Nos. 2019-1290(L) & 2019-1302

IN THE UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

SANFORD HEALTH PLAN; MONTANA HEALTH CO-OP,

Plaintiffs-Appellees,

v.

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims
in Case Nos. 18-136C & 18-143C, Judge Elaine D. Kaplan.

BRIEF FOR APPELLANT

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STATEMENT OF RELATED CASES

No other appeal in or from the present civil actions has previously been before this Court or any other appellate court. The issues presented in these consolidated appeals are also presented in *Community Health Choice v. United States*, No. 19-1633 (Fed. Cir.). This Court has designated these appeals and the *Community Health Choice* appeal as companion cases, to be assigned to the same panel.

The following cases, which are pending before the Court of Federal Claims, are related cases within the meaning of Federal Circuit Rule 47.5(b):

Blue Cross & Blue Shield of Vermont v. United States, No. 18-373 (Horn, J.);

Common Ground Healthcare Cooperative v. United States, No. 17-877 (Sweeney, C.J.);

Guidewell Mutual Holding Corp. v. United States, No. 18-1791 (Griggsby, J.);

Harvard Pilgrim Health Care, Inc. v. United States, No. 18-1820 (Smith, J.);

Health Alliance Medical Plans, Inc. v. United States, No. 18-334 (Campbell-Smith, J.);

Local Initiative Health Authority for Los Angeles County v. United States, No. 17-1542 (Wheeler, J.);

Maine Community Health Options v. United States, No. 17-2057 (Sweeney, C.J.);

Molina Healthcare of California, Inc. v. United States, No. 18-333 (Wheeler, J.);

Noridian Mutual Ins. Co. v. United States, No. 18-1983 (Horn, J.).

INTRODUCTION

To defray health insurance costs, the Patient Protection and Affordable Care Act (ACA) addressed the two key components of pricing for any given health insurance plan. The first is the premium (or rate). The second is cost sharing—the deductibles, coinsurance, and copayments that shift costs to the insured. Holding all other factors constant, the premium and cost-sharing components are inversely related. An insurer can raise either component and lower the other and still make the same profit.

Two adjacent provisions of the ACA address those two components. Section 1401 authorized tax credits to defray premiums for eligible individuals, and provided a permanent appropriation to fund those tax credits. Section 1402 requires insurers to reduce cost sharing for eligible insureds. Anticipating that insurers would otherwise pass along those cost-sharing expenses to consumers in the form of higher premiums, section 1402 further provided that the Department of Health & Human Services (HHS) "shall make periodic and timely payments to the issuer equal to the value of the reductions." ACA 1402(c)(3)(A). Unlike in section 1401, however, Congress did not provide a permanent appropriation for those payments. Instead, in enacting section 1402, Congress deferred the issue of funding to the regular annual appropriations process. The ACA thus left to future Congresses the policy decision whether, and to what extent, to compensate insurers for their cost-sharing expenses in

order to prevent insurers from passing on those expenses in the form of higher premiums.

In enacting section 1402, Congress did not give insurers a right to damages if future Congresses chose not to fund cost-sharing payments (or to fund them only in part). Congress had no reason to give insurers a damages remedy, because insurers—which generally could recoup their cost-sharing expenses by raising premiums if they did not receive cost-sharing payments equal to those expenses—would not be injured either way. Moreover, the ACA's structure mitigates the impact of such premium increases on consumers. Under section 1401, the amount of an eligible person's premium tax credit is linked to premiums for certain plans; thus, premium tax credits rise when premiums for those plans rise. That is what happened when the government announced that it would no longer reimburse insurers' cost-sharing expenses. Indeed, for 2018, the government will likely pay substantially *more* in increased premium tax credits than the value of the cost-sharing reductions. Insurers thus are better off financially as a result.

Plaintiffs and scores of other insurers nonetheless contend that they have a statutory right to damages on an ongoing basis for any cost-sharing payments that Congress declines to fund—regardless of whether the insurers also recoup those expenses through increased premiums and tax credits. In accepting that argument here and in parallel cases, the trial judges emphasized that section 1402 of the ACA commands HHS to pay insurers for their cost-sharing expenses. But even when a

statute imposes an unqualified obligation on an agency, the claimant in a Tucker Act suit must show that Congress intended to mandate compensation in the event the agency fails to perform. *See United States v. Bormes*, 568 U.S. 6, 15-16 (2012). When Congress declined to fund the section 1402 payments, it made clear its intent that these cost-sharing expenses should not be a liability of the United States. And it is utterly implausible to conclude that Congress intended for insurers to collect their cost-sharing expenses twice, or that Congress intended to penalize taxpayers by allowing duplicative payments from the fisc.

The trial judges' reasoning also fails on its own terms, because section 1402 does not impose an unqualified obligation on HHS. Section 1402's directive to HHS to make payment is qualified by the Anti-Deficiency Act, which forbids federal agencies from making payments unless and until Congress provides an appropriation. The complete instruction that Congress gave HHS was therefore to compensate insurers for their cost-sharing expenses if and only if funds were later appropriated. The rulings below turn the Anti-Deficiency Act upside down, by treating the agency's obedience to that instruction as a violation of its legal obligations and the basis for monetary relief.

Plaintiffs' alternative argument, which the trial judges in the parallel cases adopted, is that they are entitled to recover damages for breach of an implied-in-fact contract. Congress, however, did not enter into a "contract" with insurers to provide cost-sharing payments—much less a contract that would allow insurers to recover the

same expenses twice. This Court has repeatedly recognized the heavy presumption against treating a statutory directive as the basis for a contract. Plaintiffs' contract claims are foreclosed by this Court's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), which rejected an analogous implied-in-fact contract claim in the context of the ACA's risk-corridors program.

STATEMENT OF JURISDICTION

Plaintiffs invoked the jurisdiction of the Court of Federal Claims under the Tucker Act, 28 U.S.C. § 1491(a)(1). The trial court entered final judgment for Montana Health Co-Op on October 9, 2018, and for Sanford Health Plan on October 17, 2018. The government filed timely notices of appeal on December 6, 2018. This Court has jurisdiction under 28 U.S.C. § 1295(a)(3).

STATEMENT OF THE ISSUES

1. Whether the insurers' statutory claims fail because Congress did not intend for insurers to receive damages as compensation for cost-sharing payments that Congress declined to fund.

2. Whether the insurers' contract claims fail because insurers do not have implied-in-fact contracts for cost-sharing payments.

STATEMENT OF THE CASE

A. Statutory Background

1. Health insurance pricing

Health insurers make money by collecting more in premiums than they pay out in claims and administrative costs. The premiums that insurers charge depend, in part, on the amount that their insureds pay as "cost sharing," such as deductibles, coinsurance, and copayments. Holding other factors constant, an insurance plan with higher cost sharing (such as a high deductible) will have a lower premium, and an insurance plan with lower cost sharing (such as a low deductible) will have a higher premium.

This inverse relationship between premiums and cost sharing occurs not only for business reasons, but also because insurance companies are subject to state regulations that require that an insurer's rates be high enough to cover the insurer's costs and ensure its solvency. *See*, *e.g.*, Office of the Assistant Secretary for Planning and Evaluation (ASPE), HHS, *ASPE Issue Brief: Potential Fiscal Consequences of Not Providing CSR Reimbursements* at 3 n.3 (Dec. 1, 2015) (explaining that "State regulations generally require state regulators to review insurance premiums to ensure that premiums are set high enough to cover costs and ensure solvency") (*ASPE Issue Brief*).[1]

[1] https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_CSRs.pdf.

2. The ACA's tax-credit and cost-sharing reduction programs

The ACA authorized two programs to reduce the cost of health insurance for consumers, beginning with the 2014 calendar year.

Under the first program, the government pays a portion of the premium that insurers charge eligible consumers. Section 1401 of the ACA (codified at 26 U.S.C. § 36B) authorized a refundable tax credit to applicable taxpayers whose household income is between 100 and 400% of the federal poverty level to subsidize their premiums. Section 1401 provided permanent funding for these new tax credits by adding them to the list of refundable tax credits payable from an existing permanent appropriation for tax credits. *See* ACA § 1401(d) (amending 31 U.S.C. § 1324(b)). Pursuant to section 1412 of the ACA, these tax credits can be paid directly to insurers in advance, so that the consumers are not required to pay the full premium. *See* 42 U.S.C. § 18082(a)(3).[2]

The second program requires insurers to reduce cost sharing (such as deductibles, coinsurance, and copays) for eligible insureds who are also eligible for tax credits. Section 1402 (codified at 42 U.S.C. § 18071) directs insurers to reduce cost-sharing for eligible insureds who are enrolled in "silver" plans through an Exchange.[3]

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[2] Section 1412 directed HHS to establish the advance-payment program in consultation with the Department of the Treasury. For simplicity, we refer to HHS, which operates the program.

[3] The ACA classifies plans offered on the Exchanges into one of four metal levels based on their cost-sharing requirements. 42 U.S.C. § 18022(d). A "silver" plan

In enacting this provision, Congress understood that insurers generally would recoup these expenses by raising premiums if the insurers were not otherwise reimbursed. Thus, section 1402 further provides that HHS "shall make periodic and timely payments to the issuer equal to the value of the reductions," ACA § 1402(c)(3)(A), which could be paid directly to insurers in advance, *id.* § 1412(a)(3). In contrast to section 1401, however—which provided permanent funding for the tax credits—the ACA did not provide any funding for cost-sharing payments. Instead, Congress left cost-sharing payments (like most government programs) to be funded in the regular appropriations process, through which Congress generally funds government programs via annual appropriations acts. The ACA thus deferred to future Congresses the policy judgment as to whether and to what extent to fund the section 1402 cost-sharing payments in order to prevent insurers from passing on cost-sharing expenses to consumers in the form of higher premiums.

B. Factual Background

When the time to begin making cost-sharing payments drew near, the prior Administration included in the President's fiscal year 2014 budget a request for an

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is a plan structured so that the insurer pays on average 70% of an enrollee's health care costs, leaving the enrollee responsible (before application of the cost-sharing subsidy) for the other 30% through cost sharing. *Id.* In a "gold" or "platinum" plan, the insurer bears a greater portion of health care costs, while the insurer is responsible for a lesser portion of those costs in a "bronze" plan. *Id.* An insurer that offers coverage on an Exchange is required to offer at least one plan at both the "silver" and "gold" levels of coverage. *Id.* § 18021(a)(1)(C)(ii).

appropriation to HHS for such payments. *See President's Fiscal Year 2014 Budget of the U.S. Government*, Budget Appendix 448 (requesting such sums as necessary for carrying out sections 1402 and 1412 of the ACA); Centers for Medicare & Medicaid Services (CMS), HHS, *Justifications of Estimates for Appropriations Committees, Fiscal Year 2014*, at 2, 7 (2013) (identifying the cost-sharing reduction program as one of "its five annually-appropriated accounts" for which it needed funding).[4]

Congress declined to provide the requested appropriation. *See* S. Rep. No. 113-71, at 123 (2013) (explaining that the committee recommendation "d[id] not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the ACA"); Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5 (providing no funding for these cost-sharing payments).

In January 2014, HHS began making monthly advance cost-sharing payments to insurers out of the permanent appropriation for refundable tax credits. That prompted a lawsuit by the House of Representatives to enjoin the payments on the ground that there is no appropriation for such payments. In May 2016, the district court rejected HHS's contention that the cost-sharing payments could properly be made from the permanent appropriation for tax credits. The court accepted the House's position on the merits, holding that there is no appropriation for cost-sharing

[4] The budget request and related documents are described in *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 172-74 (D.D.C. 2016).

payments. The district court enjoined further cost-sharing payments unless and until Congress provided an appropriation, but stayed the injunction pending appeal. *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 189 (D.D.C. 2016).[5]

Cost-sharing payments continued until October 2017, when the Attorney General—responding to an inquiry from HHS and the Department of the Treasury—determined that the permanent appropriation for refundable tax credits in 31 U.S.C. § 1324 cannot be used for cost-sharing payments. *See* Letter from the Attorney General Letter to the Secretary of the Treasury and the Acting Secretary of HHS, at 1 (Oct. 11, 2017). The following day, HHS sent a memorandum to CMS explaining that cost-sharing payments "are prohibited unless and until a valid appropriation exists." Memorandum from the Acting Secretary of HHS to the Administrator of CMS, Payments to Issuers for Cost-Sharing Reductions, at 1 (Oct. 12, 2017).[6] Accordingly, HHS ceased making such payments to insurers.

Predictably, most insurers raised premiums for the 2018 benefit year in order to recoup their ongoing expense of reducing cost sharing for eligible insureds as required by section 1402. *See California v. Trump*, 267 F. Supp. 3d 1119, 1134 (N.D. Cal. 2017). Even before the Administration announced that the payments would cease, thirty-eight States accounted for the possible termination of cost-sharing payments by

[5] The injunctive relief was later vacated due to a settlement.

[6] The Attorney General's letter and the subsequent memorandum from the Acting HHS Secretary are available at https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

approving increases in certain premiums in the rate-setting process for 2018. *See id.* at 1136. Many more States did so after the announcement was made. *See id.* These regulatory approvals were unsurprising because, as explained above, state insurance regulations require that an insurer's rates be set high enough to cover its expenses, which include the insurer's expense of reducing cost sharing for eligible enrollees pursuant to section 1402. *See supra*, p.5.

The structure of the ACA mitigates the impact of increased premiums on consumers who receive tax credits. The statutory formula establishing the amount of the section 1401 tax credit ensures that eligible enrollees are not required to pay more than a specified percentage of their household income in order to purchase the second-lowest-cost silver plan available in their rating area. *See* 26 U.S.C. § 36B(b)(2)(B). As a result, an increase in silver-plan premiums generally triggers a dollar-for-dollar increase in the amount of the tax credit. That increase in the tax credit is available to all individuals eligible for tax credits—not just to those whose cost sharing is reduced under section 1402.

Thus, tax credits would have risen for 2018 even if insurers had recouped their cost-sharing expenses by raising premiums across-the-board, for all plan levels. The impact on tax credits was amplified because many state regulators approved targeted rate increases for silver-plan premiums only, a practice known as "silver loading." *California*, 267 F. Supp. 3d at 1134. As noted, tax credits are pegged to silver-plan premiums, so silver loading had the effect of causing a massive increase in the

government's advance payment of premium tax credits. In 2018 alone, the federal government expects to pay insurers billions of dollars more in additional tax credits than the value of the cost-sharing payments forgone. That pattern of increased government spending—which HHS anticipated years before it ceased making cost-sharing payments—is expected to continue as long as Congress declines to fund cost-sharing payments and silver loading is permitted. *See ASPE Issue Brief* at 4 (Dec. 1, 2015); *see also* Congressional Budget Office (CBO), *Appropriation of Cost-Sharing Reduction Subsidies* at 6 (Mar. 19, 2018) (projecting that net expenditures would decrease by $32 billion if cost-sharing payments were directly funded for the 2019-2021 period).[7]

C. Tucker Act Suits By Insurers

In a dozen Tucker Act suits—including a class action joined by more than ninety insurers—insurers are seeking damages from the United States as compensation for HHS's failure to make cost-sharing payments since October 2017.

[7] Every State except Vermont, North Dakota, and the District of Columbia allowed silver loading for 2018. Vermont and North Dakota began allowing silver loading for 2019. The District of Columbia has not allowed silver loading, but few people qualify for cost-sharing reductions in the District because its Medicaid program covers individuals with household income up to 215% of the federal poverty level. "The Administration supports a legislative solution that would appropriate CSR payments and end silver loading." HHS Notice of Benefit and Payment Parameters for 2020, 84 Fed. Reg. 227, 283 (Jan. 24, 2019) (proposed rule). "In the absence of Congressional action," the agency has sought "comment on ways in which HHS might address silver loading, for potential action in future rulemaking applicable not sooner than plan year 2021." *Id.*

The insurers concede that Congress did not provide funding for HHS to make these payments, and that HHS thus had no choice but to cease making cost-sharing payments. The insurers contend, however, that Congress intended that insurers receive damages on an ongoing basis for any unfunded cost-sharing payments—even though insurers can recover their ongoing cost-sharing expenses by raising premiums, as insurers in fact have done, and even though the government likely has been paying insurers substantially more in tax credits than the value of the cost-sharing payments.

The insurers allege a statutory right to damages under section 1402 of the ACA, and many also allege that section 1402 created implied-in-fact contracts for cost-sharing payments. Although the total amount that insurers will seek is unknown, there were approximately $433 million in unmade cost-sharing payments during the last quarter of 2017 and approximately $6.7 billion in unmade advance cost-sharing payments during the 2018 calendar year. The insurers assert an ongoing right to damages for every year that Congress elects not to fund cost-sharing payments.

1. Judge Kaplan's rulings in these cases

These two cases were the first of the Tucker Act suits to be decided, both by Judge Kaplan. In substantially identical opinions, Judge Kaplan ruled in favor of the insurers on their statutory claims, without reaching their implied-in-fact contract claims. Judge Kaplan concluded that the ACA's "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 ACA." Appx8.[8] Based on language in the first part of this Court's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), she concluded that "the lack of appropriated funds" is "irrelevant to whether such an obligation was enforceable" in a damages action. Appx9.

