridors payments—is "unambiguously mandatory"). Moreover, the mandatory payment obligation fits logically within the statutory scheme established by Congress. The cost-sharing reduction payments were meant to reimburse insurers for paying an increased share of their insureds' cost-sharing obligations, 42 U.S.C. § 18071(a)(2), (c)(3)(A), and the reduction of insureds' cost-sharing obligations was meant to make obtaining health care more affordable, *see*, *e.g.*, *id.* § 18071(c)(1)(A) (describing how cost-sharing reductions would be achieved by reducing insureds' out-of-pocket limits). In short, the plain language, structure, and purpose of the Affordable Care Act reflect the intent of Congress to require the Secretary of HHS to make cost-sharing reduction payments to insurers.

Defendant does not dispute this conclusion. Rather, it contends that the cost-sharing reduction payment obligation is unenforceable because Congress never specifically appropriated funds—either in the Affordable Care Act or thereafter—to make cost-sharing reduction payments.

1. The Lack of Specific Appropriating Language in the Affordable Care Act

As defendant observes, the Affordable Care Act does not include any language specifically appropriating funds for cost-sharing reduction payments. Defendant also correctly observes that the Act's cost-sharing reduction provision lacks any appropriating language,

while its companion provision—the premium tax credit—included an explicit funding mechanism.[13] *Compare* Affordable Care Act § 1401(d) (amending the permanent appropriation set forth in 31 U.S.C. § 1324 to allow for the payment of the premium tax credit), *with id*. § 1402 (containing no appropriating language). According to defendant, the absence of any funding mechanism for cost-sharing reduction payments, and Congress's decision to provide a funding mechanism for premium tax credit payments and not cost-sharing reduction payments, reflect the intent of Congress, when enacting the Affordable Care Act, to preclude liability for cost-sharing reduction payments. Defendant is mistaken for several reasons.

First, it is well settled that the government can create a liability without providing for the means to pay for it. *See*, *e.g.*, *Moda Health Plan*, 892 F.3d at 1321 ("[I]t 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."); *Collins v. United States*, 15 Ct. Cl. 22, 35 (1879) ("[T]he legal liabilities incurred by the United States under . . . the laws of Congress . . . may be created where there is no appropriation of money to meet them . . . ."). Thus, the absence of a specific appropriation for cost-sharing reduction payments in the Affordable Care Act does not, on its own, extinguish the government's obligation to make the payments.

Second, that Congress provided a funding mechanism for premium tax credit payments and not

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[13] Both provisions appear in subpart A of part I of subtitle E of the Affordable Care Act, which is titled "Premium Tax Credits and Cost-Sharing Reductions." 124 Stat. at 213-24.

for cost-sharing reduction payments does not reflect congressional intent to foreclose liability for the latter. Defendant relies on the proposition that when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." *Russello v. United States*, 464 U.S. 16, 23 (1983) (quoting *United States v. Wong Kim Bo*, 472 F.2d 720, 722 (5th Cir. 1972)); *accord Digital Realty Trust, Inc. v. Somers*, 138 S. Ct. 767, 777 (2018). Here, although Congress may have acted intentionally by treating the two related provisions differently,[14] it is difficult to discern what that intent might be. In addition to the intent inferred by defendant, there are other reasonable explanations for the disparity. One possible explanation is that it was a simple matter to add the premium tax credit to a preexisting permanent appropriation in the Internal Revenue Code for the payment of tax credits, whereas no such permanent appropriation existed that would apply to cost-sharing reduction payments. Another possible explanation is that Congress understood that other funds available to HHS could be used to make the cost-sharing reduction payments; indeed, the cost-sharing reduction provision lacks any language, such as "subject to the availability of appropriations," reflecting Congress's recognition that appropriations were unavailable, *see Greenlee Cty., Ariz. v. United*

[14] Alternatively, it is possible that the disparate treatment does not reflect any intent at all. As the United States Supreme Court ("Supreme Court") recognized in *King*, "[t]he Affordable Care Act contains more than a few examples of inartful drafting." 135 S. Ct. at 2492. Thus, Congress's failure to include any appropriating language in the cost-sharing reduction provision may simply have been an oversight.

States, 487 F.3d 871, 878 (Fed. Cir. 2007) (observing that "in some instances the statute creating the right to compensation . . . may restrict the government's liability . . . to the amount appropriated by Congress" with language such as "subject to the availability of appropriations"). A third possible explanation is that Congress intended to defer appropriating funds for cost-sharing reduction payments until 2014, when insurers began to offer qualified health plans on the exchanges and incur cost-sharing reduction liabilities. Because it is unclear which of these explanations—if any—is correct, the court declines to ascribe any particular intent to Congress based on Congress's disparate treatment of the two provisions.

Third, the court is unpersuaded by defendant's related contention that insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses from the government's nonpayment of cost-sharing reduction reimbursements, is evidence that Congress did not intend to provide a statutory damages remedy for the government's failure to make the cost-sharing reduction payments. *Accord Montana Health Co-op*, 139 Fed. Cl. at 221. Defendant does not identify any statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation (even if insurers intentionally increased premiums to obtain larger premium tax credit payments to make up for lost cost-sharing reduction payments). Nor does defendant identify any evidence in the Affordable Care Act's legislative history suggesting that Congress intended to limit its liability to make cost-sharing reduction payments by increasing its premium tax credit payments. That insurers and states discovered a way to mitigate the insurers' losses

from the government's failure to make cost-sharing reduction payments does not mean that Congress intended this result. Moreover, defendant's concern that Congress could not have intended to allow a double recovery of cost-sharing reduction payments is not well taken. The increased amount of premium tax credit payments that insurers receive from increasing silver-level plan premiums are still premium tax credit payments, not cost-sharing reduction payments. Indeed, under the statutory scheme as it exists, even if the government were making the required cost-sharing reduction payments, insurers could (to the extent permitted by their state insurance regulators) increase their silver-level plan premiums; in such circumstances, it could not credibly be argued that the insurers were obtaining a double recovery of cost-sharing reduction payments. While the premium tax credit and cost-sharing reduction provisions were enacted to reduce an individual's health-care-related costs (to obtain insurance and to obtain health care, respectively), they are not substitutes for each other.[15]

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[15] The California district court's decision in *California v. Trump* does not assist defendant. Although the court described how insurers are coping with the lost cost-sharing reduction payments by raising silver-level qualified health plan premiums to obtain larger premium tax credit payments, nowhere in its decision does the court hold that the government's liability for cost-sharing reduction payments is lessened or eliminated by the government making larger premium tax credit payments to insurers. Indeed, the court very clearly emphasized that the premium tax credit program and the cost-sharing reduction program were separate and distinct. *See California*, 267 F. Supp. 3d at 1131. Moreover, the court's discussion of the approach taken by insurers to obtain increased premium tax credit payments was included within its analysis of "whether the absence of a preliminary injunction would harm the public and impede the objectives of health care reform." *Id.* at 1133. In other words, the

Fourth, it would defy common sense to conclude that Congress obligated the Secretary of HHS to reimburse insurers for their mandatory cost-sharing reductions without intending to actually reimburse the insurers. If Congress did not intend to create such an obligation, it would not have included any provision for reimbursing cost-sharing reductions in the Act.

In sum, Congress's failure to include any appropriating language in the Affordable Care Act does not reflect congressional intent to preclude liability for cost-sharing reduction payments. This conclusion, however, does not end the court's analysis because defendant also argues that Congress's subsequent failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise signals congressional intent to foreclose liability.

2. The Lack of Specific Appropriating Language in Subsequent Appropriations Acts

The Appropriations Clause of the United States Constitution provides that "[n]o Money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law[.]" U.S. Const. art. I, § 9, cl. 7. The statute commonly referred to as the Antideficiency Act further provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure or obligation exceeding an amount available in an appropriation or fund for the expenditure or obligation[.]" 31 U.S.C. § 1341(a)(1)(A). These directives are unambiguous: disbursements from the United States Treasury require an appropri-

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court's focus was on how the increase in premiums would affect the public, and not on the government's obligation to make payments to insurers.

ation from Congress. However, "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." *N.Y. Airways*, *Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (per curiam), *cited in Moda Health Plan*, 892 F.3d at 1321-22; *cf. Moda Health Plan*, 892 F.3d at 1322 (recognizing that the Supreme Court "rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government").

Defendant does not contend that any appropriations acts—or, indeed, any statutes at all—enacted after the Affordable Care Act contain language that "expressly or by clear implication" modifies or repeals the Act's cost-sharing reduction payment obligation. Rather, it relies on Congress's complete failure to appropriate funds for cost-sharing reduction payments as evidence that Congress intended to suspend the cost-sharing reduction payment obligation. Defendant's reliance is misplaced. None of the appropriations acts enacted after the Affordable Care Act expressly or impliedly disavowed the payment obligation; they were completely silent on the issue. Thus, this case is distinguishable from those relied upon by defendant—*Mitchell v. United States*, 109 U.S. 146 (1883), *Dickerson v. United States*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980)—that concerned situations in which Congress made affirmative statements in appropriations acts that reflected an intent to suspend the underlying substantive law.

Here, Congress has had ample opportunity to modify, suspend, or eliminate the statutory obligation to make cost-sharing reduction payments but has not

done so. Congress's inaction stands in stark contrast to its treatment of the Affordable Care Act's risk corridors program. Under that program, which was established in section 1342 of the Affordable Care Act, the Secretary of HHS was required to make annual payments to insurers pursuant to a statutory formula. 42 U.S.C. § 18062; *Moda Health Plan*, 892 F.3d at 1320. However, Congress included riders in two appropriations acts enacted after the Affordable Care Act that prohibited appropriated funds from being used to make risk corridors payments. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, tit. II, § 225, 129 Stat. 2242, 2624; Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, § 227, 128 Stat. 2130, 2491. These riders have been interpreted to suspend the government's obligation to make risk corridors payments from appropriated funds. *Moda Health Plan*, 892 F.3d at 1322-29. Congress has never enacted any such appropriations riders with respect to cost-sharing reductions payments, even when cost-sharing reduction payments were being made—during both the Obama and Trump administrations—from the permanent appropriation for tax credits described in 31 U.S.C. § 1324. Thus, the congressional inaction in this case may be interpreted, contrary to defendant's contention, as a decision not to suspend or terminate the government's cost-sharing reduction payment obligation.[16]

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[16] The court recognizes that drawing inferences from congressional inaction can be highly problematic. *See Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) ("Congressional inaction lacks 'persuasive significance' because 'several equally tenable inferences' may be drawn from such inaction . . . ." (quoting *United States v. Wise*, 370 U.S. 405, 411 (1962)); *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 306

In short, Congress's failure to appropriate funds to make cost-sharing reduction payments through annual appropriations acts or otherwise does not reflect a congressional intent to foreclose, either temporarily or permanently, the government's liability to make those payments.

