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

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 OF PLAINTIFFS-APPELLEES

May 1, 2019

Stephen J. McBrady
(Counsel of Record)
Crowell & Moring LLP
1001 Pennsylvania Ave., NW
Washington, DC 20004-2595
Tel: (202) 624-2547
Fax: (202) 628-5116
SMcBrady@crowell.com

Attorney for Plaintiffs-Appellees Sanford Health Plan and Montana Health CO-OP

CERTIFICATE OF INTEREST

Counsel for Plaintiffs-Appellees certifies the following:

1. Full name of every party represented by me:

   Sanford Health Plan, Montana Health CO-OP

2. Name of Real Party in interest (Please only include any real party in interest NOT identified in Question 3) represented by me is:

   Sanford Health Plan, Montana Health CO-OP

3. Parent corporations and publicly held companies that own 10% or more of stock in the party:

   Sanford Health Plan is a wholly owned subsidiary of Sanford Health, which is a wholly owned subsidiary of Sanford

   Montana Health CO-OP has no parent corporation, and no publicly held company owns more than 10% of its stock

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (and who have not or will not enter an appearance in this case) are:

Xavier Baker, Clifton S. Elgarten, and Monica Sterling (Crowell & Moring), and John Morrison (Morrison, Sherwood, Wilson, & Deola PLLP).

5. The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal: The following cases pending before the Court of Federal Claims are related cases within the meaning of Federal Circuit Rule 47.5:

Case	Docket Number	Judge
Blue Cross & Blue Shield of Vermont v. United States	No. 18-373	Judge Horn
Common Ground Healthcare Cooperative v. United States	No. 17-877C	Judge Sweeney
Guidewell Mutual Holdings Corp v. United States	No. 18-1791C	Judge Griggsby
Harvard Pilgrim Health Care, Inc. v. United States	No. 18-1820C	Judge Smith
Health Alliance Medical Plans, Inc. v. United States	No. 18-334C	Judge Campbell-Smith
Local Initiative Health Authority for Los Angeles County v. United States	No. 17-1542C	Judge Wheeler
Maine Community Health Options v. United States	No. 17-2057C	Judge Sweeney
Molina Healthcare of California, et al. v. United States	No. 18-333C	Judge Wheeler
Noridian Mutual Ins. Co. v. United States	No. 18-1983	Judge Horn

Montana Health CO-OP v. United States	No. 19-568C	Judge Kaplan
Sanford Health Plan v. United States	No. 19-569	Judge Kaplan

The following cases pending before this Court are related cases within the meaning of Federal Circuit Rule 47.5:

Case	Docket Number	Circuit
Community Health Choice Inc. v. United States	No. 19-1633	Federal Circuit

May 1, 2019

/s/ Stephen J. McBrady
Stephen J. McBrady
(Counsel of Record)

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STATEMENT OF RELATED CASES

(a) No prior appeal related to the same civil proceeding has been filed.

(b) The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal:

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INTRODUCTION

Section 1402 of the Affordable Care Act ("ACA" or "Act"), 42 U.S.C. § 18071, contains two relevant requirements. First, it requires that insurers providing coverage on ACA exchanges reduce the out-of-pocket "cost-sharing" expenses that eligible plan customers would otherwise incur at the point of receiving health care, such as co-pays. Second, it requires the United States to reimburse insurers dollar for dollar for those cost-sharing reductions ("CSRs"). Specifically, Section 1402 directs that the Secretary of the U.S. Department of Health and Human Services ("HHS") "shall make periodic and timely payments to the [insurer] equal to the value of the reductions."

The United States made its required "CSR payments" to insurers for 45 consecutive months from January of 2014 to October of 2017. Then it stopped. The sole issue in these consolidated appeals is whether the United States is liable to Plaintiffs-Appellees for the CSR payments that it stopped making in October 2017, or whether Congress' mere failure to appropriate money for Section 1402 payments somehow renders that statutory obligation unenforceable (or even non-existent)

and therefore excuses the United States from making the payments despite the "unambiguously mandatory" language of the statute.

There is no question that, at all relevant times, Plaintiffs-Appellees—themselves health insurance companies that provided coverage on the ACA exchanges—honored the first requirement of Section 1402, namely, to provide eligible plan enrollees with the obligatory cost-sharing reductions. They expected—indeed, relied upon—the United States to honor its separate requirement to reimburse them for those CSRs. And for over three-and-a-half years, it did.