Judge Kaplan did not dispute that her interpretation of section 1402 would result in double recoveries by insurers and double payments by the government. *See* Appx11 & n.7. She rejected the government's argument that the insurers' ability to recoup their cost-sharing expenses by raising premiums demonstrates that Congress did not intend to give insurers a damages remedy. *See id.* She reasoned that "[t]here is no evidence in either the language of the ACA or its legislative history that Congress intended that the statutory obligation to make CSR payments should or would be subject to an offset based on an insurer's premium rates." *Id.* She declared that "premium rates have no bearing on whether § 1402 created a statutory obligation to pay insurers compensation for the cost-sharing reductions they implemented." *Id.*

The parties stipulated to the amount of cost-sharing payments that would have been due to the plaintiff insurers for the last quarter of 2017 after reconciliation. Based on those stipulations, Judge Kaplan awarded approximately $1.2 million in damages to Montana Health, *see* Appx13, and approximately $360,000 to Sanford Health, *see* Appx1. Both insurers explicitly reserved the right to seek damages for

[8] For ease of reference, the citations are to the *Sanford Health* opinion.

cost-sharing payments not funded in 2018, 2019, and subsequent years. *See* Appx159 (Sanford Health); Appx300 (Montana Health).

2. The rulings by Chief Judge Sweeney and Judge Wheeler in analogous cases

After Judge Kaplan issued her decisions in these cases, Chief Judge Sweeney and Judge Wheeler issued liability rulings in insurers' favor in analogous cases, including a class action brought by more than ninety insurers. *See Common Ground Healthcare Cooperative v. United States*, No. 17-877C, 2019 WL 642892 (Fed. Cl. Feb. 15, 2019) (Sweeney, J.) (class action); *Community Health Choice, Inc. v. United States*, No. 18-5C, 2019 WL 643011 (Fed. Cl. Feb. 15, 2019) (Sweeney, J.); *Maine Community Health Options v. United States*, 2019 WL 642968, No. 17-2057C (Fed. Cl. Feb. 15, 2019) (Sweeney, J.); *Local Initiative Health Authority for L.A. County v. United States*, No. 17-1524C, 2019 WL 625446 (Fed. Cl. Feb. 14, 2019) (Wheeler, J.) (*LIHA*).

Chief Judge Sweeney and Judge Wheeler accepted the insurers' implied-in-fact contract claims, as well as their statutory claims.[9] Both judges rejected the government's argument that "Congress could not have intended to allow a double recovery of cost-sharing reduction payments." *Community Health Choice*, 2019 WL 643011, at *10 (Sweeney, J.); *see LIHA*, 2019 WL 625446, at *10 (Wheeler, J.) (declaring that "[n]owhere in the legislative history, statutory text or implementing

[9] The insurers in the *Common Ground* class action did not allege an implied-in-fact contract claim.

regulations are CSR payments subject to alteration based on the availability of offsetting funds derived from premium increases permitted by state regulators").

SUMMARY OF ARGUMENT

Section 1402 of the ACA requires insurers to reduce cost sharing (such as deductibles, coinsurance, and copayments) for eligible enrollees. To discourage insurers from passing those costs along to consumers in the form of higher premiums, section 1402 further directs HHS to make periodic payments to insurers equal to the value of the cost-sharing reductions. Although the ACA permanently appropriated funds for the premium tax credits authorized in section 1401, the ACA did not do so for the cost-sharing payments in section 1402. Instead, the ACA left the issue of funding for cost-sharing payments to be decided in the regular appropriations process, through which Congress determines whether and to what extent to fund most government programs.

In enacting section 1402, Congress did not give insurers a right to damages in the event that future Congresses made the policy choice not to fund cost-sharing payments (or to fund them only in part). Congress had no reason to give insurers a damages remedy, because insurers can recoup their cost-sharing expenses by raising premiums—as insurers in fact have done. Moreover, the ACA's structure mitigates the impact of such premium increases on many consumers, because tax credits go up when benchmark premiums rise. Indeed, for 2018, it is expected that the government will pay insurers substantially *more* in increased tax credits than the value of their

reduced cost sharing. *See California*, 267 F. Supp. 3d at 1139 (explaining that that "the increased federal expenditure for tax credits will be far more significant than the decreased federal expenditure for CSR payments").

Contrary to the trial court's premise, nothing in the ACA or any subsequent legislation suggests that Congress intended to authorize double recoveries for insurers. Plaintiffs' statutory claims thus fail even assuming that section 1402 imposed an unqualified obligation on HHS to make cost-sharing payments. In any event, section 1402 is not an unqualified directive to HHS to make payment. That directive is qualified by the Anti-Deficiency Act, which prohibits an agency from making payment without an appropriation. Read together, the two statutes direct HHS to make payment if Congress provides the necessary appropriation. It is conceded that Congress did not provide an appropriation for cost-sharing payments; thus, HHS has acted in compliance with the law and there is no violation to rectify.

Plaintiffs' alternative argument—that section 1402 gave insurers implied-in-fact contracts for cost-sharing payments—is foreclosed by this Court's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), which rejected an analogous implied-in-fact contract claim in the context of the ACA's risk-corridors program.

STANDARD OF REVIEW

The decisions below rest on conclusions of law that are subject to de novo review in this Court. *See, e.g.*, *Starr Int'l Co. v. United States*, 856 F.3d 953, 963 (Fed. Cir. 2017).

ARGUMENT

I. Congress Did Not Intend For Insurers To Receive Damages As Compensation For Cost-Sharing Payments That Congress Declined To Fund.

A. Legal Standard

The Tucker Act and its companion statutes, the Little Tucker Act and the Indian Tucker Act, "do not themselves creat[e] substantive rights, but are simply jurisdictional provisions that operate to waive sovereign immunity for claims premised on other sources of law." *United States v. Bormes*, 568 U.S. 6, 10 (2012) (citation and quotation marks omitted). Therefore, a claimant must identify another source of law that "confer[s] a substantive right to recover money damages from the United States." *United States v. Testan*, 424 U.S. 392, 398 (1976).

Justice Scalia, writing for a unanimous Supreme Court in *Bormes*, explained that "the test for determining whether a statute that imposes an obligation but does not provide the elements of a cause of action qualifies for suit under the Tucker Act"—and "more specifically, whether the failure to perform an obligation undoubtedly imposed on the Federal Government creates a right to monetary relief"—is "whether the statute can fairly be interpreted as mandating compensation by the Federal

Government for the damage sustained." *Bormes*, 568 U.S. at 15-16 (quotation marks omitted). As with any question of statutory interpretation, the touchstone is Congress's intent. *See Bowen v. Massachusetts*, 487 U.S. 879, 905 n.42 (1988) (explaining that in determining whether a substantive statute "can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained," the "touchstone" is Congress's intent).

It is undisputed that Congress did not provide funding for HHS to make cost-sharing payments under section 1402 of the ACA, and that HHS thus had no choice but to cease making these payments. For the reasons discussed below, it is equally clear that Congress did not intend to grant insurers an unstated entitlement to money damages for the very payments that Congress itself in future years declined to fund.

B. The Insurers' Interpretation Of Section 1402 Would Result In Double Recoveries For Insurers And Double Payments By The Government.

Section 1402 of the ACA requires insurers to reduce cost sharing for eligible enrollees. Anticipating that insurers generally would pass such costs along to consumers through higher premiums if the costs were not otherwise reimbursed, Congress directed HHS to compensate insurers for their cost-sharing expenses. But in contrast to section 1401—which provided a permanent appropriation for the ACA's tax credits—section 1402 did not provide any funding for cost-sharing payments. Instead, Congress left the issue of funding for future Congresses to decide in the regular appropriations process. In this way, the ACA allowed future

Congresses to make the policy decision whether to compensate insurers for their cost-sharing expenses in order to prevent insurers from passing on cost-sharing expenses to consumers in the form of higher premiums.

Nothing in the ACA suggests that Congress intended for insurers to receive, as damages, the very cost-sharing payments that future Congresses might decide not to fund. Congress had no reason to provide a damages remedy because insurers—which could recoup their costs by raising premiums—would not be injured. Moreover, the ACA's structure would mitigate the impact of such premium increases on consumers, because tax credits go up as silver-plan premiums rise.

That is what happened when HHS announced that cost-sharing payments would cease. Nearly every State allowed insurers to raise premiums for 2018, which in turn caused tax credits to increase.[10] Indeed, for 2018, the government likely has paid insurers substantially *more* in increased tax credits than the value of their cost-sharing reductions. The same is expected to occur in 2019 and 2020. If damages were awarded as well, insurers would receive double recoveries—an obvious windfall—and the government would end up making duplicative payments.

In ruling that the "windfall for insurers" is not "unwarranted," *Community Health Choice*, 2019 WL 643011 at *14, Chief Judge Sweeney and the other judges who

[10] The experience of the insurer Community Health Choice is illustrative. That insurer raised its rates for 2018 on the explicit assumption that "CSRs will not continue to be reimbursed." Milliman, *Part III Actuarial Memorandum, Community Health Choice Individual Rate Filing Effective January 1, 2018*, at 3, https://go.usa.gov/xEFjG.

ruled for insurers failed to grasp the relationship between cost sharing and premiums, and between premiums and tax credits. Judge Wheeler, for example, believed that double recoveries were justified because "[p]remium rate adjustment is a state-specific decision, entirely separate from the CSR program." *LIHA*, 2019 WL 625446 at *10. Similarly, Judge Kaplan declared that "[t]here is no evidence in either the language of the ACA or its legislative history that Congress intended that the statutory obligation to make CSR payments should or would be subject to an offset based on an insurer's premium rates." Appx11; *see also Community Health Choice*, 2019 WL 643011 at *10 (Sweeney, C.J.) (similar).

Congress, however, enacted the ACA against the background of state regulations that generally required (and still require) insurers to set rates high enough to cover their expenses, which include their cost-sharing expenses. *See supra*, p.5. Congress was thus well aware that insurers would generally raise premiums if they were not compensated by the government for the cost-sharing reductions they were required to make for eligible enrollees. In other words, if future Congresses declined to provide all or part of the necessary funding, the consequence would simply be that the ACA's objective of reducing premiums would not be (fully) realized. That is a familiar outcome when a program authorized by Congress is not funded. No monetary remedy for insurers was needed, because insurers would not be out of pocket. Nothing in the text or legislative history of the ACA suggests Congress intended for insurers to be compensated for their cost-sharing expenses twice—once

through premium increases, and a second time in damages. The windfall that the insurers' interpretation of section 1402 would produce is wholly unwarranted.

That conclusion would be inescapable even if the insurers' premium increases were paid exclusively *by consumers*. But Congress also would have understood that, because of the structure of the ACA itself, premium increases trigger an increase in the tax credits paid *by the government*. That relationship flows from the ACA's plain text. The statutory formula establishing the amount of the section 1401 tax credit ensures that eligible enrollees are not required to pay more than a specified percentage of their household income in order to purchase the second-lowest-cost silver plan available in their rating area. Thus, an increase in silver-plan premiums generally triggers a dollar-for-dollar increase in the amount of the tax credit. *See supra*, p.10. To be sure, Congress may not have specifically contemplated that insurers would engage in the particular practice of "silver loading," through which insurers generally recouped the entirety of their section 1402 cost-sharing expenses (and more) exclusively from massive increases in the section 1401 tax credits, by raising premiums for silver plans only. But under the formula that Congress itself prescribed in the text of section 1401, tax credits would have increased even if the insurers had spread their premium increases across all plan levels, including (but not limited to) silver plans. Thus, not only would the insurers' interpretation of section 1402 enable *them* to

recoup the same cost-sharing expenses twice; it also would require *the government* to make duplicative payments.[11]

The question is not, as Chief Judge Sweeney suggested, whether Congress "intend[ed] to actually reimburse the insurers" when it enacted section 1402 of the ACA. *Community Health Choice*, 2019 WL 643011, at *10. It is undisputed that the ACA provided no permanent appropriation for cost-sharing payments, and thus relegated the funding of such payments to the regular appropriation process. By doing so, the Congress that enacted the ACA gave future Congresses the policy choice whether to defray insurers' cost-sharing expenses—and thus prevent premiums from increasing—or to decline to provide some or all of the necessary funding and thus allow premiums and tax credits to rise. Although insurers may welcome a windfall of double recoveries, nothing in the text or history of the ACA suggests that Congress intended for insurers to collect their cost-sharing expenses twice—a result that defies common sense.

[11] Chief Judge Sweeney suggested that insurers might raise silver-plan premiums even if CSR payments were being made, just to increase tax credits. *See Community Health Choice*, 2019 WL 643011, at *10. But as she recognized, insurers have to justify premium increases to state regulators. *See id.* Likewise, HHS regulations require that an insurer's rates be "actuarially justified." 45 C.F.R. § 156.80(d)(2). Moreover, under an ACA provision known as the medical loss ratio, 42 U.S.C. § 300gg-18(b), an insurer must provide premium rebates to its insureds if the insurer's profits and administrative costs exceed 20% of its premium revenues.

C. Section 1402's Instruction To HHS Is Qualified By The Anti-Deficiency Act, Which Barred HHS From Making The Payments At Issue Here.

For the reasons discussed above, the insurers' statutory claims fail even assuming that HHS failed to perform "an obligation undoubtedly imposed on the Federal Government." *Bormes*, 568 U.S. at 15-16. But their argument fails even on its own terms for an independent reason: Congress did *not* impose an unqualified obligation on HHS to make cost-sharing payments.

The trial judges inferred an entitlement to damages from the instruction that Congress issued to HHS in section 1402. That instruction cannot be read in isolation; it must be construed together with the other instructions Congress gave HHS. In particular, this Court has previously recognized that a payment instruction to an agency must be read in light of the Anti-Deficiency Act, 31 U.S.C. § 1341, which forbids federal agencies from making payments unless and until Congress provides the necessary appropriation. *See Highland Falls-Fort Montgomery Central School District v. United States*, 48 F.3d 1166, 1171 (Fed. Cir. 1995). In *Highland Falls*, the amounts earmarked in annual appropriations acts were insufficient for the Secretary of Education to pay school districts the full amount to which they were entitled under a statutory formula in the underlying substantive statute. The Secretary thus reduced the payments *pro rata*. This Court rejected the school district's claim for damages, reasoning that, by making *pro rata* reductions in the amounts to which school districts were entitled, the Secretary "harmonized the requirements of [the substantive statute]

and the appropriations statutes with the requirements of 31 U.S.C. §§ 1341(a)(1)(A)," *i.e.*, the Anti-Deficiency Act. *Id.* The Secretary having dutifully followed Congress's complete instructions, there was no violation to be remedied.

The same is true here. The insurers concede that Congress did not enact an appropriation for HHS to make the cost-sharing payments that section 1402 directs. There is no reason to infer that Congress intended insurers to collect the very cost-sharing payments it declined to fund, through the after-the-fact mechanism of damages actions paid from the permanent appropriation for court judgments. If Congress had wished to provide a permanent appropriation for cost-sharing payments, it would have done so directly, just as Congress did for the premium tax credits in section 1401 of the ACA.

As the Court in *Highland Falls* explained, "[w]hen two statutes are capable of co-existence, it is the duty of the courts, absent a clearly expressed congressional intention to the contrary, to regard each as effective." 48 F.3d at 1171 (quoting *Morton v. Mancari*, 417 U.S. 535, 551 (1974)); *see also Radzanower* v. *Touche Ross & Co.*, 426 U.S. 148, 155 (1976) (noting that courts should strive to harmonize statutes unless they are in "irreconcilable conflict"). Section 1402 and the Anti-Deficiency Act are readily harmonized by understanding section 1402 as imposing a mandate to make payments that is contingent on appropriations. The trial judges' approach, in contrast, would read the ACA as vitiating the Anti-Deficiency Act's central command by directing agency officials to make payments for which no appropriation exists, and

then deeming the officials' failure to do so (which could subject them to criminal sanctions) a breach of the agency's statutory obligations and the basis for money damages.

The trial judges believed that language in this Court's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), compelled a contrary result. That is incorrect. The language on which the trial judges relied was not necessary to the Court's decision and is thus not binding precedent. *See National Am. Ins. Co. v. United States*, 498 F.3d 1301, 1306 (Fed. Cir. 2007) (explaining that "statements made by a court that are unnecessary to the decision in the case" are "not precedential") (internal quotation marks omitted). And as we explain below, that language in *Moda* rested on a misunderstanding of the Supreme Court's decision in *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182 (2012) (*Ramah*), that this Court has elsewhere rejected.