B. Plaintiff Can Recover Unpaid Cost-Sharing Reduction Reimbursements in the United States Court of Federal Claims

Plaintiff asserts that because the government has breached its statutory obligation to make cost-sharing reduction payments, recovery is available in the United States Court of Federal Claims ("Court of Federal Claims") under the Tucker Act. The Tucker Act, the principal statute governing the jurisdiction of this court, waives sovereign immunity for claims against the United States, not sounding in tort, that are founded upon the United States Constitution, a federal statute or regulation, or an express or implied contract with the United States. 28 U.S.C. § 1491(a)(1) (2012). It is merely a jurisdictional statute and "does not create any substantive right enforceable against the United States for money damages." *United States v. Testan*, 424 U.S. 392, 398 (1976). Instead, the substantive right must appear in another source of law, such as a "money-mandating constitutional provision, statute or regulation that has been violated, or an express or implied contract with the United States." *Loveladies Harbor, Inc. v. United States*, 27 F.3d 1545, 1554 (Fed. Cir. 1994) (en banc). It is well accepted that a statute "is money-mandating for jurisdictional purposes if it 'can fairly be interpreted

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(1988) ("This Court generally is reluctant to draw inferences from Congress' failure to act.").

as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s].'" *Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (panel portion) (quoting *United States v. Mitchell*, 463 U.S. 206, 219 (1983)). Under this rule, "[i]t is enough . . . that a statute creating a Tucker Act right be reasonably amenable to the reading that it mandates a right of recovery in damages. While the premise to a Tucker Act claim will not be 'lightly inferred,' a fair inference will do." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 473 (2003) (citation omitted).

The cost-sharing reduction provision of the Affordable Care Act, codified at 42 U.S.C. § 18071, is a money-mandating statute for Tucker Act purposes: the Secretary of HHS is required to reimburse insurers for their mandatory cost-sharing reductions, 42 U.S.C. § 18071(c)(3)(A), and his failure to make such payments is a violation of that duty that deprives the insurers of money to which they are statutorily entitled. *Accord Montana Health Co-op*, 139 Fed. Cl. at 217; *see also Moda Health Plan*, 892 F.3d at 1320 n.2 (holding that the statute providing for risk corridors payments "is money-mandating for jurisdictional purposes"). Consequently, an insurer that establishes that the government failed to make the cost-sharing reduction payments to which the insurer was entitled can recover the amount due in this court.[17]

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[17] Defendant appears to contend that for plaintiffs to recover under a money-mandating statute, they must separately establish that the statute authorizes a damages remedy for its violation. Defendant is incorrect. Although some money-mandating statutes include a separate provision authorizing a damages remedy, *see*, *e.g.*, 41 U.S.C. § 7104(b) (2012) (allowing contractors to bring claims arising under the Contract Disputes Act of 1978

Moreover, the lack of a specific appropriation for cost-sharing reduction payments does not preclude such a recovery. Appropriations merely constrain government officials' ability to obligate or disburse funds. *See Moda Health Plan*, 892 F.3d at 1322 ("The Anti-Deficiency Act simply constrains government officials. . . . Budget authority is not *necessary* to create an obligation of the government; it is a means by which an officer is afforded that authority."); *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892) ("An 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."). Thus, the lack of an appropriation, standing alone,

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in the Court of Federal Claims), other money-mandating statutes pursuant to which the Court of Federal Claims can enter judgment do not, *see*, *e.g.*, 5 U.S.C. § 5942 (2012) (governing federal employees' entitlement to a remote duty allowance); 37 U.S.C. § 204 (2012) (governing military service members' entitlement to basic pay). Indeed, "[t]o the extent that the Government would demand an explicit provision for money damages to support every claim that might be brought under the Tucker Act, it would substitute a plain and explicit statement standard for the less demanding requirement of fair inference that the law was meant to provide a damages remedy for breach of a duty." *White Mountain Apache Tribe*, 537 U.S. at 477; *accord Fisher*, 402 F.3d at 1173 (en banc portion) ("[T]he determination that the source is money-mandating shall be determinative both as to the question of the court's jurisdiction and thereafter as to the question of whether, on the merits, plaintiff has a money-mandating source on which to base his cause of action."); *Montana Health Co-op*, 139 Fed. Cl. at 217 n.5 ("Plaintiffs have never been required to make some separate showing that the money-mandating statute that establishes this court's jurisdiction over their monetary claims also grants them an express (or implied) cause of action for damages.").

does not constrain the court's ability to entertain a claim that the government has not discharged the underlying statutory obligation or to enter judgment for the plaintiff on that claim. *See Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (en banc) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid."); *N.Y. Airways*, 369 F.2d at 752 ("[T]he 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."); *Collins*, 15 Ct. Cl. at 35 (remarking that a legal liability "incurred by the United States under . . . the laws of Congress," such as "[t]he compensation to which public officers are legally entitled . . . , exists independently of the appropriation, and may be enforced by proceedings in this court").

In fact, judgments of this court are payable from the Judgment Fund, *see* 31 U.S.C. § 1304(a)(3)(A), which "is a permanent, indefinite appropriation . . . available to pay many judicially and administratively ordered monetary awards against the United States," 31 C.F.R. § 256.1 (2016); *accord Bath Iron Works Corp. v. United States*, 20 F.3d 1567, 1583 (Fed. Cir. 1994) (stating that 31 U.S.C. § 1304 "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"). Indeed, as applicable here, "funds may be paid out [of the Judgment Fund] only on the basis of a judgment based on a substantive

right to compensation based on the express terms of a specific statute." *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 432 (1990); *accord Moda Health Plan*, 892 F.3d at 1326 ("[A]ccess to the Judgment Fund presupposes liability."); *cf.* 31 U.S.C. § 1304(a)(1) (indicating that the Judgment Fund is available when "payment is not otherwise provided for"). Because plaintiff's claim arises from a statute mandating the payment of money damages in the event of its violation, the Judgment Fund is available to pay a judgment entered by the court on that claim.[18]

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[18] Defendant acknowledged this possibility in other litigation. *See* Defs.' Mem. Supp. Mot. Summ. J. 20, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("The [Affordable Care] Act requires the government to pay cost-sharing reductions to issuers. The absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation. Under the Tucker Act, a plaintiff may bring suit against the United States in the Court of Federal Claims to obtain monetary payments based on statutes that impose certain types of payment obligations on the government. If the plaintiff is successful, it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund. The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund." (citations omitted)); Defs.' Mem. Opp'n Pl.'s Mot. Summ. J. 12-13, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("Indeed, had Congress not permanently funded the cost-sharing reductions, it would have exposed the government to litigation by insurers, who could bring damages actions under the Tucker Act premised on the government's failure to make the mandatory cost-sharing reduction payments that the Act requires."); Defs.' Reply Mem. Supp. Mot. Summ. J. 9, *Burwell*, 185 F. Supp. 3d at 165 (No. 1:14-cv-01967-RMC) ("[T]he House's interpretation of the [Affordable Care Act]—under which the Act would require the government to make the cost-sharing payments but provide no appropriation for doing so directly—would invite potentially costly lawsuits under the Tucker Act. The House asserts that insurers could not prevail in such suits '[a]bsent a valid appropriation.' But courts have held

C. Plaintiff Is Entitled to Recover Unpaid Cost-Sharing Reduction Reimbursements

Plaintiff seeks to recover the cost-sharing reduction payments that it has not received for 2017 and 2018. As noted above, plaintiff has established that the government is obligated to reimburse it for its cost-sharing reductions pursuant to 42 U.S.C. § 18071(c)(3)(A) and that the government stopped making such reimbursements in October 2017. Accordingly, at a minimum, it is entitled to recover the cost-sharing reduction payments that the government did not make for 2017.

With respect to 2018, defendant contends—as discussed above, albeit in the course of arguing that the structure of the Affordable Care Act reflects a congressional intent to preclude cost-sharing reduction payments absent an appropriation for that purpose—that plaintiff's ability to increase the premiums for its silver-level qualified health plans to obtain greater premium tax credit payments precludes recovery under the Act's cost-sharing reduction provision. Specifically, defendant asserts that the statutory scheme enacted by Congress permits insurers to make up any lost cost-sharing reduction payments by increasing silver-level plan premiums, which would prevent monetary injury to insurers. Defendant also expresses concern that allowing insurers to both obtain greater premium tax credits and obtain a judgment for their

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that the absence of an appropriation does not necessarily preclude recovery from the Judgment Fund in a Tucker Act suit. The House does not explain how, given this precedent, the government could avoid Tucker Act litigation by insurers in the wake of a ruling that the ACA did not permanently fund the cost-sharing reduction payments that the Act directs the government to make." (citations omitted)).

lost cost-sharing reduction payments would provide an unwarranted windfall for insurers. As noted above, the court is not convinced by defendant's arguments. Accordingly, it finds that plaintiff may recover the cost-sharing reduction payments that the government did not make for 2018.

IV. CONCLUSION

For the reasons set forth above, the court concludes that the government's failure to make cost-sharing reduction payments to plaintiff violates 42 U.S.C. § 18071. Therefore, it GRANTS plaintiff's motion for summary judgment and DENIES defendant's motion to dismiss. By no later than Thursday, February 28, 2019, the parties shall file a joint status report indicating the amount due to plaintiff and the other class members for the cost-sharing payments they did not receive for 2017 and 2018. For each class member, the parties shall indicate (1) the amount due for 2017, (2) the amount due for 2018, and (3) the sum of the amounts due for 2017 and 2018. If the parties are unable to provide the amounts due for 2018, they shall (1) suggest a deadline for providing the court with that information and (2) indicate whether an RCFC 54(b) judgment limited to the cost-sharing reduction claims for 2017 would be appropriate. If the parties are able to provide the amounts due for 2018, the court will direct the entry of judgment on the class's cost-sharing reduction claims for 2017 and 2018 pursuant to RCFC 54(b).

IT IS SO ORDERED.

s/ Margaret M. Sweeney
MARGARET M. SWEENEY
Chief Judge

APPENDIX C

NOTE: This order is nonprecedential.

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2020-1286

COMMON GROUND HEALTHCARE COOPERATIVE, on behalf of itself and all others similarly situated,

Plaintiff-Appellee

v.

UNITED STATES,

Defendant-Appellant

Appeal from the United States Court of Federal Claims in No. 1:17-cv-00877-MMS, Chief Judge Margaret M. Sweeney.

ON PETITION FOR REHEARING EN BANC

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

PER CURIAM.

ORDER

Appellee Common Ground Healthcare Cooperative filed a petition for rehearing en banc. At the court's invitation and with leave of the court, the United States filed a response to the petition and incorporated

a conditional cross-petition for rehearing en banc. The petitions were first referred as petitions for rehearing to the panel that heard the appeal, and thereafter the petitions for rehearing en banc were referred to the circuit judges who are in regular active service.

Upon consideration thereof,

IT IS ORDERED THAT:

The petitions for panel rehearing are denied. The petitions for rehearing en banc are denied.

The mandate of the court will issue on December 23, 2020.