In 2017, however, the Attorney General concluded that the appropriated funds from which HHS had been making those Section 1402 payments were not properly available for that purpose and could no longer be used for that purpose. Deprived of funds to make additional payments, HHS had no choice but to cease reimbursing insurers for CSRs. Insurers, meanwhile, were still required to reduce (and did reduce) out-of-pocket "cost-sharing" expenses for their customers.

Consequently, Plaintiffs-Appellees (and several similarly situated insurers) filed suit in the Court of Federal Claims, invoking that court's Tucker Act jurisdiction over claims against the United States for obligations arising, *inter alia*, under money-mandating statutes. 28 U.S.C. § 1491(a)(1). The Government opposed, arguing, on various theories, that it had no obligation to make the CSR payments absent an appropriation for that purpose.

Following a long line of precedent from this Court, confirmed most recently in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), the Court of Federal Claims (in these cases and several others[1]), rejected the Government's theories. The court held that under the plain language of Section 1402—"shall make periodic and timely payments to the [insurer] equal to the value of the reductions"—the United States is liable to Plaintiffs-Appellees for the CSRs that they provided their eligible enrollees but which the Government, beginning

[1] *Montana Health CO-OP v. United States*, 139 Fed. Cl. 213 (2018), *appeal docketed* No. 19-1302 (Fed. Cir. Dec. 12, 2018); *Sanford Health Plan v. United States*, 139 Fed. Cl. 701 (2018), *appeal docketed* No. 19-1290 (Fed. Cir. Dec. 11, 2018); *see also Cmty. Health Choice, Inc. v. United States*, 141 Fed. Cl. 744 (2019), *appeal docketed* No. 19-1633 (Fed. Cir. Mar. 8, 2019); *Local Initiative Health Auth. for L.A. Cty. v. United States*, 142 Fed. Cl. 1 (2019); *Maine Cmty. Health Options v. United States*, 142 Fed. Cl. 53 (2019).

October 2017, did not reimburse. Under longstanding principles, the statutory obligation to pay is distinct from whether Congress appropriated money to make the payments. A failure to pay on an obligation, or to appropriate or set aside money to meet that obligation, does not negate the obligation itself. To the contrary, where an obligation to pay is created by a money-mandating statute like Section 1402 of the ACA, the obligation to pay is enforceable in the Court of Federal Claims and ultimately payable from the standing appropriation for the Judgment Fund. 31 U.S.C. § 1304(a).

In this Court, the Government renews some of the arguments it presented below and adds a few more.

The Government argues that Congress would not have created a binding obligation to pay without simultaneously funding the obligation. But this assertion is contrary to this Court's longstanding precedents, including *Moda*, the relevant holding of which the Government seeks to evade by characterizing it as dictum.

The Government also seeks to evade the plain language of Section 1402 by arguing that the real inquiry here is into Congress' "intent"—specifically, that Congress' intent is not well-evidenced by the words of

Section 1402 itself directing payments to be made. It contrives a contrary congressional intent: that despite the "shall make" payment directive of Section 1402, payments might or might not be made, depending on whether a subsequent Congress appropriated funds for that purpose, and that the insurers that provided the CSRs to eligible enrollees would have no enforceable right to insist on Section 1402 reimbursement.

As explained below, the Government's position ignores over 100 years of Court precedent reflecting the difference between Congress acting to create an obligation of the United States in the first instance and Congress acting separately on whether and how to fund that obligation. All of the Government's result-oriented theories about congressional intent are unsupported by any evidence that the Congress that enacted the ACA "intended" something other than what it wrote in the text of Section 1402: that payments under Section 1402 "shall" be made according to the terms of the statute.

STATEMENT OF THE ISSUE

Whether the Court of Federal Claims correctly decided that Section 1402 requires the United States to reimburse Plaintiffs-

Appellees for the amount of cost-sharing reductions that Plaintiffs-Appellees extended to policyholders as required by Section 1402.[2]

STATEMENT OF THE CASE

A. The ACA Requires the Government to Reimburse Insurers for the Cost-Sharing Reductions They Must Extend to Eligible Insureds.