Moda involved the risk-corridors program, a temporary program for the 2014, 2015, and 2016 calendar years under which amounts collected from profitable insurance plans were used to fund payments to unprofitable plans. 892 F.3d at 1314, 1318-20. Section 1342 of the ACA provided HHS shall collect amounts from profitable insurers in accordance with a statutory formula, and that HHS "shall pay" amounts to unprofitable insurers in accordance with a statutory formula. The ACA did not appropriate any funding for risk-corridors payments. In subsequent appropriations acts, Congress allowed HHS to use the amounts collected from insurers as the funding source for risk-corridors payments, but barred HHS from

using other funds. This Court ruled in the government's favor in light of those appropriations restrictions. Thus, the insurers were not awarded any damages.[12]

The trial judges in the cost-sharing cases relied on an earlier part of the *Moda* opinion, in which this Court disagreed with the government's contention that Congress originally "designed section 1342 to be budget neutral." 892 F.3d at 1320. The *Moda* opinion stated that section 1342 is "unambiguously mandatory," *id.*, and believed it "of no moment" that "HHS could not have made payments out to insurers in an amount totaling more than the amount of payments in without running afoul of the Anti-Deficiency Act," reasoning that "the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government." *Id.* at 1322 (citing *Ramah*, 567 U.S. at 197).

However, this Court elsewhere recognized that *Ramah* rested on principles of government contracting law that do not extend to statutory claims. *See Prairie County v. United States*, 782 F.3d 685 (Fed. Cir. 2015). The statute at issue in *Ramah*, the Indian Self-Determination and Education Assistance Act (ISDA), directed the Secretary of the Interior to enter into contracts with willing tribes, pursuant to which those tribes will provide services such as education and law enforcement that otherwise would have been provided by the federal government. *Ramah*, 567 U.S. at 185. ISDA mandated that the Secretary shall pay the full amount of "contract

[12] This Court denied the insurers' petitions for rehearing en banc by a 9-2 vote. The insurers filed petitions for a writ of certiorari, which are pending.

support costs" incurred by tribes in performing their contracts. *Id.* The Supreme Court emphasized that "the Government's obligation to pay contract support costs should be treated as an ordinary contract promise," noting that ISDA "uses the word 'contract' 426 times to describe the nature of the Government's promise." *Id.* at 189. The Supreme Court concluded that ISDA's proviso stating that "the provision of funds under [ISDA] is subject to the availability of appropriations" is satisfied as long as Congress appropriates adequate legally unrestricted funds to pay each of the contracts at issue, even if the appropriation is insufficient to pay all of the contracts in full. *Id.* at 189-90.

The Supreme Court emphasized that this conclusion "followed directly from well-established principles of Government contracting law" and that it "safeguards both the expectations of Government contractors and the long-term fiscal interests of the United States." *Ramah*, 467 U.S. at 190, 191. Furthermore, the Supreme Court noted that "Congress expressly provided in ISDA that tribal contractors were entitled to sue for 'money damages' under the Contract Disputes Act upon the Government's failure to pay." *Id.* at 198. In that context, the Supreme Court rejected the government's argument that its holding "could cause the Secretary to violate the Anti–Deficiency Act." *Id.* at 197. The Supreme Court explained that "the Anti–Deficiency Act's requirements 'apply to the official, but they do not affect the rights in this court of the citizen honestly contracting with the Government.'" *Id.* (noting that "[a]n appropriation *per se* merely imposes limitations upon the Government's own

agents; . . . but its insufficiency does not pay the Government's debts, nor cancel its obligations").

In *Prairie County*, this Court explicitly rejected efforts to extend *Ramah* to statutory claims. *See* 782 F.3d at 689-90. As the *Moda* Court itself recognized, there is a heavy presumption against treating a statutory directive as a contract. *See Moda*, 892 F.3d at 1329 ("Absent clear indication to the contrary, legislation and regulation cannot establish the government's intent to bind itself in a contract.") (citing *National R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985) (*Atchison*)). Interpreting statutory directives to an agency to make payment without regard to the Anti-Deficiency Act would effectively transform such statutory directives into contracts, reversing the presumption that the Supreme Court established in *Atchison*.

Ramah's reasoning regarding contract claims thus has no application to the *statutory* claims at issue here. As discussed above, when a statutory program is at issue, the Anti-Deficiency Act makes clear that an instruction to an agency to make payment is contingent upon appropriations. A damages award in the circumstances presented here would, to our knowledge, be unprecedented. The cases on which the trial judges relied did not award damages as a statutory remedy for payments that Congress declined to fund. In *Greenlee County v. United States*, 487 F.3d 871 (Fed. Cir. 2007), the Court concluded that a payment directive to an agency was sufficient to establish

Tucker Act jurisdiction, but held on the merits that damages could not be awarded for amounts that Congress had not appropriated. In *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (en banc), and *Fisher v. United States*, 402 F.3d 1167 (Fed. Cir. 2005) (en banc in part), the Court addressed jurisdiction rather than the merits. And in *New York Airways, Inc. v. United States*, 369 F.2d 743, 748 (Cl. Ct. 1966) (per curiam), the appropriations explicitly treated the underlying obligation as contractual. *See Moda*, 892 F.3d at 1330 (explaining that the court in *N.Y. Airways* found an "intent to form a contract where Congress specifically referred to "Liquidation of Contract Authorization").

The Supreme Court's decision in *United States v. Langston*, 118 U.S. 389 (1886), likewise furnishes no support for the trial judges' reasoning. That case set out the analysis for determining whether the underfunding of a pre-existing statutory entitlement was deliberate (thus suspending the full entitlement for the period covered by the appropriations act) or inadvertent (which would leave the full entitlement in place for the period covered by the appropriations act). The substantive statute at issue in *Langston* provided that "[t]he representative at Hayti shall be entitled to a salary of $7,500 a year." *Id.* at 390 (quoting Rev. St. § 1683 (1872)). Congress appropriated the full sum of $7,500 annually appropriated for more than a decade, from the creation of the office until the year 1883. *See id.* at 390-91. For three subsequent years, however, only $5,000 per year was appropriated. *See id.* at 391-92. Based on a close analysis of the text and context of the annual appropriations acts, the

Supreme Court inferred that Congress had not intended those appropriations acts to deny the minister the full statutory salary for which he had worked. *See id.* at 391-94. In that context, the Supreme Court regarded the underfunding as inadvertent, while expressly acknowledging that the case was "not free from difficulty." *Id.* at 394. The Court thus affirmed the Court of Claims judgment declaring that Langston was entitled to $7,666.66. *See id.* at 392, 394. That declaratory judgment did not include an order to pay damages, however. *Langston* predated the Judgment Fund, so an Act of Congress was needed to pay the judgment. *See* Act of August 4, 1886, ch. 903, 24 Stat. 256, 275, 281-82. In effect, the Supreme Court's decision was simply a recommendation that Congress was free to accept or disregard at its pleasure.[13]

Just seven years later, the Supreme Court cautioned that *Langston*'s ruling in the claimant's favor expressed "the limit in that direction." *Belknap v. United States*, 150 U.S. 588, 595 (1893) (ruling for the government). The substantive statute at issue in *Belknap* authorized the appointment of Indian agents "at an annual salary of eighteen hundred dollars, each," *id.* at 592, but Congress repeatedly appropriated a lesser amount for the agent of the Tule River agency in California, *see id.* at 593. Noting that

[13] The trial judges in the cost-sharing cases correctly refrained from suggesting that the Judgment Fund itself provides a basis for liability. As this Court explained in *Moda*, the Judgment Fund is a general appropriation of necessary amounts "to pay final judgments." *See* 892 F.3d at 1326 (quoting 31 U.S.C. § 1304(a)). "The Judgment Fund 'does not create an all-purpose fund for judicial disbursement.'" *Id.* (quoting *Office of Pers. Mgmt. v. Richmond*, 496 U.S. 414, 431 (1990)). "Rather, access to the Judgment Fund presupposes liability." *Id.*

Congress had never appropriated more than $1,500 for the Tule River agent's salary, the Supreme Court concluded that "the matter was present to the consideration of congress, and that, in naming the various amounts during these several years," Congress "was fixing the entire compensation which it intended should be given." *Id.* at 595. The Court treated the annual appropriations acts as "a legislative readjustment of salaries, for it is not to be believed that congress, during all these years, was simply appropriating a part of that which it knew was due to its officers." *Id.*

It is thus incontestable that Congress can through its funding decisions demonstrate an intent to modify or suspend a substantive statute. Here, as in *Belknap*—and unlike in *Langston*—Congress made clear through its annual appropriations acts that it did not intend for cost-sharing payments to be made. Indeed, Congress pointedly refused the prior Administration's request to appropriate the funds HHS would need to make cost-sharing payments. *See* S. Rep. No. 113-71, at 123 (2013) (explaining that the committee recommendation "d[id] not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the ACA"); Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5 (2014) (providing no funding for cost-sharing payments).

Contrary to Chief Judge Sweeney's understanding, an appropriations act is not congressional "inaction." *Community Health Choice*, 2019 WL 643011, at *11. An appropriations act is duly enacted legislation. When, as here, Congress enacts an

appropriations bill for HHS that provides no funding for HHS to make cost-sharing payments, Congress has by "clear implication" suspended section 1402's instruction to HHS to make such payments. *Id.*

Chief Judge Sweeney suggested that Congress may have concluded that "other funds available to HHS could be used to make the cost-sharing reduction payments." *Community Health Choice*, 2019 WL 643011, at *9. But the insurers themselves made no such argument. On the contrary, they conspicuously declined to defend the prior Administration's conclusion that cost-sharing payments could properly be made from the permanent appropriation for tax credits. Nor did they argue that there is any other funding source that HHS could use to make cost-sharing payments. It is thus conceded that Congress *never* provided funding for cost-sharing payments.

II. Insurers Do Not Have Implied-In-Fact Contracts For Cost-Sharing Payments.

Insurers do not have implied-in-fact contracts for cost-sharing payments. To allege a binding implied-in-fact contract, a plaintiff must allege facts demonstrating (1) mutuality of intent to contract, (2) consideration, (3) an unambiguous offer and acceptance, and (4) actual authority of the government's representative whose conduct is relied upon to bind the government. *See Moda*, 892 F.3d at 1329. The ACA did not bind the government in contract to make cost-sharing payments or authorize HHS to enter into such contracts, and HHS did not purport to do so.

A. The ACA Did Not Create Implied-In-Fact Contracts For Cost-Sharing Payments.

The insurers' attempt to derive an implied-in-fact contract from the text of section 1402 of the ACA is foreclosed by Supreme Court and Circuit precedent. "The Supreme Court 'has maintained that absent some clear indication that the legislature intends to bind itself contractually, the presumption is that a law is not intended to create private contractual or vested rights, but merely declares a policy to be pursued until the legislature shall ordain otherwise.'" *Brooks v. Dunlop Mfg.*, 702 F.3d 624, 630 (Fed. Cir. 2012) (quoting *Atchison*, 470 U.S. at 465-66 (1985)) (other quotation marks omitted). "This is because the legislature's function is to make laws establishing policy, not contracts, and policies 'are inherently subject to revision and repeal.'" *Moda*, 892 F.3d at 1329 (quoting *Atchison*, 470 U.S. at 466). Accordingly, "the party asserting the creation of a contract must overcome this well-founded presumption and [courts should] proceed cautiously both in identifying a contract within the language of a regulatory statute and in defining the contours of any contractual obligation." *Brooks*, 702 F.3d at 630-31 (quoting *Atchison*, 470 U.S. at 466).

This Court has repeatedly rejected efforts to derive implied-in-fact contracts from statutes. In *Brooks*, for example, this Court rejected the contention that a *qui tam* relator entered into a contract with the United States by filing suit against a third party for false patent marketing. The *qui tam* statute at issue in *Brooks* provided that "[a]ny person may sue for the penalty, in which one-half shall go to the person suing and the

other to the use of the United States," 702 F.3d at 631, but Congress amended the statute in a way that denied the plaintiff the penalty. Rejecting the implied-in-fact contract claim, this Court explained that "[n]othing in this language 'create[s] or speak[s] of a contract' between the United States and a *qui tam* relator." *Id.* (quoting *Atchison*, 470 U.S. at 467).

Similarly, this Court has recognized that federal employees' "entitlement to retirement benefits must be determined by reference to the statute and regulations governing these benefits, rather than to ordinary contract principles." *Schism v. United States*, 316 F.3d 1259, 1274 (en banc). "[A]pplying th[is] doctrine ... courts have consistently refused to give effect to government-fostered expectations that, had they arisen in the private sector, might well have formed the basis for a contract or an estoppel." *Id.*; *see also Hanlin v. United States*, 316 F.3d 1325, 1329 (Fed. Cir. 2003) (finding no contract where the "statute is a directive from the Congress to the [agency], not a promise from the [agency] to" a third party).

In *Moda*, this Court held that no implied-in-fact contract could be derived from the text of section 1342 of the ACA. This Court explained that "the statute contains no promissory language from which" it could find an intent by Congress to bind the government in contract. *Moda*, 892 F.3d at 1339. This Court explicitly rejected the insurers' reliance on *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Cl. Ct. 1957), explaining that the Atomic Energy Commission regulations at issue in *Radium Mines* established "guaranteed minimum prices" for uranium delivered to the Commission;

invited uranium dealers to make an "offer"; and promised to "offer a form of contract" setting forth "terms" of acceptance. *Moda*, 892 F.3d at 1329, 1330. By contrast, the *Moda* Court explained, the risk-corridors program "lacks the trappings of a contractual arrangement that drove the result in *Radium Mines*." *Id.* at 1330.

The same is true here. As Chief Judge Sweeney acknowledged, section 1402 and its implementing regulations "do not include language traditionally associated with contracting, such as 'offer,' 'acceptance,' 'consideration,' or 'contract.'" *Community Health Choice*, 2019 WL 643011, at *17.[14]

That should have been the end of the implied-in-fact contract claim. Chief Judge Sweeney nonetheless declared that "the parties' intent to enter into a contractual relationship can be implied from the quid pro quo nature of the cost-sharing reduction program." Judge Wheeler likewise opined that the cost-sharing reduction program is a "traditional quid pro quo exchange." *LIHA*, 2019 WL 625446, at *12. These pronouncements reflect a basic misunderstanding of the way section 1402 works.

Section 1402 has two distinct provisions that do two different things. The first provision requires insurers to reduce cost-sharing for eligible individuals who enroll in

[14] By contrast, other ACA provisions do use the language of contract. *See, e.g.*, ACA § 2703(b) (providing that the Secretary "shall enter into a contract" with an independent entity to evaluate certain State programs); ACA § 5203(b) (providing that the Secretary "shall enter into contracts with qualified health professionals" that agree to provide certain pediatric specialty care).

silver plans sold on an Exchange. That is the type of straightforward regulation of the business of insurance that is routinely enacted pursuant to Congress's Commerce Clause power. It is not different in kind from the ACA's requirement that all plans offered on the Exchanges provide certain essential health benefits. *See Moda*, 892 F.3d at 1314 (citing 42 U.S.C. §§ 18021, 18031(c)). The requirement to cover essential health benefits may increase an insurer's cost of doing business, which the insurer may recoup by raising premiums.

The second provision in section 1402 directs HHS to make payments to insurers equal to the value of their reduced cost sharing for enrollees. This provision "is a directive from the Congress to the [agency], not a promise from the [agency] to" third parties. *Hanlin*, 316 F.3d at 1329. If Congress does not provide the funding that is necessary for HHS to implement Congress's directive, the only consequence is that insurers may raise premiums to recoup their cost-sharing expenses. Section 1402 "contains no promissory language from which" a court could find an intent by Congress to bind the government in contract. *Moda*, 892 F.3d at 1329.

Furthermore, as with the insurers' statutory claims, the consequence of their contract theory is that insurers would recover their cost-sharing expenses twice: once through increased premiums and a second time as damages for a (putative) breach of contract. It is difficult to imagine a weaker case for "implying" an intent to contract on the part of the government.

B. HHS Had No Authority To Bind The Government In Contract For Cost-Sharing Payments And Did Not Purport To Do So.

The insurers' attempt to imply a contract from HHS's regulations, conduct, and statements is equally baseless. HHS has no authority to bind the government in contract for cost-sharing payments and did not purport to do so.

An implied-in-fact contract cannot arise without "actual authority" on the part of the government's representative to bind the government. *Schism*, 316 F.3d at 1278. "A law may be construed . . . to authorize making a contract for the payment of money in excess of an appropriation only if the law specifically states that . . . such a contract may be made." 31 U.S.C. § 1301(d). Without such "special authority," an "officer cannot bind the Government in the absence of an appropriation." *Cherokee Nation of Oklahoma v. Leavitt*, 543 U.S. 631, 643 (2005).

Thus, in *Schism*, this Court held that promises of free lifetime medical care made by military recruiters did not bind the government because the "[t]he recruiters lacked actual authority, meaning the parties never formed a valid, binding contract." 316 F.3d at 1284. This Court emphasized that even the President, as Commander-in-Chief, "does not have the constitutional authority to make promises about entitlements for life to military personnel that bind the government because such powers would encroach on Congress' constitutional prerogative to appropriate funding." *Id.* at 1288.