FOR THE COURT

December 16, 2020
Date

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

APPENDIX D

IN THE UNITED STATES COURT OF FEDERAL CLAIMS

No. 17-877 C

COMMON GROUND HEALTHCARE COOPERATIVE, on behalf of itself and all others similarly situated

v.

THE UNITED STATES

Filed October 22, 2019

RULE 54(b)

JUDGMENT

Pursuant to the court's Opinion and Order, filed February 15, 2019, granting plaintiff's motion for summary judgment and denying defendant's motion to dismiss; and Order, filed October 22, 2019, directing the entry of judgment under Rule 54(b), there being no just reason for delay,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that judgment is entered for the cost-sharing reduction (CSR) class in the amount of $1,587,108,397.81, with the CSR class members entitled to the amounts set forth in the attached table. Plaintiff is entitled to costs.

Lisa L. Reyes,
Clerk of Court

By: s/ Debra L. Samler,
Deputy Clerk

NOTE: As to appeal to the United States Court of Appeals for the Federal Circuit, 60 days from this date, see RCFC 58.1, re number of copies and listing of all plaintiffs. Filing fee is $505.00.

Issuer ID	Name	2017 Damages	2018 Damages	2017 + 2018 Damages
CLASS ACTION ISSUERS				
77606	AMERIHEALTH HMO, INC.	N/A	$ 3,047,605.42	$ 3,047,605.42
91762	AMERIHEALTH INS COMPANY OF NEW JERSEY	N/A	$ 32,618,681.42	$ 32,618,681.42
86584	ASPIRUS ARISE HEALTH PLAN OF WISCONSIN, INC.	$ 2,019,112.83	$ 5,721,342.44	$ 7,740,455.27
32536	ATRIO HEALTH PLANS, INC.	$ 744,629.96	N/A	$ 744,629.96
60536	AVERA HEALTH PLANS, INC.	N/A	$ 9,586,878.41	$ 9,586,878.41
15287	BLUE CROSS & BLUE SHIELD OF RHODE ISLAND	$ 2,384,359.45	$ 4,095,632.21	$ 6,479,991.66
46944	BLUE CROSS AND BLUE SHIELD OF ALABAMA	N/A	N/A	N/A
18558	BLUE CROSS AND BLUE SHIELD OF KANSAS, INC.	N/A	$ 32,292,758.48	$ 32,292,758.48
26065	BLUE CROSS AND BLUE SHIELD OF SOUTH CAROLINA	$ 7,429,833.05	$ 124,625,479.03	$ 132,055,312.08
27811	BLUECROSS BLUESHIELD KANSAS SOLUTIONS, INC.	$ 4,440,640.38	N/A	$ 4,440,640.38
82569	BOSTON MEDICAL CENTER HEALTH PLAN, INC. D/B/A BOSTON MEDICAL CENTER HEALTHNET PLAN	$ 15,402,807.36	$ 54,854,071.27	$ 70,256,878.63
70285	CALIFORNIA PHYSICIANS' SERVICE D/B/A BLUE SHIELD OF CALIFORNIA	$ 3,555,835.11	$ 155,399,758.50	$ 158,955,593.61
45127	CAPITAL ADVANTAGE ASSURANCE COMPANY	$ 43,610.93	$ 12,570,291.68	$ 12,613,902.61
28137	CAREFIRST BLUECHOICE, INC.	$ 418,513.76	$ 22,856,588.53	$ 23,275,102.29
86052	CAREFIRST BLUECHOICE, INC.	N/A	$ 32,233.00	$ 32,233.00
10207	CAREFIRST BLUECHOICE, INC.	$ 335,195.47	$ 1,324,970.10	$ 1,660,165.57
45532	CAREFIRST OF MARYLAND, INC.	$ 528,650.22	$ 1,814,032.42	$ 2,342,682.64
77552	CARESOURCE	$ 3,622,711.49	$ 26,162,878.94	$ 29,785,590.43
54192	CARESOURCE INDIANA, INC.	$ 1,732,023.65	$ 24,030,047.16	$ 25,762,070.81
45636	CARESOURCE KENTUCKY CO.	$ 4,303,746.23	$ 17,716,337.86	$ 22,020,084.09
50328	CARESOURCE WEST VIRGINIA CO.	$ 89,800.35	$ 4,816,047.85	$ 4,905,848.20

Issuer ID	Name	2017 Damages	2018 Damages	2017 + 2018 Damages
94788	CDPHP	$ 5,018.48	$ 39,551.94	$ 44,570.42
14630	CHILDREN'S COMMUNITY HEALTH PLAN	$ 426,521.77	$ 20,086,027.47	$ 20,512,549.24
47579	CHINESE COMMUNITY HEALTH PLAN	N/A	N/A	N/A
72034	CHRISTUS HEALTH PLAN	N/A	$ 680,352.03	$ 680,352.03
66252	CHRISTUS HEALTH PLAN	$ 121,354.15	$ 12,174,529.60	$ 12,295,883.75
87416	COMMON GROUND HEALTHCARE COOPERATIVE	$ 10,542,927.12	$ 46,286,304.63	$ 56,829,231.75
18581	COMMUNITY HEALTH PLAN OF WASHINGTON	$ 27,437.69	N/A	$ 27,437.69
38345	DEAN HEALTH PLAN	$ 4,955,476.60	$ 11,102,317.80	$ 16,057,794.40
66699	DENVER HEALTH MEDICAL PLAN, INC	$ 6,063.52	$ 413,674.24	$ 419,737.76
78124	EXCELLUS HEALTH PLAN, INC.	$ 15,291.35	$ 238,299.05	$ 253,590.40
88806	FALLON COMMUNITY HEALTH PLAN, INC.	$ 26,283.75	$ 3,496,255.83	$ 3,522,539.58
63312	FRIDAY HEALTH PLANS	$ 200,244.19	$ 1,785,778.01	$ 1,986,022.20
22444	GEISINGER HEALTH PLAN	N/A	$ 18,448,473.36	$ 18,448,473.36
34102	GROUP HEALTH PLAN, INC.	$ 78,756.48	$ 754,533.00	$ 833,289.48
40308	GROUP HOSPITALIZATION AND MEDICAL SERVICES INC.	$ 669,613.84	$ 698,846.25	$ 1,368,460.09
78079	GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.	$ 90.00	$ 34,777.41	$ 34,867.41
94084	GROUP HOSPITALIZATION AND MEDICAL SERVICES, INC.	$ 389,536.09	$ 395,647.98	$ 785,184.07
91058	GUNDERSEN HEALTH PLAN, INC.	$ 160,545.91	N/A	$ 160,545.91
18350	HAWAII MEDICAL SERVICE ASSOCIATION	N/A	$ 4,024,958.29	$ 4,024,958.29
36194	HEALTH FIRST COMMERCIAL PLANS, INC.	$ 2,817,386.96	N/A	$ 2,817,386.96
95865	HEALTH PLAN OF NEVADA, INC.	N/A	$ 10,378,194.40	$ 10,378,194.40
20173	HEALTHPARTNERS INSURANCE COMPANY	N/A	$ 1,037,501.77	$ 1,037,501.77
19636	HMO LOUISIANA, INC.	$ 33,165.59	$ 43,202,480.58	$ 43,235,646.17
31609	INDEPENDENCE BLUE CROSS (QCC INS. CO.)	$ 2,267,519.74	$10,062,712.51	$ 12,330,232.25
21032	KAISER FOUNDATION HEALTH PLAN OF COLO.	N/A	$ 13,489,220.40	$ 13,489,220.40
89942	KAISER FOUNDATION HEALTH PLAN OF GEORGIA	$ 156,398.60	$ 51,089,026.15	$ 51,245,424.75

Issuer ID	Name	2017 Damages	2018 Damages	2017 + 2018 Damages
90296	KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.	$ 63,371.39	$ 26,513,262.17	$ 26,576,633.56
95185	KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.	$ 61,701.69	$ 38,056,818.93	$ 38,118,520.62
94506	KAISER FOUNDATION HEALTH PLAN OF THE MID-ATLANTIC STATES, INC.	$ 1,224.78	$ 55,430.36	$ 56,655.14
80473	KAISER FOUNDATION HEALTH PLAN OF WASHINGTON	$ 1,110,167.97	$ 10,307,941.21	$ 11,418,109.18
60612	KAISER FOUNDATION HEALTH PLAN, INC.	$ 24,215.34	$ 3,511,518.83	$ 3,535,734.17
40513	KAISER FOUNDATION HEALTH PLAN, INC.	$ 261,138.16	$ 64,873,628.99	$ 65,134,767.15
71287	KAISER FOUNDATION HEALTHPLAN OF THE NW	$ 14,310.27	$ 7,964,082.28	$ 7,978,392.55
23371	KAISER FOUNDATION HEALTHPLAN OF THE NW	$ 404,267.71	$ 2,391,083.25	$ 2,795,350.96
33871	KEYSTONE HEALTH PLAN EAST, INC	N/A	$ 34,872,091.13	$ 34,872,091.13
38498	LIFEWISE HEALTH PLAN OF WA	$ 976,334.93	$ 4,986,181.98	$ 5,962,516.91
97176	LOUISIANA HEALTH SERVICE & INDEMNITY COMPANY, D/B/A BLUE CROSS AND BLUE SHIELD OF LOUISIANA	$ 40,501.02	$ 1,949,070.66	$ 1,989,571.68
58594	MERIDIAN HEALTH PLAN OF MICHIGAN, INC.	$ 262,197.21	$1,349,340.00	$ 1,611,537.21
11177	METROPLUS HEALTH PLAN	$ 25,454.56	$ 305,038.90	$ 330,493.46
73331	MINUTEMAN HEALTH, INC	$ 287,589.87	N/A	$ 287,589.87
61163	MINUTEMAN HEALTH, INC	$ 1,067,484.30	N/A	$ 1,067,484.30
39424	MODA HEALTH PLAN, INC.	N/A	$ 11,020,016.97	$ 11,020,016.97
56184	MVP HEALTH PLAN, INC.	$ 463,460.26	$ 659,118.21	$ 1,122,578.47
77566	MVP HEALTH PLAN, INC.	$ 406,386.81	$ 4,770,789.34	$ 5,177,176.15
81413	NETWORK HEALTH PLAN	$ 457,083.57	$ 1,863,260.62	$ 2,320,344.19
93091	NEW MEXICO HEALTH CONNECTIONS	$ 19,320.61	$ 7,783,770.57	$ 7,803,091.18
20507	OPTIMA HEALTH PLAN	$ 4,455,124.77	$ 45,519,921.54	$ 49,975,046.31
23818	OSCAR GARDEN STATE INSURANCE CORPORATION	N/A	$ 1,670,792.24	$ 1,670,792.24

Issuer ID	Name	2017 Damages	2018 Damages	2017 + 2018 Damages
10544	OSCAR HEALTH PLAN OF CALIFORNIA	N/A	$ 2,868,234.47	$ 2,868,234.47
23552	OSCAR INSURANCE COMPANY	N/A	$ 7,251,042.10	$ 7,251,042.10
20069	OSCAR INSURANCE COMPANY	$ 1,332,495.62	$ 54,108,574.53	$ 55,441,070.15
74289	OSCAR INSURANCE CORPORATION	N/A	$ 218,943.45	$ 218,943.45
45845	OSCAR INSURANCE CORPORATION OF OHIO	N/A	$ 3,073,467.50	$ 3,073,467.50
60597	PACIFICSOURCE HEALTH PLANS	$ 68,888.81	N/A	$ 68,888.81
10091	PACIFICSOURCE HEALTH PLANS	N/A	$ 2,855,185.77	$ 2,855,185.77
23603	PACIFICSOURCE HEALTH PLANS	N/A	$ 3,049,818.66	$ 3,049,818.66
74313	PARAMOUNT INSURANCE COMPANY	$ 536,850.12	N/A	$ 536,850.12
60829	PHYSICIANS HEALTH PLAN	$ 160,115.21	$ 2,115,273.52	$ 2,275,388.73
49831	PREMERA BLUE CROSS	$ 1,139,974.36	$ 6,956,926.22	$ 8,096,900.58
38344	PREMERA BLUE CROSS BLUE SHIELD OF ALASKA	N/A	$ 11,054,226.50	$ 11,054,226.50
26734	PREMIER HEALTH PLAN, INC.	$ 485,870.13	N/A	$ 485,870.13
29698	PRIORITY HEALTH	$ 9,497,198.62	$ 14,592,689.48	$ 24,089,888.10
37392	PROMINENCE HEALTHFIRST OF TEXAS, INC.	$ 61,820.56	N/A	$ 61,820.56
56707	PROVIDENCE HEALTH PLAN	N/A	$ 18,003,012.55	$ 18,003,012.55
38166	SECURITY HEALTH PLAN OF WISCONSIN, INC.	$ 313,857.88	$ 19,853,798.12	$ 20,167,656.00
26002	SELECTHEALTH	$ 4,414,757.46	$ 11,834,181.55	$ 16,248,939.01
68781	SELECTHEALTH	$ 16,341,918.82	$ 90,677,777.04	$ 107,019,695.86
26539	SHA, LLC DBA FIRSTCARE HEALTH PLANS	N/A	$ 8,505,436.22	$ 8,505,436.22
92499	SHARP HEALTH PLAN	$ 25,312.75	$ 4,197,709.69	$ 4,223,022.44
52664	SUMMA INSURANCE COMPANY, INC.	$ 21,128.56	$ 1,676,637.09	$ 1,697,765.65
59763	TUFTS HEALTH PUBLIC PLANS INC.	$ 8,370,566.22	$ 45,034,657.98	$ 53,405,224.20
85736	UCARE MINNESOTA	$ 95,369.42	$ 1,088,402.29	$ 1,183,771.71
54235	UNITEDHEALTHCARE OF NEW YORK, INC.	$ 18,557.38	$ 88,123.67	$ 106,681.05
38599	UNITEDHEALTHCARE OF THE MID-ATLANTIC INC	$ 280,357.81	N/A	$ 280,357.81
37833	UNITY HEALTH PLANS INSURANCE CORPORATION	$ 2,589,106.18	$ 12,506,806.19	$ 15,095,912.37
42261	UNIVERSITY OF UTAH HEALTH INSURANCE PLANS	$ 945,062.42	$ 15,025,864.94	$ 15,970,927.36

Issuer ID	Name	2017 Damages	2018 Damages	2017 + 2018 Damages
16322	UPMC HEALTH OPTIONS, INC.	$ 2,329,917.99	$ 38,669,887.09	$ 40,999,805.08
75293	USABLE MUTUAL INSURANCE COMPANY	$ 1,790,505.66	$ 21,905,927.13	$ 23,696,432.79
67243	VANTAGE HEALTH PLAN, INC.	N/A	$ 2,019,226.88	$ 2,019,226.88
93689	WESTERN HEALTH ADVANTAGE	N/A	$ 2,796,242.31	$ 2,796,242.31
		$ 131,172,069.27	**$ 1,455,936,328.54**	**$ 1,587,108,397.81**
		2017 Total	**2018 Total**	**Combined 2017-2018 Total**

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APPENDIX E

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

2019-1633

COMMUNITY HEALTH CHOICE, INC.,

Plaintiff-Appellee

v.

UNITED STATES,

Defendant-Appellant

Appeal from the United States Court of Federal Claims in No. 1:18-cv-00005-MMS, Chief Judge Margaret M. Sweeney.

2019-2102

MAINE COMMUNITY HEALTH OPTIONS,

Plaintiff-Appellee

v.

UNITED STATES,

Defendant-Appellant

Appeal from the United States Court of Federal Claims in No. 1:17-cv-02057-MMS, Chief Judge Margaret M. Sweeney.

Decided: August 14, 2020

WILLIAM LEWIS ROBERTS, Faegre Drinker Biddle & Reath LLP, Minneapolis, MN, argued for plaintiff-appellee in 19-1633. Also represented by JONATHAN WILLIAM DETTMANN, NICHOLAS JAMES NELSON.

DANIEL WILLIAM WOLFF, Crowell & Moring, LLP, Washington, DC, argued for plaintiff-appellee in 19-2102. Also represented by STEPHEN JOHN MCBRADY, SKYE MATHIESON, CHARLES BAEK, CLIFTON S. ELGARTEN.

ALISA BETH KLEIN, Appellate Staff, Civil Division, United States Department of Justice, Washington, DC, argued for defendant-appellant. Also represented by MARK B. STERN, ETHAN P. DAVIS.

STEPHEN A. SWEDLOW, Quinn Emanuel Urquhart & Sullivan, LLP, Chicago, IL, for amicus curiae Common Ground Healthcare Cooperative. Also represented by DAVID COOPER, New York, NY; J. D. HORTON, ADAM WOLFSON, Los Angeles, CA.

Before DYK, BRYSON, and TARANTO, *Circuit Judges.*

DYK, *Circuit Judge*.

Today in *Sanford Health Plan v. United States* ("*Sanford*"), No. 19-1290, we hold that the United States failed to comply with section 1402 of the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119, 220–24 (2010) (codified at 42 U.S.C. § 18071)—which requires the government to reimburse insurers for "cost-sharing reductions." We hold that section 1402 "imposes an unambiguous obligation on the government to pay money and that the obligation is enforceable through a damages action in the Court of Federal Claims [('Claims Court')] under the Tucker Act." *Sanford*, No. 19-1290, slip op. at 3.

In these cases, following our decision in *Sanford*, we affirm the Claims Court's decisions as to liability. As in *Sanford*, we conclude that the government is not entitled to a reduction in damages with respect to cost-sharing reductions not paid in 2017. As to 2018, we address an issue not presented in *Sanford*: the appropriate measure of damages. We hold that the Claims Court must reduce the insurers' damages by the amount of additional premium tax credit payments that each insurer received as a result of the government's termination of cost-sharing reduction payments. We reverse and remand for further proceedings with respect to damages.

BACKGROUND

I

In 2010, Congress enacted the ACA, which includes "a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). "[T]he Act requires the creation of an '[e]xchange' in each State—basically, a marketplace that allows people to compare and purchase insurance plans." *Id.* Insurance plans sold on the ACA exchanges must provide a minimum level of "essential health benefits" and are referred to as "qualified health plans." *See* 42 U.S.C. § 18031. The ACA defines four levels of coverage: bronze, silver, gold, and platinum, which are based on the percentage of essential health benefits that the insurer pays for under each type of plan. *Sanford*, No. 19-1290, slip op. at 4. For example, under a silver-level plan, the health insurance provider pays for 70 percent of the actuarial value of the benefits, and either the insured or the government pays the remaining 30 percent. *Id.*

Under most health insurance plans, the insured individual must bear two types of costs. First, the insured must pay a monthly premium to maintain coverage. Second, the insured must pay an additional fee—called "cost-sharing"—when medical expenses are incurred. Deductibles, coinsurance, and co-payments are examples of such fees. *See* 42 U.S.C. § 18022(c)(3)(A)(i). The ACA includes two sections, 1401 and 1402, that reduce the premiums and cost-sharing for low-income insureds by government payments to the insurers. These sections "work together: the [premium reductions] help people obtain insurance, and the cost-sharing reductions help people get treatment once they have insurance." *See Cmty. Health Choice, Inc. v. United States*, 141 Fed. Cl. 744, 750 (2019) (quoting *California v. Trump*, 267 F. Supp. 3d 1119, 1123 (N.D. Cal. 2017)). These sections apply to taxpayers with a household income of between 100 percent and 400 percent of the federal poverty line. *See* 42 U.S.C. § 18071(b)(2); 26 U.S.C. § 36B(c)(1)(A); *Sanford*, No. 19-1290, slip op. at 5, 7. The statute refers to them as "applicable taxpayer[s]" in the case of section 1401, 26 U.S.C. § 36B(c)(1)(A), and "eligible insured[s]" in the case of section 1402, 42 U.S.C. § 18071(b).

Premium reductions. Under section 1401, each "applicable taxpayer" enrolled in an ACA exchange plan at any level of coverage is entitled to a "premium assistance credit amount" ("premium tax credit") to offset part of the monthly premiums of the enrollee entitled to the premium tax credit. 26 U.S.C. § 36B. The ACA specifies a formula for determining the amount of premium tax credits, which depends on the applicable taxpayer's household income, but not on the monthly premium or the coverage level for the applicable taxpayer's plan. The premium tax credit

cannot exceed the actual monthly premium for the individual's plan. *See id.* § 36B(b)(2). The government pays these premium tax credit amounts directly to insurers. *See Sanford*, No. 19-1290, slip op. at 8; 31 U.S.C. § 1324. Thus, the amount of the premiums charged by the insurers to the insured is effectively reduced.

Premium review. The ACA includes various measures for regulating insurance premiums. Section 1003 of the ACA establishes a "premium review process" that requires insurers to report their premium rate increases to the Secretary of Health and Human Services ("the Secretary") and state regulators. *See* 42 U.S.C. § 300gg-94 (codifying ACA section 1003). State authorities can review the proposed rates. However, "[t]he rate review process does not establish federal authority to deny implementation of a proposed rate increase; it is a sunshine provision designed to publicly expose rate increases determined to be unreasonable." *See* Bernadette Fernandez, Vanessa C. Forsberg & Ryan J. Rosso, Cong. Rsch. Serv., R45146, Federal Requirements on Private Health Insurance Plans 9 (2018). If a state regulator finds that an insurer's premium rate increases are "excessive or unjustified," it is required to recommend that the Secretary "exclude[] [the insurer] from participation in the [state] [e]xchange." 42 U.S.C. § 300gg-94(b)(1)(B).

Following the enactment of the ACA, states have taken a varied approach to premium rate review programs. Some, but not all, states have reserved the express authority to approve or deny premium rate increases. *See* Mark Newsom & Bernadette Fernandez, Cong. Rsch. Serv., R41588, Private Health Insurance Premiums and Rate Reviews 15 (2011) ("There is substantive variation in state regulation of

health insurance rates."). In states where there is no express approval requirement, insurers are still required to notify state regulators of premium increases above a certain threshold. *See* 42 U.S.C. § 300gg-94(a)(2); Fernandez et al., Federal Requirements on Private Health Insurance Plans at 9. The damages issue here does not turn on whether the states have required express approval of premium increases.