The same principles foreclose the insurers' claims. Section 1402 did not vest HHS with any contracting authority, much less with specific authority to make "a contract for the payment of money in excess of an appropriation." 31 U.S.C. § 1301(d). Given that absence of authority, it is unsurprising that HHS did not purport to offer such contracts. The HHS regulation that implements section 1402 simply tracks the language of the statute and contains no contractual language. *See* 45 C.F.R. § 156.430. Chief Judge Sweeney suggested that HHS's "conduct in making cost-sharing reduction payments until October 2017 reflects the parties' intent to contract." *Community Health Choice*, 2019 WL 643011, at *16. But even assuming that a stream of payments could in some circumstances be regarded as an offer to contract (if made by an agency with contracting authority), no such inference can be drawn from a stream of payments that—by the insurers' own admission—exceeded the agency's authority.

Moreover, the insurers continued to offer plans on the Exchanges for the 2018 and 2019 years, even though the stream of cost-sharing payments had ended. Insurers have a strong profit motive for doing so, because the Exchanges are the only commercial channel in which they can market their plans to the millions of individuals who receive tax credits to subsidize the purchase of insurance. No government contracts were needed to induce the insurance industry to take advantage of these major new business opportunities, and no such contracts were made.

CONCLUSION

The judgments of the trial court should be reversed.

Respectfully submitted,

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March 2019

CERTIFICATE OF SERVICE

I hereby certify that on March 22, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Alisa B. Klein
Alisa B. Klein

CERTIFICATE OF COMPLIANCE

This brief complies with the volume limit of Federal Circuit Rule 32(a) because it contains 9,469 words. This brief complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

s/ Alisa B. Klein
Alisa B. Klein

STATUTORY ADDENDUM

Ppaca & Hcera; Public Laws 111-148 & 111-152: Consolidated Print

One Hundred Eleventh Congress of the United States of America

AT THE SECOND SESSION

Begun and held at the City of Washington on Tuesday, the fifth day of January, two thousand and ten

An Act

Entitled The Patient Protection and Affordable Care Act.

Be it enacted by the Senate and House of Representatives of the United States of America in Congress assembled,

SECTION 1. SHORT TITLE; TABLE OF CONTENTS.

(a) SHORT TITLE.—This Act may be cited as the "Patient Protection and Affordable Care Act".

[Note: *This print is of the Patient Protection and Affordable Care Act ("PPACA"; Public Law 111–148) consolidating the amendments made by title X of the Act and the Health Care and Education Reconciliation Act of 2010 ("HCERA"; Public Law 111–152). The text of the Indian Health Care Improvement Reauthorization and Extension Act of 2009 (S. 1790), as enacted (in amended form) by section 10221 of PPACA, is shown in a separate, accompanying document. This document has been prepared by the House Office of the Legislative Counsel (HOLC) for the use of its attorneys and its clients; it is not an official document of the House of Representatives or its committees and may not be cited as "the law". HOLC welcomes any corrections or suggestions to this document; these should be emailed to edward.grossman@mail.house.gov*.]

(b) TABLE OF CONTENTS.—The table of contents of this Act is as follows:

Subtitle E—Affordable Coverage Choices for All Americans

PART I—PREMIUM TAX CREDITS AND COST-SHARING REDUCTIONS

Subpart A—Premium Tax Credits and Cost-sharing Reductions

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

(a) IN GENERAL.—Subpart C of part IV of subchapter A of chapter 1 of the Internal Revenue Code of 1986 (relating to refundable credits) is amended by inserting after section 36A the following new section:

"SEC. 36B. REFUNDABLE CREDIT FOR COVERAGE UNDER A QUALIFIED HEALTH PLAN.

"(a) IN GENERAL.—In the case of an applicable taxpayer, there shall be allowed as a credit against the tax imposed by this subtitle for any taxable year an amount equal to the premium assistance credit amount of the taxpayer for the taxable year.

"(b) PREMIUM ASSISTANCE CREDIT AMOUNT.—For purposes of this section—

"(1) IN GENERAL.—The term 'premium assistance credit amount' means, with respect to any taxable year, the sum of the premium assistance amounts determined under paragraph (2) with respect to all coverage months of the taxpayer occurring during the taxable year.

"(2) PREMIUM ASSISTANCE AMOUNT.—The premium assistance amount determined under this subsection with respect to any coverage month is the amount equal to the lesser of—

"(A) the monthly premiums for such month for 1 or more qualified health plans offered in the individual market within a State which cover the taxpayer, the taxpayer's spouse, or any dependent (as defined in section 152) of the taxpayer and which were enrolled in through an Exchange established by the State under 1311 of the Patient Protection and Affordable Care Act, or

"(B) the excess (if any) of—

"(i) the adjusted monthly premium for such month for the applicable second lowest cost silver plan with respect to the taxpayer, over

"(ii) an amount equal to 1/12 of the product of the applicable percentage and the taxpayer's household income for the taxable year.

"(3) OTHER TERMS AND RULES RELATING TO PREMIUM ASSISTANCE AMOUNTS.—For purposes of paragraph (2)—

"(A) APPLICABLE PERCENTAGE.—

"(i) IN GENERAL.—[*As revised by section 1001(a)(1)(A) of HCERA*] Except as provided in clause (ii), the applicable percentage for any taxable year shall be the percentage such that the applicable percentage for any taxpayer whose household income

is within an income tier specified in the following table shall increase, on a sliding scale in a linear manner, from the initial premium percentage to the final premium percentage specified in such table for such income tier:

"In the case of household income (expressed as a percent of poverty line) within the following income tier:	The initial premium percentage is—	The final premium percentage is—
Up to 133%	2.0%	2.0%
133% up to 150%	3.0%	4.0%
150% up to 200%	4.0%	6.3%
200% up to 250%	6.3%	8.05%
250% up to 300%	8.05%	9.5%
300% up to 400%	9.5%	9.5%

"(ii) INDEXING.—[*As added by section 1001(a)(1)(B) of HCERA instead of clauses (ii) and (iii) previously here*]

"(I) IN GENERAL.—Subject to subclause (II), in the case of taxable years beginning in any calendar year after 2014, the initial and final applicable percentages under clause (i) (as in effect for the preceding calendar year after application of this clause) shall be adjusted to reflect the excess of the rate of premium growth for the preceding calendar year over the rate of income growth for the preceding calendar year.

"(II) ADDITIONAL ADJUSTMENT.—Except as provided in subclause (III), in the case of any calendar year after 2018, the percentages described in subclause (I) shall, in addition to the adjustment under subclause (I), be adjusted to reflect the excess (if any) of the rate of premium growth estimated under subclause (I) for the preceding calendar year over the rate of growth in the consumer price index for the preceding calendar year.

"(III) FAILSAFE.—Subclause (II) shall apply for any calendar year only if the aggregate amount of premium tax credits under this section and cost-sharing reductions under section 1402 of the Patient Protection and Affordable Care Act for the preceding calendar year exceeds an amount equal to 0.504 percent of the gross domestic product for the preceding calendar year.

"(B) APPLICABLE SECOND LOWEST COST SILVER PLAN.—The applicable second lowest cost silver plan with respect to any applicable taxpayer is the second lowest cost silver plan of the individual market in the rating area in which the taxpayer resides which—

"(i) is offered through the same Exchange through which the qualified health plans taken into account under paragraph (2)(A) were offered, and

"(ii) provides—

"(I) self-only coverage in the case of an applicable taxpayer—

"(aa) whose tax for the taxable year is determined under section 1(c) (relating to unmarried individuals other than surviving spouses and heads of households) and who is not allowed a deduction under section 151 for the taxable year with respect to a dependent, or

"(bb) who is not described in item (aa) but who purchases only self-only coverage, and

"(II) family coverage in the case of any other applicable taxpayer.

If a taxpayer files a joint return and no credit is allowed under this section with respect to 1 of the spouses by reason of subsection (e), the taxpayer shall be treated as described in clause (ii)(I) unless a deduction is allowed under section 151 for the taxable year with respect to a dependent other than either spouse and subsection (e) does not apply to the dependent.

"(C) ADJUSTED MONTHLY PREMIUM.—The adjusted monthly premium for an applicable second lowest cost silver plan is the monthly premium which would have been charged (for the rating area with respect to which the premiums under paragraph (2)(A) were determined) for the plan if each individual covered under a qualified health plan taken into account under paragraph (2)(A) were covered by such silver plan and the premium was adjusted only for the age of each such individual in the manner allowed under section 2701 of the Public Health Service Act. In the case of a State participating in the wellness discount demonstration project under section 2705(d) of the Public Health Service Act, the adjusted monthly premium shall be determined without regard to any premium discount or rebate under such project.

"(D) ADDITIONAL BENEFITS.—If—

"(i) a qualified health plan under section 1302(b)(5) of the Patient Protection and Affordable Care Act offers benefits in addition to the essential health benefits required to be provided by the plan, or

"(ii) a State requires a qualified health plan under section 1311(d)(3)(B) of such Act to cover benefits in addition to the essential health benefits required to be provided by the plan,

the portion of the premium for the plan properly allocable (under rules prescribed by the Secretary of Health and Human Services) to such additional benefits shall not be taken into account in determining either the monthly premium or the adjusted monthly premium under paragraph (2).

"(E) SPECIAL RULE FOR PEDIATRIC DENTAL COVERAGE.—For purposes of determining the amount of any monthly premium, if an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) of the Patient Protection and Affordable Care Act for any plan year, the portion of the premium for the plan described in such section that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required

to be provided by a qualified health plan under section 1302(b)(1)(J) of such Act shall be treated as a premium payable for a qualified health plan.

"(c) DEFINITION AND RULES RELATING TO APPLICABLE TAXPAYERS, COVERAGE MONTHS, AND QUALIFIED HEALTH PLAN.—For purposes of this section—

"(1) APPLICABLE TAXPAYER.—

"(A) IN GENERAL.—**[***As revised by section 10105(b)***]** The term 'applicable taxpayer' means, with respect to any taxable year, a taxpayer whose household income for the taxable year equals or exceeds 100 percent but does not exceed 400 percent of an amount equal to the poverty line for a family of the size involved.

"(B) SPECIAL RULE FOR CERTAIN INDIVIDUALS LAWFULLY PRESENT IN THE UNITED STATES.—If—

"(i) a taxpayer has a household income which is not greater than 100 percent of an amount equal to the poverty line for a family of the size involved, and

"(ii) the taxpayer is an alien lawfully present in the United States, but is not eligible for the medicaid program under title XIX of the Social Security Act by reason of such alien status,

the taxpayer shall, for purposes of the credit under this section, be treated as an applicable taxpayer with a household income which is equal to 100 percent of the poverty line for a family of the size involved.

"(C) MARRIED COUPLES MUST FILE JOINT RETURN.—If the taxpayer is married (within the meaning of section 7703) at the close of the taxable year, the taxpayer shall be treated as an applicable taxpayer only if the taxpayer and the taxpayer's spouse file a joint return for the taxable year.

"(D) DENIAL OF CREDIT TO DEPENDENTS.—No credit shall be allowed under this section to any individual with respect to whom a deduction under section 151 is allowable to another taxpayer for a taxable year beginning in the calendar year in which such individual's taxable year begins.

"(2) COVERAGE MONTH.—For purposes of this subsection—

"(A) IN GENERAL.—The term 'coverage month' means, with respect to an applicable taxpayer, any month if—

"(i) as of the first day of such month the taxpayer, the taxpayer's spouse, or any dependent of the taxpayer is covered by a qualified health plan described in subsection (b)(2)(A) that was enrolled in through an Exchange established by the State under section 1311 of the Patient Protection and Affordable Care Act, and

"(ii) the premium for coverage under such plan for such month is paid by the taxpayer (or through advance payment of the credit under subsection (a) under section 1412 of the Patient Protection and Affordable Care Act).

"(B) EXCEPTION FOR MINIMUM ESSENTIAL COVERAGE.—

"(i) IN GENERAL.—The term 'coverage month' shall not include any month with respect to an individual if for such month the individual is eligible for minimum essential coverage other than eligibility for coverage

described in section 5000A(f)(1)(C) (relating to coverage in the individual market).

"(ii) MINIMUM ESSENTIAL COVERAGE.—The term 'minimum essential coverage' has the meaning given such term by section 5000A(f).

"(C) SPECIAL RULE FOR EMPLOYER-SPONSORED MINIMUM ESSENTIAL COVERAGE.—For purposes of subparagraph (B)—

"(i) COVERAGE MUST BE AFFORDABLE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage—

"(I) consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)), and

"(II) the employee's required contribution (within the meaning of section 5000A(e)(1)(B)) with respect to the plan exceeds 9.5 percent of the applicable taxpayer's household income. **[***As revised by section 1001(a)(2)(A) of HCERA***]**

This clause shall also apply to an individual who is eligible to enroll in the plan by reason of a relationship the individual bears to the employee.

"(ii) COVERAGE MUST PROVIDE MINIMUM VALUE.—Except as provided in clause (iii), an employee shall not be treated as eligible for minimum essential coverage if such coverage consists of an eligible employer-sponsored plan (as defined in section 5000A(f)(2)) and the plan's share of the total allowed costs of benefits provided under the plan is less than 60 percent of such costs.

"(iii) EMPLOYEE OR FAMILY MUST NOT BE COVERED UNDER EMPLOYER PLAN.—Clauses (i) and (ii) shall not apply if the employee (or any individual described in the last sentence of clause (i)) is covered under the eligible employer-sponsored plan or the grandfathered health plan.

"(iv) INDEXING.—**[***As revised by section 10105(c) and sections 1001(a)(2)(A) and (B) of HCERA***]** In the case of plan years beginning in any calendar year after 2014, the Secretary shall adjust the 9.5 percent under clause (i)(II) in the same manner as the percentages are adjusted under subsection (b)(3)(A)(ii).

"(D) EXCEPTION FOR INDIVIDUAL RECEIVING FREE CHOICE VOUCHERS.—**[***As added by section 10107(h)(1), effective for taxable year beginning after December 31, 2013***]** The term 'coverage month' shall not include any month in which such individual has a free choice voucher provided under section 10108 of the Patient Protection and Affordable Care Act.

"(3) DEFINITIONS AND OTHER RULES.—

"(A) QUALIFIED HEALTH PLAN.—The term 'qualified health plan' has the meaning given such term by section 1301(a) of the Patient Protection and Affordable Care Act, except that such term shall not include a qualified health plan which is a catastrophic plan described in section 1302(e) of such Act.

"(B) GRANDFATHERED HEALTH PLAN.—The term 'grandfathered health plan' has the meaning given such term

by section 1251 of the Patient Protection and Affordable Care Act.

"(d) TERMS RELATING TO INCOME AND FAMILIES.—For purposes of this section—

"(1) FAMILY SIZE.—The family size involved with respect to any taxpayer shall be equal to the number of individuals for whom the taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year.

"(2) HOUSEHOLD INCOME.—

"(A) HOUSEHOLD INCOME.—The term 'household income' means, with respect to any taxpayer, an amount equal to the sum of—**[***Clauses (i) and (ii) revised by section 1004(a)(1)(A) of HCERA***]**

"(i) the modified adjusted gross income of the taxpayer, plus

"(ii) the aggregate modified adjusted gross incomes of all other individuals who—

"(I) were taken into account in determining the taxpayer's family size under paragraph (1), and

"(II) were required to file a return of tax imposed by section 1 for the taxable year.

"(B) MODIFIED ADJUSTED GROSS INCOME.—**[***Replaced by section 1004(a)(2) of HCERA***]** The term 'modified adjusted gross income' means adjusted gross income increased by—

"(i) any amount excluded from gross income under section 911, and

"(ii) any amount of interest received or accrued by the taxpayer during the taxable year which is exempt from tax.

"(3) POVERTY LINE.—

"(A) IN GENERAL.—The term 'poverty line' has the meaning given that term in section 2110(c)(5) of the Social Security Act (42 U.S.C. 1397jj(c)(5)).

"(B) POVERTY LINE USED.—In the case of any qualified health plan offered through an Exchange for coverage during a taxable year beginning in a calendar year, the poverty line used shall be the most recently published poverty line as of the 1st day of the regular enrollment period for coverage during such calendar year.

"(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

"(1) IN GENERAL.—If 1 or more individuals for whom a taxpayer is allowed a deduction under section 151 (relating to allowance of deduction for personal exemptions) for the taxable year (including the taxpayer or his spouse) are individuals who are not lawfully present—

"(A) the aggregate amount of premiums otherwise taken into account under clauses (i) and (ii) of subsection (b)(2)(A) shall be reduced by the portion (if any) of such premiums which is attributable to such individuals, and

"(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

"(i) A method under which—

"(I) the taxpayer's family size is determined by not taking such individuals into account, and

"(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

"(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

"(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

"(ii) A comparable method reaching the same result as the method under clause (i).