Cost-sharing reductions. Section 1402 of the ACA requires insurers to reduce the insured's "cost-sharing" payments and requires the Secretary to "make periodic and timely payments to the [insurer] equal to the value of the [cost-sharing] reductions." 42 U.S.C. § 18071(c)(3)(A). The section applies to "eligible insured[s]" enrolled in silver-level plans offered on the exchanges. *Id.* § 18071(a), (b). Eligibility under section 1402 is tied to eligibility under section 1401, and the amount of cost-sharing reductions is directly tied to the household income of the eligible insured. *See Id.* § 18071(c), (f)(2); *Sanford*, No. 19-1290, slip op. at 7 n.2.

II

On October 12, 2017, the Secretary announced that the government would cease payment of cost-sharing reduction reimbursements. *Sanford*, No. 19-1290, slip op. at 11–12. The suspension of cost-sharing reduction reimbursements did not relieve the insurers of their statutory obligation to "offer plans with cost-sharing reductions to customers," meaning that "the federal government's failure to meet its [cost-sharing reduction] payment obligations meant the insurance companies would be losing that money." *California*, 267 F. Supp. 3d at 1134. The solution for the insurers was to increase premiums. These states "began working with the insurance companies to develop a plan for how to

respond" "in a fashion that would avoid harm to consumers." *See id.* The resulting plan involved the tax credit provision of section 1401 of the ACA.

Under section 1401, the government is required to subsidize an amount equal to the lesser of (1) the monthly premium for the applicable taxpayer's plan and (2) the difference between the monthly premium for the "applicable second lowest cost silver plan [(the 'benchmark plan')] with respect to the taxpayer" and a statutorily-defined percentage of the eligible taxpayer's monthly household income. 26 U.S.C. § 36B(b)(2) (codifying ACA section 1401(b)(2)). This percentage generally varies from 2% to 9.5% based on the eligible taxpayer's income relative to the federal poverty line. *Id.* § 36B(b)(3)(A). These payments are guaranteed since, unlike the cost-sharing reduction payments situation, there is a permanent appropriation for premium tax credits. *See Sanford*, No. 19-1290, slip op. at 8.

In effect, if the insurers increased the monthly premium for their benchmark silver plans, each insurer would receive an additional dollar-for-dollar increase in the amount of the premium tax credit for each applicable taxpayer under its silver plans, all while keeping the out-of-pocket premiums paid by each applicable taxpayer the same. *See California*, 267 F. Supp. 3d at 1134. But premium increases for silver-level plans would have an effect on other plans as well: the insurers would also receive additional tax credits for applicable taxpayers that were enrolled in bronze, gold, and platinum plans, whether or not the premiums for those plans were increased. *Id.* at 1135. Even if the insurers kept premiums the same for those other plans, they would receive additional tax credits. *See id.*

Because of the government's refusal to make cost-sharing reduction payments, most states agreed to allow insurers to raise premiums for silver-level health plans, but not for other plans. *Cmty.*, 141 Fed. Cl. at 755; *Me. Cmty. Health Options v. United States*, 143 Fed. Cl. 381, 390 (2019). "As a result, in these states, for everyone between 100% and 400% of the federal poverty level who wishe[d] to purchase insurance on the exchanges, the available tax credits r[o]se substantially. Not just for people who purchase[d] the silver plans, but for people who purchase[d] other plans too." *Cmty.*, 141 Fed Cl. at 755 (quoting *California*, 267 F. Supp. 3d at 1135). And the insurers received "more money from the premium tax credit program, . . . mitigat[ing] the loss of the cost-sharing reduction payments." *Id.* This practice was referred to as "silver loading." *Id.*

This was, however, not a perfect solution. The premium tax credits could only offset premium increases for applicable taxpayers, i.e., insureds with a household income of between 100 percent and 400 percent of the federal poverty line. Thus, people having a higher household income would be paying significantly more in premiums for their silver-level plans since they did not receive premium tax credits. *See California*, 267 F. Supp. 3d at 1137. States took a varied approach to this issue. Although this does not appear to be the case in Texas or Maine, some states negotiated with insurers to offer off-exchange, silver-equivalent plans at the pre-silver-load premium rates. *Id.* Such off-exchange policies were not subject to the ACA's premium tax credits or cost-sharing reduction requirements. In other states, non-eligible individuals could still switch to bronze, gold, or platinum plans (which did not have premium rate increases). *Id.*

III

Community Health Choice, Inc. ("Community") and Maine Community Health Options ("Maine Community") are health insurance providers that sell qualified health plans in Texas and Maine, respectively. *See Cmty.*, 141 Fed. Cl. at 756; *Me. Cmty.*, 143 Fed. Cl. at 391.[1] Both insurers offered cost-sharing reductions, as required under section 1402, to insured individuals,[2] and "as with every other insurer offering qualified health plans on the exchanges, stopped receiving these payments effective October 12, 2017." *Cmty.*, 141 Fed. Cl. at 756.

The two insurers involved here filed separate actions in the Claims Court, asserting that they were entitled to recover the unpaid cost-sharing reduction reimbursements for 2017 and 2018.[3] The insurers asserted two theories of liability.[4] First, the insurers

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[1] Unless otherwise noted, the Claims Court's decisions in *Community* and *Maine Community* contain identical language. For convenience, we limit our citations to *Community*.

[2] For example, the record shows that "approximately 58% of [Community]'s insured population—over 80,000 individuals—received cost-sharing reductions." *Cmty.*, 141 Fed. Cl. at 756.

[3] Community's complaint also claimed damages related to unpaid payments under the ACA's risk corridors program for 2014, 2015, and 2016. *Cmty.*, 141 Fed. Cl. at 756. Those claims were addressed by the Supreme Court's decision in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020). Maine Community's complaint in this case did not assert a claim under the risk corridors program.

[4] Community asserted a third theory of liability: that the government's failure to pay cost-sharing reduction reimbursements constituted a breach of so-called "Qualified Health Plan Issuer" agreements between Community and the government, which "require[d] [the government], as part of a monthly reconciliation process, to make payments to insurers that underesti-

alleged that "in failing to make the cost-sharing reduction payments . . . , the government violated the statutory and regulatory mandate" of the ACA. *Id.* Second, the insurers alleged that the government's nonpayment constituted a "breach[] [of] an implied-in-fact contract." *Id.*

On the insurers' motions for summary judgment, the Claims Court "conclude[d] that the government's failure to make cost-sharing reduction payments to [the insurers] violate[d] 42 U.S.C. § 18071 [(codifying ACA section 1402)] and constitute[d] a breach of an implied-in fact contract." *Id.* at 770. The Claims Court concluded that each insurer was entitled to recover as damages the full amount of unpaid cost-sharing reduction reimbursements for both 2017 and 2018. The Claims Court was "unpersuaded by the [government]'s . . . contention that [the] insurers' ability to increase premiums for their silver-level qualified health plans to obtain greater premium tax credit payments, and thus offset any losses from the government's nonpayment of cost-sharing reduction reimbursements," precluded or reduced the insurers' damages. *Id.* at 760.

The government appealed the Claims Court's decisions to this court, challenging the decisions as to both

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mated their cost-sharing obligations and collect payments from insurers who overestimated their cost-sharing obligations." *Cmty.*, 141 Fed. Cl. at 764–65. The Claims Court held that the obligation to reconcile payments was different from the obligation to make cost-sharing reduction payments and that the insurers "ha[d] not established that the . . . [a]greements obligated the government to make cost-sharing reduction payments," and dismissed Community's claim for breach of an express contract. *Id.* at 765–66. Community does not cross-appeal the Claims Court's dismissal, and we need not address it.

liability and damages. We have jurisdiction under 28 U.S.C. § 1295(a)(3).

On April 27, 2020, the Supreme Court issued its decision in *Maine Community Health Options v. United States*, 140 S. Ct. 1308 (2020), holding that section 1342 of the ACA ("[t]he Risk Corridors statute," *id.* at 1329), which states that the government "shall pay" money to insurers offering "unprofitable plans" on the ACA exchanges, *id.* at 1316, created a "money-mandating obligation requiring the Federal Government to make payments under [section] 1342's formula," *id.*, at 1331, and that health insurance providers were entitled to "seek to collect [such] payment through a damages action in the [Claims Court]," *id.*

Today in *Sanford*, following the Supreme Court's decision in *Maine Community,* we hold that the government violated its obligation to make cost-sharing reduction payments under section 1402; "that the cost-sharing-reduction reimbursement provision imposes an unambiguous obligation on the government to pay money[;] and that the obligation is enforceable through a damages action in the [Claims Court] under the Tucker Act." *Sanford*, No. 19-1290, slip op. at 3.

DISCUSSION

I

As noted, the government argues that section 1402 did not create a statutory obligation on the part of the government to pay cost-sharing reduction reimbursements and that its failure to make payments did not violate the statute. Our decision in *Sanford* resolves these issues in favor of the insurers here. *Sanford*, No. 19-1290, slip op. at 18. Because we affirm the Claims

Court's decisions as to statutory liability, and the damages are the same under either theory of liability (as discussed below), we need not address the insurers' implied-in-fact contract theory.

II

The government nonetheless argues that, even if section 1402 created a statutory obligation, the insurers are not entitled to recover the full amount of the unpaid 2017 and 2018 cost-sharing reduction payments as damages. We find no merit to the government's argument that the insurers' 2017 damages should be reduced. Like the insurers in *Sanford*, Community and Maine Community did not raise their silver-level plan premiums in 2017 or receive increased tax credits for that year from the elimination of the cost-sharing reduction payments. Here, as in *Sanford*, we see no basis for a 2017 damages offset and affirm the Claims Court's award of 2017 damages. *See Sanford*, No. 19-1290, slip op. at 9, 12.

III

We turn to the 2018 cost-sharing payments. Neither the Supreme Court in *Maine Community* nor our decision in *Sanford* resolves this question. The government asserts that, beginning in 2018, both insurers raised the premiums for their silver-level plans "to account for the absence of direct reimbursement for cost-sharing reductions," resulting in the receipt of increased premium tax credits. *See* Gov't Suppl. Damages Br. 12–14. It argues that the Claims Court erred when it failed to credit the government with "economic benefits" flowing from the increased tax credits when awarding damages. *Id.* at 15.

The government's theory is based on an analogy to contract law—specifically, the rule that "a non-breaching party is not entitled, through the award of damages, to achieve a position superior to the one it would reasonably have occupied had the breach not occurred." *LaSalle Talman Bank, F.S.B. v. United States*, 317 F.3d 1363, 1371 (Fed. Cir. 2003). The government argues that silver loading was a direct result of the insurers' mitigation efforts, i.e., increasing premiums for silver-level plans, and that the insurers' recovery must be reduced by the additional payments the insurers received in the form of tax credits.

The Claims Court rejected these arguments in both cases on the same ground, holding that there was no "statutory provision permitting the government to use premium tax credit payments to offset its cost-sharing reduction payment obligation," and that "[t]he increased amount of premium tax credit payments that insurers receive[d]" was not a "substitute[]" for its "cost-sharing reduction payments." *Cmty.*, 141 Fed. Cl. at 760. At oral argument, the parties agreed that the Claims Court's decisions rejected the government's mitigation theory on the merits. On appeal, the insurers similarly argue that the "[g]overment cannot invoke deductions not set forth in the statute itself." Appellees' Suppl. Damages Br. 4–5.

A

In addressing the mitigation issue, it is important to distinguish between two different types of statutes providing for the grant of federal funds: those that impose an "affirmative obligation[]" or "condition[]" in exchange for federal funding, and those that do not. *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17, 24 (1981). The Supreme Court has previously

"characterized . . . [the former category of] Spending Clause legislation as 'much in the nature of a contract: in return for federal funds, the [recipients] agree to comply with federally imposed conditions." *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (third alteration in original) (quoting *Pennhurst*, 451 U.S. at 17). On the other hand, the latter category of statutes does not involve contract-like obligations. *See id.* at 186; *Pennhurst*, 451 U.S. at 17; *Sossamon v. Texas*, 563 U.S. 277, 290 (2011).

Section 1402 belongs in the first category of Spending Clause legislation because it imposes contract-like obligations: in exchange for federal funds, the insurers must "'participat[e] in the healthcare exchanges' under the statutorily specified conditions." *Sanford*, No. 19-1290, slip op. at 18 (quoting *Me. Cmty.*, 140 S. Ct. at 1320); *see also Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 576 (2012) (analyzing the Medicaid provisions of the ACA as Spending Clause legislation). Specifically, in exchange for "the [insurer] . . . reduc[ing] the cost-sharing under [silver plans] in the manner specified in [section 1402(c)]" and "notify[ing] the Secretary of such reductions," "the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. §§ 18071(a)(2), (c)(3)(A); *see also Cmty.*, 141 Fed. Cl. at 768 ("[T]he cost-sharing reduction program is less of an incentive program and more of a quid pro quo.").

Under these contract-like Spending Clause statutes—where the statute itself does not provide a remedial framework—a contract-law "analogy applies . . . in determining the scope of damages remedies" in a suit by the government against the recipient of federal funds or by a third-party beneficiary standing in the

government's shoes. *Barnes*, 536 U.S. at 186–87; *see also Gebser v. Lago Vista Indep. Sch. Dist.*, 524 U.S. 274, 287 (1998) ("Title IX's contractual nature has implications for our construction of the scope of available remedies."). In *Barnes*, the Court considered the government's damages remedies available under Title VI in a suit charging the federal funds recipient with failure to comply with its obligations. The Court explained that, when the statute "contains no express remedies, a recipient of federal funds is nevertheless subject to suit for compensatory damages . . . and injunction . . . forms of relief traditionally available in suits for breach of contract." *Barnes*, 536 U.S. at 187 (citations omitted). Thus, "[w]hen a federal-funds recipient violates conditions of Spending Clause legislation, the wrong done is the failure to provide what the contractual obligation requires; and that wrong is 'made good' when the recipient compensates the Federal Government or a third-party beneficiary (as in this case) for the loss caused by that failure." *Id.* at 189. On the other hand, forms of relief that are "generally not available for breach of contract," such as punitive damages, are not available in suits under such Spending Clause legislation. *Id.* at 187–89.[5]

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[5] This contract-law analogy does not apply where the statute does not impose contract-like obligations. *See, e.g.*, *Heinzelman v. Sec'y of HHS*, 681 F.3d 1374, 1379–80 (Fed. Cir. 2012) (holding that, with respect to a damages award under the National Childhood Vaccine Injury Act, 42 U.S.C. §§ 300aa-1–300aa-34, the government was not entitled to an offset due to Social Security Disability Insurance ("SSDI") benefits because the Vaccine Act "provides for offsets where compensation is made via one of the enumerated programs," and SSDI was not identified in the statute); *Modoc Lassen Indian Hous. Auth. v. United States HUD*, 881 F.3d 1181, 1194 (10th Cir. 2017) (noting that "rules that traditionally govern contractual relationships don't

The same, we think, is true when an action for damages is brought against the government, under this type of Spending Clause legislation. The available remedy is defined by analogy to contract law where the statute does not provide its own remedies for government breach.[6] We have indeed previously applied the contract-law analogy to limit damages in suits against the government under the Back Pay Act, 5 U.S.C. § 5596, another money-mandating statute.[7]

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necessarily apply in the context of federal grant programs" that do not impose contract-like obligations such as the Native American Housing Assistance and Self-Determination Act, 25 U.S.C. § 4101 et seq.); *Md. Dep't of Human Res. v. Dep't of Health & Human Servs.*, 762 F.2d 406, 408–09 (4th Cir. 1985) (declining to infer a "contractual" relationship in the Aid to Families with Dependent Children program, 42 U.S.C. § 601 et seq., a "grant in aid" program); *Mem'l Hosp. v. Heckler*, 706 F.2d 1130, 1136 (11th Cir. 1983) (noting that hospitals participating in the Medicare program did not receive a "contractual right" because the statute did not "obligate the [government] to provide reimbursement for any particular expenses"); *PAMC, Ltd. v. Sebelius*, 747 F.3d 1214, 1221 (9th Cir. 2014) (citing *Mem'l Hospital*).

[6] The amicus argues that the insurers are not seeking "compensation for the failure to pay," but are instead seeking "specific relief" under section 1402. Common Ground Healthcare Cooperative Suppl. Damages Amicus Br. 5. As the Supreme Court held in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), "the Court of Claims has no [general] power to grant equitable relief." *Id.* at 905 (quoting *Richardson v. Morris*, 409 U.S. 464, 465 (1973) (per curiam)). Furthermore, the Supreme Court made clear that the type of relief that the insurers are seeking is best characterized as "specific sums, already calculated, past due, and designed to compensate for completed labors." *Me. Cmty.*, 140 S. Ct. at 1330–31.

[7] *See Bowen*, 487 U.S. at 905 n.42 ("To construe statutes such as the Back Pay Act . . . as 'mandating compensation by the Federal Government for the damage sustained,' . . . one must imply from the language of such statutes a cause of action." (quoting *Eastport S.S. Corp. v. United States*, 372 F.2d 1002, 1009

Our predecessor court held that in suits brought for improper discharge for federal employment, damages had to be reduced by the amount earned by the federal employee in the private sector under a mitigation theory.[8] *See Craft v. United States*, 589 F.2d 1057, 1068 (Ct. Cl. 1978) ("Unless there is a regulation or a statute that provides otherwise, cases in this court routinely require the deduction of civilian earnings [from a back pay award] on an analogy to the principle of mitigation of damages."); *Laningham v. United States*, 5 Cl. Ct. 146, 158 (Ct. Cl. 1984) ("This rule has been utilized as an analog to the private contract law principle of mitigation of damages."); *see also Motto v. United States*, 360 F.2d 643, 645 (Ct. Cl. 1966); *Borak v. United States*, 78 F. Supp. 123, 125 (Ct. Cl. 1948).

Here the contract-law analogy applies because the statute "contains no express remedies" at all with respect to the government's obligation. *Barnes*, 536 U.S. at 187. While the ACA provides specific remedies for failure of the insurers or insured to comply with their obligations, *see* 42 U.S.C. §§ 300gg-22, 18081(h), "the [ACA] did not establish a [statutory] remedial scheme" for the government's non-compliance, *Me. Cmty.*, 140 S. Ct. at 1330. Section 1402's silence as to remedies in this respect suggests that "forms of relief

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(Ct. Cl. 1967))); *Hambsch v. United States*, 848 F.2d 1228, 1231 (Fed. Cir. 1988) ("By the Back Pay Act's own terms, a tribunal must also look for an 'applicable law, rule, regulation, or collective bargaining agreement' as the source of an employee entitlement which an 'unjustified or unwarranted personnel action' has denied or impaired.").

[8] The Back Pay Act was later amended to expressly provide for such offsets. *See* 5 U.S.C. § 5596(b)(1). That amendment to the statute, however, does not change the principles underlying the previous decisions.

traditionally available in suits for breach of contract" are appropriate. *Barnes*, 536 U.S. at 187; *see also Me. Cmty.*, 140 S. Ct. at 1330. We therefore look to government contract law to determine the scope of the insurers' damages remedy.

With respect to contract claims, the government is "to be held liable only within the same limits that any other defendant would be in any other court," and "its rights and duties . . . are governed generally by the law applicable to contracts between private individuals." *United States v. Winstar Corp.*, 518 U.S. 839, 892, 895 (1996) (first quoting *Horowitz v. United States*, 267 U.S. 458, 461 (1925), and then quoting *Lynch v. United States*, 292 U.S. 571, 579 (1934)).

B

The traditional damages remedy under contract law is compensatory in nature. Restatement (Second) of Contracts § 347 (1981); *Barnes v. Gorman*, 536 U.S. at 187–90.

> The fundamental principle that underlies the availability of contract damages is that of compensation. That is, the disappointed promisee is generally entitled to an award of money damages in an amount reasonably calculated to make him or her whole and neither more nor less; any greater sum operates to punish the breaching promisor and results in an unwarranted windfall to the promisee, while any lesser sum rewards the promisor for his or her wrongful act in breaching the contract and fails to provide the promisee with the benefit of the bargain he or she made.

24 Samuel Williston & Richard A. Lord, *Williston on Contracts* § 64:1 (4th ed. 2020); *see also* 11 Joseph M. Perillo & Helen Hadjiyannakis Bender, *Corbin on Contracts* § 55.3 (2020) ("[I]t is a basic tenet of contract law that the aggrieved party will not be placed in a better position than it would have occupied had the contract been fully performed.").

Thus, courts have uniformly held—as a matter of both state and federal law—that a plaintiff suing for breach of contract is not entitled to a windfall, i.e., the non-breaching party "[i]s not entitled to be put in a better position by the recovery than if the [breaching party] had fully performed the contract." *Miller v. Robertson*, 266 U.S. 243, 260 (1924); *Bluebonnet Sav. Bank, F.S.B. v. United States*, 339 F.3d 1341, 1345 (Fed. Cir. 2003) ("[T]he non-breaching party should not be placed in a better position through the award of damages than if there had been no breach."); *LaSalle*, 317 F.3d at 1372 ("[T]he non-breaching party is not entitled, through the award of damages, to achieve a position superior to the one it would reasonably have occupied had the breach not occurred." (citing 3 E. Allan Farnsworth, *Farnsworth on Contracts* 193 (2d ed. 1998)).[9]

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[9] *See, e.g., John Hancock Life Ins. Co. v. Abbott Labs.*, 863 F.3d 23, 44 (1st Cir. 2017) (same under Illinois law); *VICI Racing, LLC v. T-Mobile USA, Inc.*, 763 F.3d 273, 303 (3d Cir. 2014) (same under Delaware law); *Hess Mgmt. Firm, LLC v. Bankston* (In re Bankston), 749 F.3d 399, 403 (5th Cir. 2014) (same under Louisiana law); *Westlake Petrochemicals, L.L.C. v. United Polychem, Inc.*, 688 F.3d 232, 243–44 (5th Cir. 2012) (same under the Uniform Commercial Code); E*d S. Michelson, Inc. v. Neb. Tire & Rubber Co.*, 63 F.2d 597, 601 (8th Cir. 1933) (treating the issue as a general matter of contract law).