"(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the credit under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

"(3) SECRETARIAL AUTHORITY.—The Secretary of Health and Human Services, in consultation with the Secretary, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans through an Exchange and taxpayers eligible for the credit allowable under this section.

"(f) RECONCILIATION OF CREDIT AND ADVANCE CREDIT.—

"(1) IN GENERAL.—The amount of the credit allowed under this section for any taxable year shall be reduced (but not below zero) by the amount of any advance payment of such credit under section 1412 of the Patient Protection and Affordable Care Act.

"(2) EXCESS ADVANCE PAYMENTS.—

"(A) IN GENERAL.—If the advance payments to a taxpayer under section 1412 of the Patient Protection and Affordable Care Act for a taxable year exceed the credit allowed by this section (determined without regard to paragraph (1)), the tax imposed by this chapter for the taxable year shall be increased by the amount of such excess.

"(B) LIMITATION ON INCREASE WHERE INCOME LESS THAN 400 PERCENT OF POVERTY LINE.—

"(i) IN GENERAL.—In the case of an applicable taxpayer whose household income is less than 400 percent of the poverty line for the size of the family involved for the taxable year, the amount of the increase under subparagraph (A) shall in no event exceed $400 ($250 in the case of a taxpayer whose tax is determined under section 1(c) for the taxable year).

"(ii) INDEXING OF AMOUNT.—In the case of any calendar year beginning after 2014, each of the dollar amounts under clause (i) shall be increased by an amount equal to—

"(I) such dollar amount, multiplied by

"(II) the cost-of-living adjustment determined under section 1(f)(3) for the calendar year, determined by substituting 'calendar year 2013' for 'calendar year 1992' in subparagraph (B) thereof.

"(3) INFORMATION REQUIREMENT.—[*As revised by section 1004(c) of HCERA*] Each Exchange (or any person carrying out 1 or more responsibilities of an Exchange under section 1311(f)(3) or 1321(c) of the Patient Protection and Affordable Care Act) shall provide the following information to the Secretary and to the taxpayer with respect to any health plan provided through the Exchange:

"(A) The level of coverage described in section 1302(d) of the Patient Protection and Affordable Care Act and the period such coverage was in effect.

"(B) The total premium for the coverage without regard to the credit under this section or cost-sharing reductions under section 1402 of such Act.

"(C) The aggregate amount of any advance payment of such credit or reductions under section 1412 of such Act.

"(D) The name, address, and TIN of the primary insured and the name and TIN of each other individual obtaining coverage under the policy.

"(E) Any information provided to the Exchange, including any change of circumstances, necessary to determine eligibility for, and the amount of, such credit.

"(F) Information necessary to determine whether a taxpayer has received excess advance payments.

If the amount of any increase under clause (i) is not a multiple of $50, such increase shall be rounded to the next lowest multiple of $50.

"(g) REGULATIONS.—The Secretary shall prescribe such regulations as may be necessary to carry out the provisions of this section, including regulations which provide for—

"(1) the coordination of the credit allowed under this section with the program for advance payment of the credit under section 1412 of the Patient Protection and Affordable Care Act, and

"(2) the application of subsection (f) where the filing status of the taxpayer for a taxable year is different from such status used for determining the advance payment of the credit.".

(b) DISALLOWANCE OF DEDUCTION.—Section 280C of the Internal Revenue Code of 1986 is amended by adding at the end the following new subsection:

"(g) CREDIT FOR HEALTH INSURANCE PREMIUMS.—No deduction shall be allowed for the portion of the premiums paid by the taxpayer for coverage of 1 or more individuals under a qualified health plan which is equal to the amount of the credit determined for the taxable year under section 36B(a) with respect to such premiums.".

(c) STUDY ON AFFORDABLE COVERAGE.—

(1) STUDY AND REPORT.—

(A) IN GENERAL.—Not later than 5 years after the date of the enactment of this Act, the Comptroller General shall conduct a study on the affordability of health insurance coverage, including—

(i) the impact of the tax credit for qualified health insurance coverage of individuals under section 36B of the Internal Revenue Code of 1986 and the tax credit for employee health insurance expenses of small employers under section 45R of such Code on maintaining and expanding the health insurance coverage of individuals;

(ii) the availability of affordable health benefits plans, including a study of whether the percentage of household income used for purposes of section 36B(c)(2)(C) of the Internal Revenue Code of 1986 (as added by this section) is the appropriate level for determining whether employer-provided coverage is affordable for an employee and whether such level may be lowered without significantly increasing the costs to the Federal Government and reducing employer-provided coverage; and

(iii) the ability of individuals to maintain essential health benefits coverage (as defined in section 5000A(f) of the Internal Revenue Code of 1986).

(B) REPORT.—The Comptroller General shall submit to the appropriate committees of Congress a report on the study conducted under subparagraph (A), together with legislative recommendations relating to the matters studied under such subparagraph.

(2) APPROPRIATE COMMITTEES OF CONGRESS.—In this subsection, the term "appropriate committees of Congress" means the Committee on Ways and Means, the Committee on Education and Labor, and the Committee on Energy and Commerce of the House of Representatives and the Committee on Finance and the Committee on Health, Education, Labor and Pensions of the Senate.

(d) CONFORMING AMENDMENTS.—

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

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

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

(3) **[***As revised by section 10105(d)***]** Section 6211(b)(4)(A) of the Internal Revenue Code of 1986 is amended by inserting "36B," after "36A,".

(e) EFFECTIVE DATE.—The amendments made by this section shall apply to taxable years ending after December 31, 2013.

SEC. 1402. REDUCED COST-SHARING FOR INDIVIDUALS ENROLLING IN QUALIFIED HEALTH PLANS.

(a) IN GENERAL.—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).

(b) ELIGIBLE INSURED.—In this section, the term "eligible insured" means an individual—

(1) who enrolls in a qualified health plan in the silver level of coverage in the individual market offered through an Exchange; and

(2) whose household income exceeds 100 percent but does not exceed 400 percent of the poverty line for a family of the size involved.

In the case of an individual described in section 36B(c)(1)(B) of the Internal Revenue Code of 1986, the individual shall be treated as having household income equal to 100 percent for purposes of applying this section.

(c) DETERMINATION OF REDUCTION IN COST-SHARING.—

(1) REDUCTION IN OUT-OF-POCKET LIMIT.—

(A) IN GENERAL.—The reduction in cost-sharing under this subsection shall first be achieved by reducing the applicable out-of pocket limit under section 1302(c)(1) in the case of—

(i) an eligible insured whose household income is more than 100 percent but not more than 200 percent of the poverty line for a family of the size involved, by two-thirds;

(ii) an eligible insured whose household income is more than 200 percent but not more than 300 percent of the poverty line for a family of the size involved, by one-half; and

(iii) an eligible insured whose household income is more than 300 percent but not more than 400 percent of the poverty line for a family of the size involved, by one-third.

(B) COORDINATION WITH ACTUARIAL VALUE LIMITS.—

(i) IN GENERAL.—The Secretary shall ensure the reduction under this paragraph shall not result in an increase in the plan's share of the total allowed costs of benefits provided under the plan above—

(I) 94 percent in the case of an eligible insured described in paragraph (2)(A); ⟦*As revised by section 1001(b)(1)(A) of HCERA*⟧

(II) 87 percent in the case of an eligible insured described in paragraph (2)(B);

⟦*section 1001(a)(1)(C) of HCERA struck subclause (III) and inserted new subclauses (III) and (IV)*⟧

(III) 73 percent in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved; and

(IV) 70 percent in the case of an eligible insured whose household income is more than 250 percent but not more than 400 percent of the poverty line for a family of the size involved.

(ii) ADJUSTMENT.—The Secretary shall adjust the out-of pocket limits under paragraph (1) if necessary to ensure that such limits do not cause the respective actuarial values to exceed the levels specified in clause (i).

(2) ADDITIONAL REDUCTION FOR LOWER INCOME INSUREDS.—The Secretary shall establish procedures under which the issuer of a qualified health plan to which this section applies shall

further reduce cost-sharing under the plan in a manner sufficient to—

(A) in the case of an eligible insured whose household income is not less than 100 percent but not more than 150 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 94 percent of such costs; ⟦*As revised by section 1001(a)(2)(A) of HCERA*⟧

(B) in the case of an eligible insured whose household income is more than 150 percent but not more than 200 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 87 percent of such costs; and ⟦*As revised by section 1001(a)(2)(B) of HCERA*⟧

(C) in the case of an eligible insured whose household income is more than 200 percent but not more than 250 percent of the poverty line for a family of the size involved, increase the plan's share of the total allowed costs of benefits provided under the plan to 73 percent of such costs. ⟦*As added by section 1001(a)(2)(C) of HCERA*⟧

(3) METHODS FOR REDUCING COST-SHARING.—

(A) IN GENERAL.—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.

(B) CAPITATED PAYMENTS.—The Secretary may establish a capitated payment system to carry out the payment of cost-sharing reductions under this section. Any such system shall take into account the value of the reductions and make appropriate risk adjustments to such payments.

(4) ADDITIONAL BENEFITS.—If a qualified health plan under section 1302(b)(5) offers benefits in addition to the essential health benefits required to be provided by the plan, or a State requires a qualified health plan under section 1311(d)(3)(B) to cover benefits in addition to the essential health benefits required to be provided by the plan, the reductions in cost-sharing under this section shall not apply to such additional benefits.

(5) SPECIAL RULE FOR PEDIATRIC DENTAL PLANS.—If an individual enrolls in both a qualified health plan and a plan described in section 1311(d)(2)(B)(ii)(I) for any plan year, subsection (a) shall not apply to that portion of any reduction in cost-sharing under subsection (c) that (under regulations prescribed by the Secretary) is properly allocable to pediatric dental benefits which are included in the essential health benefits required to be provided by a qualified health plan under section 1302(b)(1)(J).

(d) SPECIAL RULES FOR INDIANS.—

(1) INDIANS UNDER 300 PERCENT OF POVERTY.—If an individual enrolled in any qualified health plan in the individual market through an Exchange is an Indian (as defined in section 4(d) of the Indian Self-Determination and Education Assistance Act (25 U.S.C. 450b(d))) whose household income is not more than 300 percent of the poverty line for a family of the size involved, then, for purposes of this section—

(A) such individual shall be treated as an eligible insured; and

(B) the issuer of the plan shall eliminate any cost-sharing under the plan.

(2) ITEMS OR SERVICES FURNISHED THROUGH INDIAN HEALTH PROVIDERS.—If an Indian (as so defined) enrolled in a qualified health plan is furnished an item or service directly by the Indian Health Service, an Indian Tribe, Tribal Organization, or Urban Indian Organization or through referral under contract health services—

(A) no cost-sharing under the plan shall be imposed under the plan for such item or service; and

(B) the issuer of the plan shall not reduce the payment to any such entity for such item or service by the amount of any cost-sharing that would be due from the Indian but for subparagraph (A).

(3) PAYMENT.—The Secretary shall pay to the issuer of a qualified health plan the amount necessary to reflect the increase in actuarial value of the plan required by reason of this subsection.

(e) RULES FOR INDIVIDUALS NOT LAWFULLY PRESENT.—

(1) IN GENERAL.—If an individual who is an eligible insured is not lawfully present—

(A) no cost-sharing reduction under this section shall apply with respect to the individual; and

(B) for purposes of applying this section, the determination as to what percentage a taxpayer's household income bears to the poverty level for a family of the size involved shall be made under one of the following methods:

(i) A method under which—

(I) the taxpayer's family size is determined by not taking such individuals into account, and

(II) the taxpayer's household income is equal to the product of the taxpayer's household income (determined without regard to this subsection) and a fraction—

(aa) the numerator of which is the poverty line for the taxpayer's family size determined after application of subclause (I), and

(bb) the denominator of which is the poverty line for the taxpayer's family size determined without regard to subclause (I).

(ii) A comparable method reaching the same result as the method under clause (i).

(2) LAWFULLY PRESENT.—For purposes of this section, an individual shall be treated as lawfully present only if the individual is, and is reasonably expected to be for the entire period of enrollment for which the cost-sharing reduction under this section is being claimed, a citizen or national of the United States or an alien lawfully present in the United States.

(3) SECRETARIAL AUTHORITY.—The Secretary, in consultation with the Secretary of the Treasury, shall prescribe rules setting forth the methods by which calculations of family size and household income are made for purposes of this subsection. Such rules shall be designed to ensure that the least burden is placed on individuals enrolling in qualified health plans

through an Exchange and taxpayers eligible for the credit allowable under this section.

(f) DEFINITIONS AND SPECIAL RULES.—In this section:

(1) IN GENERAL.—Any term used in this section which is also used in section 36B of the Internal Revenue Code of 1986 shall have the meaning given such term by such section.

(2) LIMITATIONS ON REDUCTION.—No cost-sharing reduction shall be allowed under this section with respect to coverage for any month unless the month is a coverage month with respect to which a credit is allowed to the insured (or an applicable taxpayer on behalf of the insured) under section 36B of such Code.

(3) DATA USED FOR ELIGIBILITY.—Any determination under this section shall be made on the basis of the taxable year for which the advance determination is made under section 1412 and not the taxable year for which the credit under section 36B of such Code is allowed.

Subpart B—Eligibility Determinations

SEC. 1411. PROCEDURES FOR DETERMINING ELIGIBILITY FOR EXCHANGE PARTICIPATION, PREMIUM TAX CREDITS AND REDUCED COST-SHARING, AND INDIVIDUAL RESPONSIBILITY EXEMPTIONS.

(a) ESTABLISHMENT OF PROGRAM.—The Secretary shall establish a program meeting the requirements of this section for determining—

(1) whether an individual who is to be covered in the individual market by a qualified health plan offered through an Exchange, or who is claiming a premium tax credit or reduced cost-sharing, meets the requirements of sections 1312(f)(3), 1402(e), and 1412(d) of this title and section 36B(e) of the Internal Revenue Code of 1986 that the individual be a citizen or national of the United States or an alien lawfully present in the United States;

(2) in the case of an individual claiming a premium tax credit or reduced cost-sharing under section 36B of such Code or section 1402—

(A) whether the individual meets the income and coverage requirements of such sections; and

(B) the amount of the tax credit or reduced cost-sharing;

(3) whether an individual's coverage under an employer-sponsored health benefits plan is treated as unaffordable under sections 36B(c)(2)(C) and 5000A(e)(2); and

(4) whether to grant a certification under section 1311(d)(4)(H) attesting that, for purposes of the individual responsibility requirement under section 5000A of the Internal Revenue Code of 1986, an individual is entitled to an exemption from either the individual responsibility requirement or the penalty imposed by such section.

(b) INFORMATION REQUIRED TO BE PROVIDED BY APPLICANTS.—

(1) IN GENERAL.—An applicant for enrollment in a qualified health plan offered through an Exchange in the individual market shall provide—

APPELLANT'S ADDENDUM

In the United States Court of Federal Claims

No. 18-136C

SANFORD HEALTH PLAN

Plaintiff

v **JUDGMENT**

THE UNITED STATES

Defendant

Pursuant to the court's Order, filed October 11, 2018, denying defendant's motion to dismiss and granting plaintiff's cross-motion for summary judgment,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiff recover of and from the United States the total amount of $360,254.00. Costs are awarded to plaintiff.

Lisa L. Reyes
Clerk of Court

October 17, 2018 s/Anthony Curry

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.

In the United States Court of Federal Claims

No. 18-136C
(Filed: October 11, 2018)

SANFORD HEALTH PLAN, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Keywords: Affordable Care Act; Cost-Sharing Reductions; Moda Health Plan; Montana Health; Statutory Obligation; Appropriations; Budgetary Authority.

Stephen McBrady, Crowell & Moring LLP, Washington, D.C., for Plaintiff. *Daniel Wolff*, *Xavier Baker*, *Skye Mathieson*, and *Monica Sterling*, Crowell & Moring LLP, Washington, D.C., Of Counsel.

Christopher J. Carney, Senior Litigation Counsel, Commercial Litigation Branch, Civil Division, U.S. Department of Justice, Washington, D.C., for Defendant, with whom were *Claudia Burke*, Assistant Director, *Robert E. Kirschman, Jr.*, Director, and *Chad A. Readler*, Acting Assistant Attorney General. *Eric E. Laufgraben*, *Veronica N. Onyema*, Trial Attorneys, U.S. Department of Justice, Of Counsel.

OPINION AND ORDER

KAPLAN, Judge.

This case arises out of a complaint filed by plaintiff Sanford Health Plan ("Sanford"), a health insurer that sells qualified health plans on health care exchanges established by the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified primarily in scattered sections of 42 U.S.C.). In its complaint Sanford alleges that it is owed some $1.6 million by the federal government, representing cost-sharing reduction payments it claims it was entitled to receive during 2017 under the cost-sharing reduction provision of the ACA, 42 U.S.C. § 18071.