This concern to limit contract damages to compensatory amounts is embodied, in part, in the doctrine of mitigation, which ensures that the non-breaching party will not benefit from a breach. The mitigation doctrine has two aspects. First, the non-breaching party is expected to take reasonable steps to mitigate his or her damages. Restatement (Second) of Contracts § 350 cmt. b ("Once a party has reason to know that performance by the other party will not be forthcoming, . . . he is expected to take such affirmative steps as are appropriate in the circumstances to avoid loss by making substitute arrangements or otherwise."). Under common-law principles, the injured party may not recover damages for any "loss that the injured party could have avoided without undue risk, burden or humiliation." *Id.* § 350(1); 3 Dan B. Dobbs, *Law of Remedies* § 12.6(1), at 127 (2d ed. 1993) ("[T]he damage recovery is reduced to the extent that the plaintiff could reasonably have avoided damages he claims and is otherwise entitled to."); *Roehm v. Horst*, 178 U.S. 1, 11 (1900) (explaining that a plaintiff for breach of contract is entitled to "damages as would have arisen from the nonperformance of the contract at the appointed time, subject, however, to abatement in respect of any circumstances which may have afforded him the means of mitigating his loss" (quoting *Frost v. Knight*, L.R. 7 Exch. 111 (1872))). We need not determine whether this first aspect of the mitigation doctrine applies here—such that the insurers were obligated to increase premiums to secure increased premium credits.

Rather, here we look to a second aspect of the mitigation doctrine, which recognizes that there must be a reduction in damages equal to the amount of benefit that resulted from the mitigation efforts that the non-

breaching party in fact undertook. [10]*Kansas Gas & Elec. Co. v. United States*, 685 F.3d 1361, 1366 (Fed. Cir. 2012) ("[M]itigation efforts may result in direct savings that reduce the damages claim."); Restatement (Second) of Contracts § 350 cmt. h (explaining that the calculation of mitigation should reflect "[a]ctual efforts to mitigate damages"); 11 *Corbin on Contracts* § 57.11 (explaining that, in the case of a buyer breaching a contract for the sale of goods, the rule "measures the seller's damages by the contract price less the market price—the price actually obtained . . . by a new sale").

For example, in *Kansas Gas and Electric*, the government breached a contract to dispose of the plaintiff utility companies' nuclear waste. *Kansas Gas & Elec.*, 685 F.3d at 1364. Anticipating that the

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[10] A related principle is that, when the non-breaching party indirectly benefits from the defendant's breach, "in order to avoid overcompensating the promisee, any savings realized by the plaintiff as a result of the . . . breach . . . must be deducted from the recovery." 24 *Williston on Contracts* § 64:3; 11 *Corbin on Contracts* § 57.10 ("A breach of contract may prevent a loss as well as cause one. In so far as it prevents loss, the amount will be credited in favor of the wrongdoer."); Charles T. McCormick, *Handbook on the Law of Damages* 146 (1935) ("Where the defendant's wrong or breach of contract has not only caused damage, but has also conferred a benefit upon [the] plaintiff . . . which he would not otherwise have reaped, the value of this benefit must be credited to [the] defendant in assessing the damages."); *LaSalle*, 317 F.3d at 1372 (citing McCormick); *Kansas Gas & Elec.*, 685 F.3d at 1367 (same); *Stern v. Satra Corp.*, 539 F.2d 1305, 1312 (2d Cir. 1976) (same); *see also DPJ Co. P'ship v. F.D.I.C.*, 30 F.3d 247, 250 (1st Cir. 1994) (holding that, with respect to reliance damages for breach of contract, "a 'deduction' is appropriate 'for any benefit received [by the claimant] for salvage or otherwise'" (alteration in original) (quoting A. Farnsworth, *Contracts* § 12.16 (2d ed. 1990))).

government would breach the contract, the utility companies began a "rerack project" to increase its storage capacity and mitigate the effects of a government breach. *Id.* We held that the plaintiffs were entitled to the costs of its rerack project taken in mitigation of the government's breach. *Id.* at 1365, 1371. We also held, however, that the plaintiffs' recovery was to be reduced by the "real-world benefit" realized by the plaintiff's rerack project. *Id.* at 1367–68. Namely, "[w]hile conducting the rerack, the [plaintiffs] both . . . used racks that could support higher enrichment fuel assemblies," which "allowed [them] to achieve the same energy output from [their] reactor with fewer fuel assemblies," thereby increasing the efficiency of their plant. *Id.* at 1364.

The plaintiffs argued that the efficiency benefits of the rerack project were "too remote and not directly related to the breach because the decision to 'pursue more highly enriched fresh nuclear fuel' was an 'independent business decision' and influenced by . . . market price[s]." *Id.* at 1367. We rejected that argument, holding that the rerack project was "part and parcel of the [plaintiffs]' mitigation efforts." *Id.* We stated that "[t]he long-term benefit of fuel cost savings [influenced by market forces] does not sever its connection to the [plaintiffs]' mitigation efforts," and that the appropriate inquiry was whether, "[b]y enhancing the racks to accommodate high-enrichment fuel assemblies, the [plaintiffs] mitigated the [g]overnment's breach in a way that produced a benefit." *Id.* at 1368. We concluded that the plaintiffs' damages were correctly reduced "by the amount of the benefit received in mitigating the [g]overnment's partial breach of the . . . [c]ontract." *Id.*

Here, each insurer mitigated the effects of the government's breach by applying for increased premiums and, as a result, received additional premium tax credits in 2018 as a direct result of the government's nonpayment of cost-sharing reduction reimbursements. Notably, the government does not argue that it is entitled to offset the premium increases in the damages calculation, but it does argue that it is entitled to offset the additional payments made by the government in the form of premium tax credits.

The insurers appear not to dispute that if the elimination of cost sharing-reduction payments directly triggered increased premium tax credits, an offset would be appropriate under a contract theory. But they argue that the premium tax credits were not "direct benefits" of the breach because they depend on actions by the insurers—the decision to pursue increased premiums. These payments were not, in the appellees' phrasing, received in the "first step." We think the relationship is no less direct because the insured's tax credits did not automatically flow from the elimination of cost sharing reduction payments, and the insurers played a role by securing the increased premiums that in turn resulted in the increased tax credits.

There is thus a direct relationship between cost-sharing reductions and premiums, and between premiums and tax credits. The text of the ACA recognizes the relationship between premiums and cost-sharing reductions. Section 1412 of the ACA provides for the "[a]dvance determination and payment of premium tax credits and cost-sharing reductions." 42 U.S.C. § 18082 (codifying ACA section 1412). Section 1412(a)(3) states: "the Secretary of the Treasury makes advance payments of [premium tax]

credits or [cost-sharing] reductions to the [insurers] . . . in order to reduce the premiums payable by individuals eligible for such credit." *Id.* § 18082(a)(3). As we noted in *Sanford*, this section may be understood to indicate that the statute recognizes that, without cost-sharing reduction reimbursements, "insurers might otherwise seek higher premiums to enable them to pay healthcare providers the amounts enrollees are not paying due to cost-sharing reductions." *Sanford*, No. 19-1290, slip op. at 22.

The Claims Court's findings show that the premium tax credits flowed directly from the insurers' mitigation efforts. As the Claims Court found, the plaintiffs themselves recognized this connection. They negotiated for increased premiums (leading to the increased tax credits) in direct response to the cessation of cost-sharing reduction payments:

> The Trump administration's termination of cost-sharing reduction payments did not come as a surprise to insurers: "Anticipating that the Administration would terminate [cost-sharing reduction] payments, most states began working with the insurance companies to develop a plan for how to respond. . . . And the states came up with an idea: allow the insurers to make up the deficiency through premium increases . . . ." *California*, 267 F. Supp. 3d at 1134–35 . . . . In other words, by raising premiums for silver-level qualified health plans, the insurers would obtain more money from the premium tax credit program, which would help mitigate the loss of the cost-sharing reduction payments.

Cmty., 141 Fed. Cl. at 754–55 (first alteration in original); *id.* at 755 n.10 (noting that "increasing silver-level qualified health plan premiums would not harm most consumers who qualify for the premium tax credit because the credit increases as the premium increases").

The practice of silver loading—and the resulting premium tax credits received by each insurer—"was a direct consequence of the government's breach" of its obligations, and "indeed was an extreme measure forced" by the government's nonpayment. *LaSalle*, 317 F.3d at 1372. The government's payment of the premium tax credits is directly traceable to the premium increase, and the premium increase is directly traceable to the government's breach. The insurers "received a benefit as a direct result of their mitigation activity." *Kansas Gas & Elec.*, 685 F.3d at 1368. The argument for an offset is particularly strong here because the insurers received direct payments (rather than indirect benefits, such as efficiency gains) from the government due to their mitigation efforts.

The insurers argue, however, that there are two exceptions to the mitigation principle that defeat the government's claim to an offset: (1) the prohibition on so-called "pass-through" defenses and (2) the collateral source rule. As to the "pass-through" defense, the insurers argue that the government, as a breaching party, may not claim mitigation of damages when the non-breaching party "passe[s] through" its losses to its customers. Appellees' Suppl. Damages. Br. 15 (citing *Hughes Commc'ns Galaxy, Inc. v. United States*, 271 F.3d 1060, 1072 (Fed. Cir. 2001)).[11] The insurers assert

[11] In addition to *Hughes*, the appellees also rely on cases arising under antitrust law, *see Hanover Shoe, Inc. v. United Shoe Mach. Corp.*, 392 U.S. 481 (1968), RICO, *see Carter v. Berger*, 777

that the cases stand for the proposition that mitigation may only be considered in the "first step," and that "later-step" recoveries such as pass-through are "irrelevant" to the calculation of damages. *Id.* at 10. But this is not a case where a third-party customer pays for the insurers' losses, as was the case in *Hughes*.[12] The complexity of the process cannot obscure the underlying economic reality that the government is paying at least some of the increased costs that the insurers incurred as a result of the government's failure to make cost-sharing reduction payments. *See* Gov't Suppl. Damages Br. 24 ("[T]he government is not urging that [the] plaintiffs' damages should be reduced merely because [the] plaintiffs passed on their cost-sharing reduction expenses to customers. The crucial point is that [the] plaintiffs . . . passed these expenses on to the government itself, which by virtue of the ACA's structure is paying the cost-sharing reduction expenses . . . in the form of higher premium tax credits.").