Currently before the Court is the government's motion to dismiss Sanford's complaint and Sanford's cross-motion for summary judgment as to liability. The government argues that Sanford has failed to state a claim because Congress did not appropriate funds to make the cost-sharing reduction payments, which it says reflects that Congress never intended to create an enforceable obligation for such payments. Sanford, on the other hand, argues that the ACA created a mandatory obligation on the part of the government to make payments to insurers who implement cost-sharing reductions under the ACA, irrespective of Congress's failure to appropriate the funds necessary to do so.

For the reasons set forth below, the Court concludes that the government violated a statutory obligation created by Congress in the ACA when it failed to provide Sanford its full cost-sharing reduction payments for 2017, and that Congress's failure to appropriate funds to make those payments did not vitiate that obligation. Accordingly, the government's motion to dismiss is **DENIED** and Sanford's cross-motion for summary judgment is **GRANTED**.

BACKGROUND

I. Statutory Framework

In 2010, Congress passed and President Obama signed the ACA. As a result of the ACA, "health benefit exchanges" were established nationwide. The exchanges serve as "virtual marketplaces in each state wherein individuals and small groups [can] purchase health coverage." Moda Health Plan, Inc. v. United States, 892 F.3d 1311, 1314 (Fed. Cir. 2018); see also 42 U.S.C. § 18031(b)(1).

As pertinent to this case, the ACA implemented two reforms aimed at ensuring that plans offered on the exchanges would be affordable. The first is a premium tax credit, which was effected by amending the Internal Revenue Code to add a new provision. See ACA § 1401, 26 U.S.C. § 36B. It is a refundable tax credit that subsidizes health insurance premiums for taxpayers with household incomes that fall between 100 and 400 percent of federal poverty levels. 26 U.S.C. § 36B(c)(1)(A). The amount of the tax credit can be based on, among other things, the enrollee's income and the price of the second-lowest cost "silver" plan available on the enrollee's exchange. See id. § 36B(b)(2).[1] Under the ACA, the tax credit is estimated and paid in advance directly to the insurer, so that the enrollee's insurance premiums are reduced. See ACA § 1412(a), 42 U.S.C. § 18082(a); see also 26 U.S.C. § 36B(f).

The second relevant ACA reform is the cost-sharing reduction (CSR) requirement imposed on issuers of certain qualified health plans. ACA § 1402, 42 U.S.C. § 18071. Enrollees eligible for cost-sharing reductions under the ACA are those who enroll in qualified plans at the silver level and whose household income is between 100 and 400 percent of applicable federal poverty levels. 42 U.S.C. § 18071(b). Pursuant to the cost-sharing reduction requirement, insurers offering health plans on the exchanges must reduce these enrollees' out-of-pocket costs for "deductibles, coinsurance, copayments, or similar charges" by a specified amount. Id. § 18071(a)(2); id. § 18022(c)(3)(A).

As pertinent to this case, the ACA, in turn, provides a mechanism to compensate insurers for the cost of making these reductions. It states that insurers "shall notify the Secretary [of Health and Human Services] of such reductions" and that "the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." Id. § 18071(c)(3)(A).

[1] Insurance plans offered on the exchanges are classified into four levels: platinum, gold, silver, and bronze. 42 U.S.C. § 18022(d)(1). The classifications are based on the percentage of an enrollee's health care costs that the issuer of the plan will pay. Id.

The Department of Health and Human Services has promulgated regulations to carry out the cost-sharing reduction provisions. They provide, in pertinent part, that the "issuer must ensure that an individual eligible for cost-sharing reductions . . . pays only the cost sharing required of an eligible individual for the applicable covered service." 45 C.F.R. § 156.410(a). In addition, "[t]he cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected." Id. With respect to the compensation of insurers that provide CSRs, the regulations specify that such insurers "will receive periodic advance payments based on the advance payment amounts calculated in accordance" with a regulatory formula. Id. § 156.430(b)(1).[2]

II. The Genesis of the Current Dispute

Under the ACA, the state and federal insurance exchanges were to be established no later than January 1, 2014. See 42 U.S.C. § 18031(b)(1). In anticipation of that deadline, in its fiscal 2014 budget (submitted in April 2013), the Obama Administration proposed the appropriation of "such sums as necessary" for, among other things, "carrying out . . . section[] 1402" of the ACA. U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 172 (D.D.C. 2016) (Burwell II) (quoting App. to Fiscal Year 2014 Budget of the U.S. Gov't at 448).[3]

On July 11, 2013, the Senate Appropriations Committee adopted S. 1284, a bill appropriating money for HHS and other agencies for FY 2014. See S. Rep. No. 113-71, at 1 (2013). In a report accompanying the bill, the Committee stated that its recommendation "d[id] not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the ACA." Id. at 123. No appropriation has since been enacted to cover the costs of CSR payments. See Burwell II, 185 F. Supp. 3d at 173–74.

Nonetheless, in January of 2014 (and continuing until October of 2017), HHS began making advance cost-sharing reduction payments to eligible insurers, funding them with money from the permanent appropriation for tax credit refunds in 31 U.S.C. § 1324. See id. at 174. According to arguments later made by the Obama Administration in litigation, this appropriation was "available to fund all components of the Act's integrated system of subsidies for the purchase of health insurance, including both the premium tax credit and cost-sharing portions of the advance payments required by the Act." Id. (quotation omitted).

Shortly thereafter, the U.S. House of Representatives brought suit in the U.S. District Court for the District of Columbia, complaining that HHS and the Department of Treasury had spent "billions of unappropriated dollars to support the Patient Protection and Affordable Care Act." U.S. House of Representatives v. Burwell, 130 F. Supp. 3d 53, 57 (D.D.C. 2015) (Burwell

[2] The regulations further provide that HHS will reconcile the amounts paid in advance and the actual cost-sharing reductions made. See 45 C.F.R. §§ 156.430(c), (d).

[3] The premium tax credits of § 1401 were not made subject to the annual appropriations process. Instead, the ACA added the tax credits to a preexisting permanent appropriation for tax refunds. ACA § 1401(d)(1); see also 31 U.S.C. § 1324(b)(2).

I). The House contended "that Section 1401 Premium Tax Credits are funded by a permanent appropriation in the Internal Revenue Code, whereas Section 1402 Cost–Sharing Offsets must be funded and re-funded by annual, current appropriations," and that "Congress has not, and never has, appropriated any funds (whether through temporary appropriations or permanent appropriations) to make any Section 1402 Offset Program payments to Insurers." Id. at 60. Therefore, the House argued, the use of funds appropriated for the premium tax credits to fund the cost-sharing reduction payments violated the Appropriations Clause of the U.S. Constitution (art. I, § 9, cl. 7). Id. at 69.

The district court agreed and issued an injunction against payment of the CSRs while there was no appropriation in place to fund them. Burwell II, 185 F. Supp. 3d at 189. The court, however, stayed the injunction pending appeal. Id. Subsequently, while the case was on appeal, members of the newly elected Trump Administration made public statements suggesting that it was reconsidering the Obama Administration's legal position and that it might withdraw the government's appeal. The House therefore sought and was granted a stay of the appeal by the D.C. Circuit. See U.S. House of Representatives v. Burwell, 676 F. App'x 1 (Mem.) (D.C. Cir. 2016) (Burwell III).

While that litigation was pending in the district court and the D.C. Circuit, HHS continued to make cost-sharing reduction payments to insurers using funds appropriated under 31 U.S.C. § 1324. On October 11, 2017, however, Attorney General Sessions sent a letter to the Secretary of Treasury and the acting Secretary of HHS, advising them that the Justice Department had concluded that § 1324 did not appropriate funds to make payments under the CSR program. Letter from Att'y Gen. Sessions to Sec'y Mnuchin & Acting Sec'y Wright (Oct. 11, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf; see also California v. Trump, 267 F. Supp. 3d 1119, 1125 (N.D. Cal. 2017). The next day, HHS's Acting Secretary issued a memorandum to the Centers for Medicare and Medicaid Services directing that, in light of the Attorney General's legal opinion "and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately." Memo from Acting Sec'y Hargan to Adm'r Verma (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

III. The Present Lawsuit

Shortly after HHS stopped making CSR payments, health insurance carriers—including the plaintiff in this case, Sanford—filed a series of lawsuits in the Court of Federal Claims. In these suits, the insurers seek monetary relief to compensate them for unpaid CSR payments to which they claim an entitlement under the ACA. See, e.g., Montana Health Co-op v. United States, No. 18-143C; Common Ground Healthcare Coop. v. United States, No. 17-877C; Maine Cmty. Health Options v. United States, No. 17-2057C.

Sanford, an issuer of qualified health plans that offers health insurance on the South Dakota, North Dakota, and Iowa exchanges, filed its complaint in the present case on January 26, 2018. Compl. ¶¶ 22–24, ECF No. 1. It alleges that, as required by the ACA, it provided cost-sharing reductions to eligible enrollees in its plans. See id. ¶¶ 47. It further alleges that notwithstanding the fact that it made these reductions, it did not receive any CSR payments for the last quarter of 2017 as a result of HHS's October 12, 2017 directive. Id. ¶¶ 40, 49. It requests

damages in the amount of $1,640,614 based on the government's alleged violation of Section 1402. Id. at 49.[4]

The government filed its motion to dismiss on May 29, 2018, arguing that Congress did not create "an unconditional entitlement to [CSR] payment[s]" and, therefore, CSR payments would only be made "to the extent appropriations are available." Mot. to Dismiss at 21, 23, ECF No. 8. On July 2, 2018, Sanford filed an opposition to the government's motion to dismiss and a cross-motion for summary judgment. See generally Pl.'s Cross-Mot. for Summ. J., Opp. to Def.'s Mot. to Dismiss, & Mem. of Law in Supp. ("Cross-Mot."), ECF No. 11.

In light of the Court's decision in Montana Health Co-op v. United States, No. 18-143C, 2018 WL 4203938 (Fed. Cl. Sept. 4, 2018), and pursuant to Rule 40.1(b) of the Rules of the Court of Federal Claims, the present case was transferred from Senior Judge Nancy B. Firestone to the undersigned on September 5, 2018. Order, Sept. 5, 2018, ECF No. 14.

The issues raised in the present case are identical to those raised in and decided in Montana Health. In addition, the parties are represented by the same counsel and have filed briefs that are almost identical to those filed in Montana Health. For those reasons, on September 6, 2018, the Court directed the parties to file a joint status report by October 4, 2018 providing guidance on how they wished to proceed. Order, Sept. 6, 2018, ECF No. 16.

The parties timely filed the requested status report, in which they informed the Court that oral argument was not necessary given the "substantially similar briefing, and [that] the attorneys are the same in both cases." Joint Status Report at 2, Oct. 4, 2018, ECF No. 17. The parties advised the Court that were it to adopt the ruling from Montana Health in the present case, "no further proceedings would be needed to determine the quantum due to Sanford Health." Id. They also stated that "[CMS] has reconciled the amounts it has paid to [QHP] issuers in advance CSR payments for benefit year 2017 against the amount of CSRs each respective issuer paid on behalf of its insureds for benefit year 2017." Id. Following this reconciliation, according to the joint status report, the amount the government would have owed Sanford is $360,254. Id.

DISCUSSION

I. Jurisdiction

Under the Tucker Act, the United States Court of Federal Claims has jurisdiction to "render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491(a)(1) (2012). The Tucker Act serves as a waiver of sovereign

[4] Sanford also claims that the government's failure to reimburse its cost-sharing reductions was a breach of an implied-in-fact contract in which the government agreed to make the cost-sharing reduction payments in exchange for Sanford's agreement to offer its plans on the ACA's exchanges. Compl. ¶¶ 51, 59. The Court does not reach this claim in light of its favorable disposition of Sanford's statutory claim.

immunity and a jurisdictional grant, but it does not create a substantive cause of action. Jan's Helicopter Serv., Inc. v. Fed. Aviation Admin., 525 F.3d 1299, 1306 (Fed. Cir. 2008). A plaintiff, therefore, must establish that "a separate source of substantive law . . . creates the right to money damages." Id. (quoting Fisher v. United States, 402 F.3d 1167, 1172 (Fed. Cir. 2005) (en banc in relevant part)).

"[A] statute is money-mandating for jurisdictional purposes if it 'can fairly be interpreted' to require payment of damages, or if it is 'reasonably amenable' to such a reading." Moda Health Plan, 892 F.3d at 1320 n.2 (quoting Greenlee Cty. v. United States, 487 F.3d 871, 877 (Fed. Cir. 2007)). In this case, § 1402 of the ACA states that insurers "shall notify the Secretary [of Health and Human Services] of [its 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) (emphasis supplied). The "use of the word 'shall' generally makes a statute money-mandating." Greenlee Cty., 487 F.3d at 877 (quoting Agwiak v. United States, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). Further, HHS's implementing regulations similarly state that insurers "will receive periodic advance payments based on the advance payment amounts calculated in accordance" with the regulatory formula. 45 C.F.R. § 156.430(b)(1) (emphasis supplied).

These provisions supply money-mandating sources of law for purposes of establishing this Court's Tucker Act jurisdiction. See Moda Health Plan, 892 F.3d at 1320–21 & n.2 (holding that § 1342 of the ACA, 42 U.S.C. § 18062, which states that "[t]he Secretary shall establish and administer" a risk corridors program and that "the Secretary shall pay" an amount according to a statutory formula under that program, is money mandating). Accordingly, this Court has jurisdiction under the Tucker Act over Sanford's claim for monetary relief under § 1402 of the ACA.[5]

II. Merits

The parties' cross-motions present a single, purely legal issue: whether the federal government had a statutory obligation to provide Sanford with the cost-sharing reduction payments described in § 1402 of the ACA, notwithstanding the lack of appropriations to fund such payments. Sanford contends that such an obligation was imposed by the plain language of § 1402. The government's central argument, on the other hand, is that Congress could not have intended to impose such an obligation because, while it made arrangements to fund the premium

[5] Although the government has not challenged this Court's jurisdiction over Sanford's claims, it suggests for the first time in its reply brief that those claims should be dismissed because § 1402 does not confer a cause of action for damages on plaintiffs where the failure to make CSR payments is based on a lack of appropriations. Def.'s Reply in Supp. of Its Mot. to Dismiss & Opp'n to Pl.'s Cross-Mot. for Summ. J. (Def.'s Reply) at 9, ECF No. 12. For the reasons set forth in Montana Health, this contention is inconsistent with this court's long-standing and well-established authority to entertain suits for money damages under the Tucker Act based on money-mandating statutes like the ACA. Montana Health, No. 18-143C, 2018 WL 4203938, at *4 (Fed. Cl. Sept. 4, 2018) (citing Moda Health Plan, 892 F.3d at 1320–21 & n.2). Therefore, the government's argument that Sanford's claims fail for lack of a cause of action is rejected.

tax credits of § 1401 through a permanent appropriation, it has never appropriated money to fund § 1402 payments, whether on a permanent or annual basis.

The determination of a statute's meaning begins (and often ends) with its language. Rosete v. Office of Pers. Mgmt., 48 F.3d 514, 517 (Fed. Cir. 1995); see also Star Athletica, L.L.C. v. Varsity Brands, Inc., 137 S. Ct. 1002, 1010 (2017) ("We thus begin and end our inquiry with the text, giving each word its ordinary, contemporary, common meaning." (quotation omitted)); McGee v. Peake, 511 F.3d 1352, 1356 (Fed. Cir. 2008). Where "Congress has expressed its intention by clear statutory language, that intention controls and must be given effect." Rosete, 48 F.3d at 517 (citing Chevron, U.S.A. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 843 n.9 (1984)). That is, where "statutory language is clear and unambiguous, the inquiry ends with the plain meaning." McGee, 511 F.3d at 1356 (quoting Myore v. Nicholson, 489 F.3d 1207, 1211 (Fed. Cir. 2007)).

In this case, the 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 ACA. It states that:

> 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) (emphasis supplied).

Notwithstanding the plain language of this provision (and HHS's implementing regulations), the government argues that § 1402 does not give rise to a statutory payment obligation because Congress has never appropriated funds to meet any such obligation. It contends that while "Congress has the power to make particular payments an 'obligation' of the government without regard to appropriations, or to vest an agency with budget authority in advance of appropriations," "in the limited circumstances where Congress intends to do so, it does so explicitly." Mot. to Dismiss at 17–18, ECF No. 8. For example, the government notes, in the Medicare Part D statute, Congress coupled a direction that the Secretary "shall provide for payment" of certain subsidies to insurers with a statement that the directive "constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section." Id. at 18 (quoting 42 U.S.C. § 1395w-115(a)). The government also argues that in previous cases where a payment obligation was found, Congress had explicitly characterized the payment as an "entitlement" in the statute. Id. at 21.

None of these arguments withstands scrutiny under controlling precedent, the most recent example of which is the court of appeals's decision in Moda Health Plan. In that case, the issue was whether § 1342 of the ACA imposed an obligation on the government to make payments to insurers under the ACA's risk corridors program. See 892 F.3d at 1314, 1320. The government argued in that case, as it does here, that notwithstanding § 1342's language (that the Secretary "shall pay" insurers), no payment obligation was created. Id. at 1321. It so argued because § 1342 "provided no budgetary authority to the Secretary of HHS and identified no source of

funds for any payment obligations beyond payments in," which were insufficient to fund the payments out in full. Id.

As the government concedes in its reply brief, "in Moda, the Federal Circuit concluded that the language in Section 1342 stating that the Secretary 'shall pay' certain amounts in accordance with a statutory formula initially created an obligation to make full risk-corridors payments without regard to appropriations or budget authority." Def.'s Reply at 5. Indeed, in Moda, the court of appeals found the language of § 1342 "unambiguously mandatory." 892 F.3d at 1320. Further, the court of appeals rejected an analogy drawn from the language in the Medicare Part D statute similar to the one the government draws in this case. See id. at 1322. The court of appeals found it "immaterial that Congress provided that the risk corridors program established by section 1342 would be 'based on the program' establishing risk corridors in Medicare Part D yet declined to provide 'budget authority in advance of appropriations acts,' as in the corresponding Medicare statute." Id. "Budget authority," it observed, "is not necessary to create an obligation of the government; it is a means by which an officer is afforded that authority." Id. In short, the court held, the obligation at issue was "created by the statute itself, not by the agency," and the government had provided "no authority for its contention that a statutory obligation cannot exist absent budget authority." Id. The court of appeals therefore "conclude[d] that the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." Id.

In a footnote in its reply brief, the government asserts that it disagrees "with this aspect of Moda's reasoning" and purports to "preserve the issue for further review." Def.'s Reply at 5 n.2. But the court of appeals broke no new ground in Moda when it held that the "shall pay" language of § 1342 created a statutory payment obligation and that the lack of appropriated funds was irrelevant to whether such an obligation was enforceable in this court. As it explained, "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances." Moda Health Plan, 892 F.3d at 1321. Thus, the court of appeals observed, its "predecessor court noted long ago that '[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties.'" Id. (quoting Ferris v. United States, 27 Ct. Cl. 542, 546 (1892)); see also Slattery v. United States, 635 F.3d 1298, 1303, 1321 (Fed. Cir. 2011) (en banc) (failure to appropriate funds did not absolve the government of its statutory obligation to pay amounts owed); Greenlee Cty., 487 F.3d at 877 (Congress's failure to appropriate funds does not "defeat a Government obligation created by statute" (quotation omitted)); N.Y. Airways, Inc. v. United States, 369 F.2d 743, 748 (Ct. Cl. 1966) ("It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute.").

To be sure, in Moda, the majority of the panel went on to address whether, notwithstanding the initial statutory obligation imposed by the ACA, Congress had capped the amount of payments the government was obligated to make under § 1324 through subsequent

specific appropriations riders. 892 F.3d at 1322–29.[6] The question before it, the court of appeals observed, was "whether [subsequent] riders on the CMS Program Management appropriations supplied the clear implication of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question, as in [United States v.]Mitchell, [109 U.S. 146 (1883)] or if Congress merely appropriated a less amount for the risk corridors program, as in [United States v.]Langston[, 118 U.S. 389 (1886)]." Id. at 1323.

The court of appeals's juxtaposition of Mitchell and Langston is instructive. In Mitchell, "the Supreme Court held that a statute that had set the salaries of certain interpreters at a fixed sum 'in full of all emoluments whatsoever' had been impliedly amended, where Congress appropriated funds less than the fixed sum set by statute, with a separate sum set aside for additional compensation at the discretion of the Secretary of the Interior." Id. (quoting Mitchell, 109 U.S. at 149). In Langston, on the other hand, the Supreme Court held that "a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation because it carried no implication of Congress's intent to amend or suspend the substantive law at issue." Id.

This case clearly falls into the same category as Langston, and is not at all like Mitchell. In this case, there was no relevant congressional action taken at all after the passage of the ACA. There have been no appropriations bills enacted that make reference to § 1402. All that exists is the payment obligation spelled out by the plain language of § 1402 and the "bare failure to appropriate funds" that the Supreme Court found insufficient to establish the congressional intent necessary to vitiate a statutory payment obligation in Langston. Id.; see also Butterbaugh v. Dep't of Justice, 336 F.3d 1332, 1342 (Fed. Cir. 2003) (observing that "congressional inaction is perhaps the weakest of all tools for ascertaining legislative intent").

Further, the Court finds unpersuasive the government's argument that "Congress made clear its intent not to fund CSR payments when it permanently appropriated funds for the only other statutory section appearing in the same subpart, while declining to do so for CSR payments." Def.'s Reply at 2 (emphasis in original). The most one can say about Congress's decision to permanently appropriate funds for the tax credits but not for CSR payments is that it reveals that Congress did not intend for CSR payments to be funded by permanent appropriations. Its failure to establish a permanent funding mechanism for the CSR payments does not, as the government would have it, give rise to the implausible inference that Congress intended "to consign CSRs 'to the fiscal limbo of an account due but not payable.'" Id. at 8 (quoting United States v. Will, 449 U.S. 200, 224 (1980)). To the contrary, the lack of a permanent funding mechanism suggests that when it enacted the ACA, Congress anticipated that the CSR payments it obligated the government to pay in § 1402 would ultimately be funded through the annual appropriations process. And, for the reasons set forth above, the Court cannot infer intent to vitiate the obligation imposed by § 1402 based solely on Congress's subsequent failure to make such appropriations.

[6] The plaintiffs in Moda have since petitioned for rehearing en banc as to that portion of the court of appeals's decision (as well as its rejection of their contract-based claims) and, at the court's request, the United States has responded to the petition. See Docket, Moda Health Plan, Inc. v. United States, No. 17-1994 (Fed. Cir.).

Finally, the government contends that "it is particularly implausible to conclude that Congress . . . intended to grant issuers a damages remedy" because issuers may be able to mitigate the lack of CSR payments by increasing the cost of their premiums. Id. at 10; see also California, 267 F. Supp. 3d at 1136 (observing that "[e]ven before the Administration announced its decision, 38 states accounted for the possible termination of CSR payments in setting their 2018 premium rates" and that more states began adopting premium increase strategies for 2018 after the announcement).[7] Of course, Sanford was unable to raise its premiums to make up for the shortfall in 2017, because by the time HHS issued its stop payment order, premiums for that year were set; in fact, the year was almost over. But in any event, even assuming that insurers could make up for the shortfall in CSR payments by raising their premiums, approval of premium rates is a matter for the states. There is no evidence in either the language of the ACA or its legislative history that Congress intended that the statutory obligation to make CSR payments should or would be subject to an offset based on an insurer's premium rates. The Court concludes, therefore, that premium rates have no bearing on whether § 1402 created a statutory obligation to pay insurers compensation for the cost-sharing reductions they implemented.

* * * * * * *

For the reasons set forth above, the government was statutorily obligated to provide Sanford with cost-sharing reduction payments for the remaining months of 2017. That obligation was not vitiated by Congress's failure to appropriate funds for that purpose. Accordingly, Sanford is entitled to judgment as to liability as a matter of law.

CONCLUSION

For the reasons set forth above, the government's motion to dismiss is **DENIED** and Sanford's cross-motion for summary judgment as to liability is **GRANTED**. The clerk is directed to enter final judgment in favor of plaintiff Sanford Health Plan in the amount of $360,254. Costs are awarded to Plaintiff.

[7] Judge Chhabria's opinion in California v. Trump includes an interesting discussion of the effect that these premium increases would have on the cost to enrollees on the exchanges. 267 F. Supp. 3d at 1133–38. Paradoxically, the majority of the participants in the exchanges (and particularly lower income participants) would actually pay less for their insurance coverage because the increases in premiums would lead to an increase in the premium tax credits to which they are entitled. Id.

IT IS SO ORDERED.

s/ Elaine D. Kaplan
ELAINE D. KAPLAN
Judge

In the United States Court of Federal Claims

No. 18-143 C

MONTANA HEALTH CO-OP

JUDGMENT

v.

THE UNITED STATES

Pursuant to the court's Order of October 5, 2018, and the court's Opinion and Order, filed September 4, 2018, denying defendant's motion to dismiss and granting plaintiff's cross-motion for summary judgment,

IT IS ORDERED AND ADJUDGED this date, pursuant to Rule 58, that plaintiff recover of and from the United States, the sum of $1,234,058.79. Costs are awarded to plaintiff.

Lisa L. Reyes
Clerk of Court

October 9, 2018 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.

In the United States Court of Federal Claims

No. 18-143C
(Filed: September 4, 2018)

MONTANA HEALTH CO-OP, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Keywords: Affordable Care Act; Cost-Sharing Reductions; Moda Health Plan; Statutory Obligation; Appropriations; Budgetary Authority.

Stephen McBrady, Crowell & Moring LLP, Washington, D.C., for Plaintiff. *Daniel Wolff*, *Skye Mathieson*, and *Monica Sterling*, Crowell & Moring LLP, Washington, D.C., and *John Morrison*, Morrison, Sherwood, Wilson, & Deola PLLP, Helena, MT, Of Counsel.

Christopher J. Carney, Senior Litigation Counsel, Commercial Litigation Branch, Civil Division, U.S. Department of Justice, Washington, D.C., for Defendant, with whom were *Claudia Burke*, Assistant Director, *Robert E. Kirschman, Jr.*, Director, and *Chad A. Readler*, Acting Assistant Attorney General. *Eric E. Laufgraben*, *Veronica N. Onyema*, Trial Attorneys, U.S. Department of Justice, Of Counsel.

OPINION AND ORDER

KAPLAN, Judge.

This case arises out of a complaint filed by plaintiff Montana Health Co-op, a health insurer that sells qualified health plans on health care exchanges established by the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010) (codified primarily in scattered sections of 42 U.S.C.). According to Montana Health, it is owed some $5 million by the federal government, representing cost-sharing reduction payments it claims it was entitled to receive during 2017 under the cost-sharing reduction provision of the ACA, 42 U.S.C. § 18071.

Currently before the Court is the government's motion to dismiss Montana Health's complaint and Montana Health's cross-motion for summary judgment as to liability. The government argues that Montana Health has failed to state a claim because Congress did not appropriate funds to make the cost-sharing reduction payments, which it says reflects that Congress never intended to create an enforceable obligation for such payments. Montana Health, on the other hand, argues that the ACA created a mandatory obligation on the part of the government to make payments to insurers who implement cost-sharing reductions under the ACA, irrespective of Congress's failure to appropriate the funds necessary to do so.

For the reasons set forth below, the Court concludes that Montana Health has the better of the arguments. It agrees that the government violated a statutory obligation created by Congress in the ACA when it failed to provide Montana Health its full cost-sharing reduction payments for 2017, and that Congress's failure to appropriate funds to make those payments did not vitiate that obligation. Accordingly, the government's motion to dismiss is **DENIED** and Montana Health's cross-motion for summary judgment is **GRANTED**.

BACKGROUND

I. Statutory Framework

In 2010, Congress passed and President Obama signed the ACA. As a result of the ACA, "health benefit exchanges" were established nationwide. The exchanges serve as "virtual marketplaces in each state wherein individuals and small groups [can] purchase health coverage." Moda Health Plan, Inc. v. United States, 892 F.3d 1311, 1314 (Fed. Cir. 2018); see also 42 U.S.C. § 18031(b)(1).

As pertinent to this case, the ACA implemented two reforms aimed at ensuring that plans offered on the exchanges would be affordable. The first is a premium tax credit, which was effected by amending the Internal Revenue Code to add a new provision. See ACA § 1401, 26 U.S.C. § 36B. It is a refundable tax credit that subsidizes health insurance premiums for taxpayers with household incomes that fall between 100 and 400 percent of federal poverty levels. 26 U.S.C. § 36B(c)(1)(A). The amount of the tax credit can be based on, among other things, the enrollee's income and the price of the second-lowest cost "silver" plan available on the enrollee's exchange. See id. § 36B(b)(2).[1] Under the ACA, the tax credit is estimated and paid in advance directly to the insurer, so that the enrollee's insurance premiums are reduced. See ACA § 1412(a), 42 U.S.C. § 18082(a); see also 26 U.S.C. § 36B(f).

The second relevant ACA reform is the cost-sharing reduction (CSR) requirement imposed on issuers of certain qualified health plans. ACA § 1402, 42 U.S.C. § 18071. Enrollees eligible for cost-sharing reductions under the ACA are those who enroll in qualified plans at the silver level and whose household income is between 100 and 400 percent of applicable federal poverty levels. 42 U.S.C. § 18071(b). Pursuant to the cost-sharing reduction requirement, insurers offering health plans on the exchanges must reduce these enrollees' out-of-pocket costs for "deductibles, coinsurance, copayments, or similar charges" by a specified amount. Id. § 18071(a)(2); id. § 18022(c)(3)(A).

As pertinent to this case, the ACA, in turn, provides a mechanism to compensate insurers for the cost of making these reductions. It states that insurers "shall notify the Secretary [of Health and Human Services] of such reductions" and that "the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." Id. § 18071(c)(3)(A).

[1] Insurance plans offered on the exchanges are classified into four levels: platinum, gold, silver, and bronze. 42 U.S.C. § 18022(d)(1). The classifications are based on the percentage of an enrollee's health care costs that the issuer of the plan will pay. Id.

The Department of Health and Human Services has promulgated regulations to carry out the cost-sharing reduction provisions. They provide, in pertinent part, that the "issuer must ensure that an individual eligible for cost-sharing reductions . . . pays only the cost sharing required of an eligible individual for the applicable covered service." 45 C.F.R. § 156.410(a). In addition, "[t]he cost-sharing reduction for which an individual is eligible must be applied when the cost sharing is collected." Id. With respect to the compensation of insurers that provide CSRs, the regulations specify that such insurers "will receive periodic advance payments based on the advance payment amounts calculated in accordance" with a regulatory formula. Id. § 156.430(b)(1).[2]

II. The Genesis of the Current Dispute

Under the ACA, the state and federal insurance exchanges were to be established no later than January 1, 2014. See 42 U.S.C. § 18031(b)(1). In anticipation of that deadline, in its fiscal 2014 budget (submitted in April 2013), the Obama Administration proposed the appropriation of "such sums as necessary" for, among other things, "carrying out . . . section[] 1402" of the ACA. U.S. House of Representatives v. Burwell, 185 F. Supp. 3d 165, 172 (D.D.C. 2016) (Burwell II) (quoting App. to Fiscal Year 2014 Budget of the U.S. Gov't at 448).[3]

On July 11, 2013, the Senate Appropriations Committee adopted S. 1284, a bill appropriating money for HHS and other agencies for FY 2014. See S. Rep. No. 113-71, at 1 (2013). In a report accompanying the bill, the Committee stated that its recommendation "d[id] not include a mandatory appropriation, requested by the administration, for reduced cost sharing assistance . . . as provided for in sections 1402 and 1412 of the ACA." Id. at 123. No appropriation has since been enacted to cover the costs of CSR payments. See Burwell II, 185 F. Supp. 3d at 173–74.

Nonetheless, in January of 2014 (and continuing until October of 2017), HHS began making advance cost-sharing reduction payments to eligible insurers, funding them with money from the permanent appropriation for tax credit refunds in 31 U.S.C. § 1324. See id. at 174. According to arguments later made by the Obama Administration in litigation, this appropriation was "available to fund all components of the Act's integrated system of subsidies for the purchase of health insurance, including both the premium tax credit and cost-sharing portions of the advance payments required by the Act." Id. (quotation omitted).

Shortly thereafter, the U.S. House of Representatives brought suit in the U.S. District Court for the District of Columbia, complaining that HHS and the Department of Treasury had spent "billions of unappropriated dollars to support the Patient Protection and Affordable Care Act." U.S. House of Representatives v. Burwell, 130 F. Supp. 3d 53, 57 (D.D.C. 2015) (Burwell

[2] The regulations further provide that HHS will reconcile the amounts paid in advance and the actual cost-sharing reductions made. See 45 C.F.R. §§ 156.430(c), (d).

[3] The premium tax credits of § 1401 were not made subject to the annual appropriations process. Instead, the ACA added the tax credits to a preexisting permanent appropriation for tax refunds. ACA § 1401(d)(1); see also 31 U.S.C. § 1324(b)(2).

I). The House contended "that Section 1401 Premium Tax Credits are funded by a permanent appropriation in the Internal Revenue Code, whereas Section 1402 Cost–Sharing Offsets must be funded and re-funded by annual, current appropriations," and that "Congress has not, and never has, appropriated any funds (whether through temporary appropriations or permanent appropriations) to make any Section 1402 Offset Program payments to Insurers." Id. at 60. Therefore, the House argued, the use of funds appropriated for the premium tax credits to fund the cost-sharing reduction payments violated the Appropriations Clause of the U.S. Constitution (art. I, § 9, cl. 7). Id. at 69.