The government's claim is not that damages should be reduced because the insurers passed on the increased costs to their customers, but that "the insurers . . . obtain[ed] more money from the premium tax credit program, which would help mitigate the loss

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F.2d 1173 (7th Cir. 1985), and utility overcharges, *see S. Pac. Co. v. Darnell-Taenzer Lumber Co.*, 245 U.S. 531 (1918).

[12] The antitrust, RICO, and utility cases too are distinguishable because they concern situations where costs are passed to a third-party. *See, e.g.*, *S. Pac.*, 245 U.S. at 534 (explaining that the pass-through doctrine is concerned with the lack of privity between the defendant railroad company and the "consumer who . . . paid [the] increased price"); *Adams v. Mills*, 286 U.S. 397, 407 (1932) (similar); *Hanover Shoe*, 392 U.S. at 490 (similar in the antitrust context).

of the cost-sharing reduction payments." *Cmty.*, 141 Fed. Cl. at 755 & n.10. The pass-through exception, to the extent that it is applicable to contract damages, does not apply here.

Second, the insurers invoke the collateral source rule, arguing that the additional premium tax credits were collateral benefits that should not be credited against their damages. The collateral source rule is a generally recognized principle of tort law that "bars a tortfeasor from reducing the damages it owes to a plaintiff 'by the amount of recovery the plaintiff receives from other sources of compensation that are independent of (or collateral to) the tortfeasor.'" *Johnson v. Cenac Towing, Inc.*, 544 F.3d 296, 304 (5th Cir. 2008) (quoting *Davis v. Odeco, Inc.*, 18 F.3d 1237, 1243 (5th Cir. 1994)); *see, e.g.*, *Chisholm v. UHP Projects, Inc.*, 205 F.3d 731, 737 (4th Cir. 2000); *Fitzgerald v. Expressway Sewerage Constr., Inc.*, 177 F.3d 71, 73 (1st Cir. 1999). Thus, the collateral source rule bars a reduction of damages due to "insurance policies and other forms of protection purchased by [the] plaintiff," *Johnson*, 544 F.3d at 305, or unemployment benefits in the case of a wrongful-discharge case, *Craig v. Y & Y Snacks, Inc.*, 721 F.2d 77, 83 (3d Cir. 1983).

As with the insurers' pass-through argument, their collateral source rule argument fails. We are aware of no authority, and the insurers cite none, holding that the collateral source rule applies to contract damages, and the prevailing authority rejects any such limitation. *See, e.g.*, *United States v. Twin Falls*, 806 F.2d 862, 873 (9th Cir. 1986) ("We have found no authority to support the application of the collateral source rule in the contracts field." (collecting cases rejecting the application of the collateral source rule to contract-

based damages)), *overruled on other grounds as recognized by Ass'n of Flight Attendants v. Horizon Air Indus., Inc.*, 976 F.2d 541, 551–52 (9th Cir. 1992); *Star Ins. Co. v. Sunwest Metals Inc.*, 691 F. App'x 358, 361 (9th Cir. 2017) (noting that "California courts have declined to extend the collateral source rule to contract-based claims" and that contract damages rules are "[u]nlike" those in tort damages); *LaSalle*, 317 F.3d at 1372 (declining to apply the collateral source rule to government contracts). In any event, even if that rule applied here, the "source of compensation" is the not "independent" of the government. The source is the government itself. *See Phillips v. W. Co. of N. Am.*, 953 F.2d 923, 931 (5th Cir. 1992) ("The [collateral source] rule is intended to ensure that the availability of outside sources of income does not diminish the plaintiff's recovery, not make the tortfeasor pay twice."). The collateral source rule does not bar the reduction in damages.

We conclude that additional premium tax credits were received by Community and Maine Community in 2018 as a direct consequence of their mitigation efforts following the government's nonpayment of 2018 cost-sharing reduction reimbursements, and the Claims Court was required to credit the government with such tax credit payments in determining damages.

IV

Determining the amount of premium tax credits paid to each insurer is necessarily a fact-intensive task. Because the Claims Court rejected the government's mitigation theory on a limited summary judgment record, it did not address these calculation issues. And as the insurers conceded in their briefing before the Claims Court, to the extent that the

insurers' premium changes are "relevant . . . to [the] quantum," they involve "factual questions that cannot be resolved on [the existing motion for summary judgment]." Community Reply in Supp. of Mot. for Summ. J. 15, *Cmty. Health Choice, Inc. v. United States*, No. 18-cv-00005, 141 Fed. Cl. 744, ECF No. 20 (Nov. 30, 2018); Maine Community Mot. for Summ. J. 1, *Me. Cmty Health Options v. United States*, No. 17-cv-02057, 143 Fed. Cl. 381, ECF No. 31 (Apr. 8, 2019) (adopting "all of the arguments regarding benefit year 2018 raised by . . . Community . . . in [its] brief[]"). We therefore remand to the Claims Court for a determination of the amount of premium increases (and resultant premium tax credits) attributable to the government's failure to make cost-sharing reduction payments. This will require either new summary judgment motions or a trial.

We note that three principles will govern the remand proceedings.

First, as the insurers argue, some of the silver-level premium increases (and resulting tax credits) may be caused by other factors, such as market forces or increased medical costs. To the extent that this is the case, the government's liability is not reduced by the tax credits attributable to these other factors.

Second, as previously mentioned, increasing the premium rates for silver plans resulted in an increase in premium tax credits for all plans on the exchange. In some states, state regulators have also allowed insurers to recoup part of their lost cost-sharing reduction reimbursements by increasing premiums for other, non-silver plans on the exchange. In these circumstances, the tax credits for these other plans (attributable to the silver plan premium increase) are still caused by the elimination of cost-sharing

reduction payments and will, of course, reduce the government's liability. But we do not address whether in situations where, as here, there have been no premium increases for other plans, the government's liability should be reduced for the increased tax credit payments with respect to other plans. We leave that issue to the Claims Court in the first instance.

Finally, the insurers will bear the burden of persuasion with respect to the amount of the tax-credit increase attributable to the loss of cost-sharing reduction reimbursements. Other circuit courts and state courts applying state law are inconsistent as to which party bears the burden of persuasion with respect to the amount of mitigation.[13] But in the federal context the rule is clear. The plaintiffs bear the burden of proof:

> [A] non-breaching plaintiff bears the burden of persuasion to establish both the costs that it incurred and the costs that it avoided as a

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[13] *Compare VICI Racing, LLC v. T-Mobile USA, Inc.*, 763 F.3d 273, 301 (3d Cir. 2014) (holding that, under Delaware law, "[a] defendant need not provide an accounting of the costs a plaintiff should have avoided, but the burden is properly on a defendant to articulate the actions that would have been reasonable under the circumstances to mitigate loss"), *with John Morrell & Co. v. Local Union 304A of United Food & Commercial Workers, AFL-CIO*, 913 F.2d 544, 557 (8th Cir. 1990) ("[T]he breaching party[] ha[s] the burden of proving that 'the breach resulted in a direct and immediate savings to the plaintiff,' . . . . [T]he defendant must prove the amount of the offset with reasonable certainty."); *Amigo Broad., LP v. Spanish Broad. Sys., Inc.*, 521 F.3d 472, 486 (5th Cir. 2008) (holding that, under Texas law, "it is the burden of [the defendants], not [the plaintiff], to show that [the plaintiff] received a benefit from its expenditures that reduce or offset the amount of reliance damages to which [the plaintiff] claims it is entitled").

> result of a breach of contract. The breaching party may be responsible for affirmatively pointing out costs that were avoided, but once such costs have been identified, the plaintiff must incorporate them into a plausible model of the damages that it would have incurred absent the breach.

Bos. Edison Co. v. United States, 658 F.3d 1361, 1369 (Fed. Cir. 2011) (citing *S. Nuclear Operating Co. v. United States*, 637 F.3d 1297, 1304 (Fed. Cir. 2011)); *see also Sys. Fuels, Inc. v. United States*, 666 F.3d 1306, 1312 (Fed. Cir. 2012) (collecting cases). Here, the government has affirmatively pointed out the insurers' avoided costs (due to increased premium tax credits). Therefore, it was the insurers burden to incorporate those benefits into their damages calculations. *Energy Nw. v. United States*, 641 F.3d 1300, 1309 (Fed. Cir. 2011) (explaining that, to establish damages, "a plaintiff [must] show what it would have done in the non-breach world, and what it did post-breach"). We think that this allocation of the burden of proof is particularly appropriate here because the insurers were already required by section 1003 of the ACA to provide "justification[s]" for premium rate increases. 42 U.S.C. § 300gg-94(a)(2). Thus, Community and Maine Community—having previously justified their silver-level premium increases—are "in the best position to adduce and establish such proof." *S. Nuclear*, 637 F.3d at 1304 (quoting 11 *Corbin on Contracts* § 57.10 n.15 (2005)).

According to the insurers, they cannot be expected to bear this burden of proof by comparing "each insurer's financial picture now in relation to what it hypothetically might have been if [the cost-sharing reduction reimbursements] had been timely paid."

Appellees' Suppl. Damages Br. 9. Specifically, the insurers argue that they cannot "submit a hypothetical model establishing what their costs would have been in the absence of breach." *Id.* at n.9 (quoting Gov't Suppl. Damages Br. 8). Given the explicit arguments that the insurers here have made for rate increases, we doubt that proof will be as difficult as the insurers' claim. In any event, as we have discussed, our cases make clear that the plaintiff seeking to recover damages must "prov[e] causation by comparing a hypothetical 'but for' world to a plaintiff's actual costs." *Energy Nw.*, 641 F.3d at 1306 (quoting *Yankee Atomic Elec. Co. v. United States*, 536 F.3d 1268, 1273–74 (Fed. Cir. 2008)). The insurers here cannot avoid their burden to prove damages.

V

Although we do not address the Claims Court's holding with respect to the insurers' implied-in-fact contract theory, the same damages analysis would apply to that claim as well, since, as the Claims Court recognized, a claim for breach of an implied-in-fact contract is subject to the same damages limitations as an ordinary contract. *See Cmty.*, 141 Fed Cl. at 767–70 (analyzing damages for breach of an implied-in-fact contract under "[t]he general rule in common law breach of contract cases" (quoting *Estate of Berg v. United States*, 687 F.2d 377, 379 (Ct. Cl. 1982)); *see, e.g.*, *Lindquist Ford, Inc. v. Middleton Motors, Inc.*, 557 F.3d 469, 481 (7th Cir. 2009), *as amended* (Mar. 18, 2009) ("[A]n implied-in-fact contract is governed by general contract principles."); *Hill v. Waxberg*, 237 F.2d 936, 939 (9th Cir. 1956) (explaining that "the general contract theory of compensatory damages should be applied" in an action for breach of an implied-in-fact contract). There is thus no need on

remand to separately address the insurers' implied-in-fact contract claim.

AFFIRMED IN PART, REVERSED AND REMANDED IN PART

COSTS

No costs.