The district court agreed and issued an injunction against payment of the CSRs while there was no appropriation in place to fund them. Burwell II, 185 F. Supp. 3d at 189. The court, however, stayed the injunction pending appeal. Id. Subsequently, while the case was on appeal, members of the newly elected Trump Administration made public statements suggesting that it was reconsidering the Obama Administration's legal position and that it might withdraw the government's appeal. The House therefore sought and was granted a stay of the appeal by the D.C. Circuit. See U.S. House of Representatives v. Burwell, 676 F. App'x 1 (Mem.) (D.C. Cir. 2016) (Burwell III).

While that litigation was pending in the district court and the D.C. Circuit, HHS continued to make cost-sharing reduction payments to insurers using funds appropriated under 31 U.S.C. § 1324. On October 11, 2017, however, Attorney General Sessions sent a letter to the Secretary of Treasury and the acting Secretary of HHS, advising them that the Justice Department had concluded that § 1324 did not appropriate funds to make payments under the CSR program. Letter from Att'y Gen. Sessions to Sec'y Mnuchin & Acting Sec'y Wright (Oct. 11, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf; see also California v. Trump, 267 F. Supp. 3d 1119, 1125 (N.D. Cal. 2017). The next day, HHS's Acting Secretary issued a memorandum to the Centers for Medicare and Medicaid Services directing that, in light of the Attorney General's legal opinion "and the absence of any other appropriation that could be used to fund CSR payments—CSR payments to issuers must stop, effective immediately." Memo from Acting Sec'y Hargan to Adm'r Verma (Oct. 12, 2017), https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

III. The Present Lawsuit

Shortly after HHS stopped making CSR payments, health insurance carriers—including the plaintiff in this case, Montana Health—filed a series of lawsuits in the Court of Federal Claims. In these suits, the insurers seek monetary relief to compensate them for unpaid CSR payments to which they claim an entitlement under the ACA. See, e.g., Common Ground Healthcare Coop. v. United States, No. 17-877C; Me. Cmty. Health Options v. United States, No. 17-2057C; Sanford Health Plan v. United States, No. 18-136C.

Montana Health, an issuer of qualified health plans that has, since 2014, provided health insurance on the Montana exchange and, since 2015, on the Idaho exchange, filed its complaint in the present case on January 30, 2018. Compl. ¶¶ 22–24, ECF No. 1. It alleges that, as required by the ACA, it provided cost-sharing reductions to eligible enrollees in its plans. See id. ¶¶ 47, 50. It further alleges that notwithstanding the fact that it made these reductions, it did not receive any CSR payments for the last quarter of 2017 as a result of HHS's October 12, 2017 directive.

Id. ¶¶ 51–52. It requests damages in the amount of $5,286,097 based on the government's alleged "violation of its cost-sharing reduction . . . payment obligations required by Section 1402." Id. at 1, 19.[4]

As noted, the government has now moved to dismiss Montana Health's complaint for failure to state a claim and Montana Health has cross-moved for summary judgment as to the government's liability. Oral argument was held on the cross-motions on August 30, 2018.

DISCUSSION

I. Jurisdiction

Under the Tucker Act, the United States Court of Federal Claims has jurisdiction to "render judgment upon any claim against the United States founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States, or for liquidated or unliquidated damages in cases not sounding in tort." 28 U.S.C. § 1491(a)(1) (2012). The Tucker Act serves as a waiver of sovereign immunity and a jurisdictional grant, but it does not create a substantive cause of action. Jan's Helicopter Serv., Inc. v. Fed. Aviation Admin., 525 F.3d 1299, 1306 (Fed. Cir. 2008). A plaintiff, therefore, must establish that "a separate source of substantive law . . . creates the right to money damages." Id. (quoting Fisher v. United States, 402 F.3d 1167, 1172 (Fed. Cir. 2005) (en banc in relevant part)).

"[A] statute is money-mandating for jurisdictional purposes if it 'can fairly be interpreted' to require payment of damages, or if it is 'reasonably amenable' to such a reading." Moda Health Plan, 892 F.3d at 1320 n.2 (quoting Greenlee Cty. v. United States, 487 F.3d 871, 877 (Fed. Cir. 2007)). In this case, § 1402 of the ACA states that insurers "shall notify the Secretary [of Health and Human Services] of [its 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) (emphasis supplied). The "use of the word 'shall' generally makes a statute money-mandating." Greenlee Cty., 487 F.3d at 877 (quoting Agwiak v. United States, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). Further, HHS's implementing regulations similarly state that insurers "will receive periodic advance payments based on the advance payment amounts calculated in accordance" with the regulatory formula. 45 C.F.R. § 156.430(b)(1) (emphasis supplied).

These provisions supply money-mandating sources of law for purposes of establishing this Court's Tucker Act jurisdiction. See Moda Health Plan, 892 F.3d at 1320–21 & n.2 (holding that § 1342 of the ACA, 42 U.S.C. § 18062, which states that "[t]he Secretary shall establish and administer" a risk corridors program and that "the Secretary shall pay" an amount according to a statutory formula under that program, is money mandating). Accordingly, this Court has

[4] Montana Health also claims that the government's failure to reimburse its cost-sharing reductions was a breach of an implied-in-fact contract in which the government agreed to make the cost-sharing reduction payments in exchange for Montana Health's agreement to offer its plans on the ACA's exchanges. Compl. ¶¶ 54, 62. The Court does not reach this claim in light of its favorable disposition of Montana Health's statutory claim.

jurisdiction under the Tucker Act over Montana Health's claim for monetary relief under § 1402 of the ACA.[5]

II. Merits

The parties' cross-motions present a single, purely legal issue: whether the federal government had a statutory obligation to provide Montana Health with the cost-sharing reduction payments described in § 1402 of the ACA, notwithstanding the lack of appropriations to fund such payments. Montana Health contends that such an obligation was imposed by the plain language of § 1402. The government's central argument, on the other hand, is that Congress could not have intended to impose such an obligation because, while it made arrangements to fund the premium tax credits of § 1401 through a permanent appropriation, it has never appropriated money to fund § 1402 payments, whether on a permanent or annual basis.

The determination of a statute's meaning begins (and often ends) with its language. Rosete v. Office of Pers. Mgmt., 48 F.3d 514, 517 (Fed. Cir. 1995); see also Star Athletica, L.L.C. v. Varsity Brands, Inc., 137 S. Ct. 1002, 1010 (2017) ("We thus begin and end our inquiry with the text, giving each word its ordinary, contemporary, common meaning." (quotation omitted)); McGee v. Peake, 511 F.3d 1352, 1356 (Fed. Cir. 2008). Where "Congress has expressed its intention by clear statutory language, that intention controls and must be given effect." Rosete, 48 F.3d at 517 (citing Chevron, U.S.A. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 843 n.9 (1984)). That is, where "statutory language is clear and unambiguous, the inquiry ends with the plain meaning." McGee, 511 F.3d at 1356 (quoting Myore v. Nicholson, 489 F.3d 1207, 1211 (Fed. Cir. 2007)).

[5] Although the government has not challenged this Court's jurisdiction over Montana Health's claims, it suggests for the first time in its reply brief that those claims should be dismissed because § 1402 does not confer a cause of action for damages on plaintiffs where the failure to make CSR payments is based on a lack of appropriations. Def.'s Reply in Supp. of Its Mot. to Dismiss & Opp'n to Pl.'s Cross-Mot. for Summ. J. (Def.'s Reply) at 9, ECF No. 16. This contention, to the extent the Court understands it, appears inconsistent with this court's long-standing and well-established authority to entertain suits for money damages under the Tucker Act based on money-mandating statutes like the ACA. 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. Indeed, in Fisher v. United States, the court of appeals observed that "the determination that the source [of the plaintiff's claim] 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." 402 F.3d at 1173; see also United States v. Testan, 424 U.S. 392, 401–02 (1976) (where statute can fairly be interpreted as mandating compensation by the federal government, it creates a cause of action for money damages). Therefore, the government's argument that Montana Health's claims fail for lack of a cause of action is rejected.

In this case, the 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 ACA. It states that:

> 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) (emphasis supplied).

Notwithstanding the plain language of this provision (and HHS's implementing regulations), the government argues that § 1402 does not give rise to a statutory payment obligation because Congress has never appropriated funds to meet any such obligation. It contends that while "Congress has the power to make particular payments an 'obligation' of the government without regard to appropriations, or to vest an agency with budget authority in advance of appropriations," "in the limited circumstances where Congress intends to do so, it does so explicitly." Mot. to Dismiss at 17–18, ECF No. 10. For example, the government notes, in the Medicare Part D statute, Congress coupled a direction that the Secretary "shall provide for payment" of certain subsidies to insurers with a statement that the directive "constitutes budget authority in advance of appropriations Acts and represents the obligation of the Secretary to provide for the payment of amounts provided under this section." Id. at 18 (quoting 42 U.S.C. § 1395w-115(a)). The government also argues that in previous cases where a payment obligation was found, Congress had explicitly characterized the payment as an "entitlement" in the statute. Id. at 21.

None of these arguments withstands scrutiny under controlling precedent, the most recent example of which is the court of appeals's decision in Moda Health Plan. In that case, the issue was whether § 1342 of the ACA imposed an obligation on the government to make payments to insurers under the ACA's risk corridors program. See 892 F.3d at 1314, 1320. The government argued in that case, as it does here, that notwithstanding § 1342's language (that the Secretary "shall pay" insurers), no payment obligation was created. Id. at 1321. It so argued because § 1342 "provided no budgetary authority to the Secretary of HHS and identified no source of funds for any payment obligations beyond payments in," which were insufficient to fund the payments out in full. Id.

As the government concedes in its reply brief, "in Moda, the Federal Circuit concluded that the language in Section 1342 stating that the Secretary 'shall pay' certain amounts in accordance with a statutory formula initially created an obligation to make full risk-corridors payments without regard to appropriations or budget authority." Def.'s Reply at 5. Indeed, in Moda, the court of appeals found the language of § 1342 "unambiguously mandatory." 892 F.3d at 1320. Further, the court of appeals rejected an analogy drawn from the language in the Medicare Part D statute similar to the one the government draws in this case. See id. at 1322. The court of appeals found it "immaterial that Congress provided that the risk corridors program established by section 1342 would be 'based on the program' establishing risk corridors in Medicare Part D yet declined to provide 'budget authority in advance of appropriations acts,' as in the corresponding Medicare statute." Id. "Budget authority," it observed, "is not necessary to

create an obligation of the government; it is a means by which an officer is afforded that authority." Id. In short, the court held, the obligation at issue was "created by the statute itself, not by the agency," and the government had provided "no authority for its contention that a statutory obligation cannot exist absent budget authority." Id. The court of appeals therefore "conclude[d] that the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." Id.

In a footnote in its reply brief, the government asserts that it disagrees "with this aspect of Moda's reasoning" and purports to "preserve the issue for further review." Def.'s Reply at 5 n.2. But the court of appeals broke no new ground in Moda when it held that the "shall pay" language of § 1342 created a statutory payment obligation and that the lack of appropriated funds was irrelevant to whether such an obligation was enforceable in this court. As it explained, "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt, at least in certain circumstances." Moda Health Plan, 892 F.3d at 1321. Thus, the court of appeals observed, its "predecessor court noted long ago that '[a]n appropriation per se merely imposes limitations upon the Government's own agents; it is a definite amount of money intrusted to them for distribution; but its insufficiency does not pay the Government's debts, nor cancel its obligations, nor defeat the rights of other parties.'" Id. (quoting Ferris v. United States, 27 Ct. Cl. 542, 546 (1892)); see also Slattery v. United States, 635 F.3d 1298, 1303, 1321 (Fed. Cir. 2011) (en banc) (failure to appropriate funds did not absolve the government of its statutory obligation to pay amounts owed); Greenlee Cty., 487 F.3d at 877 (Congress's failure to appropriate funds does not "defeat a Government obligation created by statute" (quotation omitted)); N.Y. Airways, Inc. v. United States, 369 F.2d 743, 748 (Ct. Cl. 1966) ("It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute.").

To be sure, in Moda, the majority of the panel went on to address whether, notwithstanding the initial statutory obligation imposed by the ACA, Congress had capped the amount of payments the government was obligated to make under § 1324 through subsequent specific appropriations riders. 892 F.3d at 1322–29.[6] The question before it, the court of appeals observed, was "whether [subsequent] riders on the CMS Program Management appropriations supplied the clear implication of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question, as in [United States v.]Mitchell, [109 U.S. 146 (1883)] or if Congress merely appropriated a less amount for the risk corridors program, as in [United States v.]Langston[, 118 U.S. 389 (1886)]." Id. at 1323.

The court of appeals's juxtaposition of Mitchell and Langston is instructive. In Mitchell, "the Supreme Court held that a statute that had set the salaries of certain interpreters at a fixed sum 'in full of all emoluments whatsoever' had been impliedly amended, where Congress

[6] The plaintiffs in Moda have since petitioned for rehearing en banc as to that portion of the court of appeals's decision (as well as its rejection of their contract-based claims) and the court has asked the United States to respond to the petition. See Docket, Moda Health Plan, Inc. v. United States, No. 17-1994 (Fed. Cir.).

appropriated funds less than the fixed sum set by statute, with a separate sum set aside for additional compensation at the discretion of the Secretary of the Interior." Id. (quoting Mitchell, 109 U.S. at 149). In Langston, on the other hand, the Supreme Court held that "a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation because it carried no implication of Congress's intent to amend or suspend the substantive law at issue." Id.

This case clearly falls into the same category as Langston, and is not at all like Mitchell. In this case, there was no relevant congressional action taken at all after the passage of the ACA. There have been no appropriations bills enacted that make reference to § 1402. All that exists is the payment obligation spelled out by the plain language of § 1402 and the "bare failure to appropriate funds" that the Supreme Court found insufficient to establish the congressional intent necessary to vitiate a statutory payment obligation in Langston. Id.; see also Butterbaugh v. Dep't of Justice, 336 F.3d 1332, 1342 (Fed. Cir. 2003) (observing that "congressional inaction is perhaps the weakest of all tools for ascertaining legislative intent").

Further, the Court finds unpersuasive the government's argument that "Congress made clear its intent not to fund CSR payments when it permanently appropriated funds for the only other statutory section appearing in the same subpart, while declining to do so for CSR payments." Def.'s Reply at 2. The most one can say about Congress's decision to permanently appropriate funds for the tax credits but not for CSR payments is that it reveals that Congress did not intend for CSR payments to be funded by permanent appropriations. Its failure to establish a permanent funding mechanism for the CSR payments does not, as the government would have it, give rise to the implausible inference that Congress intended "to consign CSRs 'to the fiscal limbo of an account due but not payable.'" Id. at 9 (quoting United States v. Will, 449 U.S. 200, 224 (1980)). To the contrary, the lack of a permanent funding mechanism suggests that when it enacted the ACA, Congress anticipated that the CSR payments it obligated the government to pay in § 1402 would ultimately be funded through the annual appropriations process. And, for the reasons set forth above, the Court cannot infer intent to vitiate the obligation imposed by § 1402 based solely on Congress's subsequent failure to make such appropriations.

Finally, the government contends that "it is particularly implausible to conclude that Congress . . . intended to grant issuers a damages remedy" because issuers may be able to mitigate the lack of CSR payments by increasing the cost of their premiums. Id. at 11; see also California, 267 F. Supp. 3d at 1136 (observing that "[e]ven before the Administration announced its decision, 38 states accounted for the possible termination of CSR payments in setting their 2018 premium rates" and that more states began adopting premium increase strategies for 2018 after the announcement).[7] Of course, Montana Health was unable to raise its premiums to make up for the shortfall in 2017, because by the time HHS issued its stop payment order, premiums for that year were set; in fact, the year was almost over. But in any event, even assuming that

[7] Judge Chhabria's opinion in California v. Trump includes an interesting discussion of the effect that these premium increases would have on the cost to enrollees on the exchanges. 267 F. Supp. 3d at 1133–38. Paradoxically, the majority of the participants in the exchanges (and particularly lower income participants) would actually pay less for their insurance coverage because the increases in premiums would lead to an increase in the premium tax credits to which they are entitled. Id.

insurers could make up for the shortfall in CSR payments by raising their premiums, approval of premium rates is a matter for the states. There is no evidence in either the language of the ACA or its legislative history that Congress intended that the statutory obligation to make CSR payments should or would be subject to an offset based on an insurer's premium rates. The Court concludes, therefore, that premium rates have no bearing on whether § 1402 created a statutory obligation to pay insurers compensation for the cost-sharing reductions they implemented.

* * * * * * *

For the reasons set forth above, the government was statutorily obligated to provide Montana Health with cost-sharing reduction payments for the remaining months of 2017. That obligation was not vitiated by Congress's failure to appropriate funds for that purpose. Accordingly, Montana Health is entitled to judgment as to liability as a matter of law.

CONCLUSION

For the reasons set forth above, the government's motion to dismiss is **DENIED** and Montana Health's cross-motion for summary judgment as to liability is **GRANTED**. The parties are directed to file a joint status report on or before **October 4, 2018**, proposing further proceedings in this case.

IT IS SO ORDERED.

s/ Elaine D. Kaplan
ELAINE D. KAPLAN
Judge