With enactment of the Affordable Care Act in 2010,[3] Congress created a new platform for delivering health insurance—the so-called health insurance "exchange" or "marketplace"—an online forum in each state through which individuals could shop for coverage from participating insurers. The principal aim of the ACA was to make comprehensive health insurance accessible and affordable to tens of millions of Americans who lacked adequate, or any, insurance.

Plans offered on the exchanges are required to have certain coverage benefits, and are referred to as qualified health plans, or

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[2] Plaintiffs-Appellees also raised an alternative claim for breach of an implied-in-fact contract. The Court of Federal Claims did not rule on that claim. The Government nonetheless addresses the implied-in-fact contract claim in its opening brief, and Plaintiffs-Appellees respond to the Government's argument in part II.

[3] The Affordable Care Act is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), and (2) the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (2010).

QHPs. Insurers offering QHPs on the exchanges agree to provide that coverage pursuant to QHP issuer agreements, or QHPIAs.

The ACA required individuals to purchase health insurance coverage if they were not otherwise insured. At the same time, however, the law established subsidies to defray both premium expenses and out-of-pocket costs that otherwise would have made insurance cost-prohibitive to millions of Americans.

Section 1402 of the ACA seeks to reduce health care costs to certain insureds directly. It requires insurers to reduce or eliminate many of the out-of-pocket cost-sharing obligations that would ordinarily be borne by the consumer at the point of health care-related service. But it also guarantees that the United States will, on a dollar-for-dollar basis, reimburse insurers for those cost-sharing reductions. *See* 42 U.S.C. § 18071. "Cost sharing" refers to out-of-pocket payments to health care providers in the form of copayments, coinsurance, and deductibles that individuals typically are required to pay under their insurance plan at the point of service.[4]

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[4] *See* Congressional Budget Office ("CBO"), *Key Issues in Analyzing Major Health Insurance Proposals* at 15-17 (Dec. 18, 2008), *available at* www.cbo.gov/publication/41746.

Specifically, Section 1402 of the Act requires insurers to provide CSRs to individuals (i) who enroll in silver plans through the exchanges,[5] (ii) who are determined eligible to receive tax credits under Section 1401 of the Act, and (iii) whose household income is below 250% of the federal poverty level. 42 U.S.C. §§ 18071(a)(2) (c)(2), (f)(2).

In turn, the Government is required to reimburse the insurers for those CSRs. Section 1402 states that HHS "***shall make*** periodic and timely payments to the issuer equal to the value of the reductions."[6] (Emphasis added.) Echoing that command in its implementing regulation, HHS states that the insurer "***will receive*** periodic advance

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[5] A "silver" plan is a plan structured so that the insurer pays approximately 70% of the average enrollee's health care costs, leaving the enrollee responsible for the other 30% through cost sharing. 42 U.S.C. § 18022(d). Under the Act, an insurer must reduce cost sharing for eligible individuals enrolled in "silver" plans through an Exchange. *Id.* § 18071(c)(2).

[6] The full text of the section reads:

> 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.

(Emphasis added.)

payments based on the advance payment amounts calculated in accordance with § 155.1030(b)(3) of this subchapter." 45 C.F.R. § 156.430(b)(1) (emphasis added). Part 155.1030(b)(3) and other regulations set forth the calculation methodologies applicable to CSR payments.

In other words, by statute, insurers participating on the exchanges are required to provide cost-sharing reductions to certain plan enrollees (based on the plan in which they are enrolled), and the Government is required to reimburse the insurers for those CSRs. By regulation, the Government is required to make these payments to insurers in advance, based on an estimate of the CSRs that insurers are expected to provide. Those payments are subject to a later reconciliation that depends on the cost-sharing reductions they have actually provided.

The Government's brief also addresses a different provision of the ACA, known as the premium tax credit, authorized by Section 1401, which amends the Internal Revenue Code, 26 U.S.C. § 36B. This credit is available to individuals with household incomes between 100% and 400% of the federal poverty level purchasing health insurance through

the exchanges. These tax credits defray much or all of the annual premium costs for which plan enrollees would otherwise be responsible. And they are funded through the permanent appropriation in the Internal Revenue Code used for refunds and similar Treasury tax disbursements. ACA § 1401; 26 U.S.C. § 36B; 31 U.S.C. § 1324.

B. HHS Ceases Making CSR Payments.

Montana Health CO-OP, Plaintiff-Appellee in No. 19-1302, and Sanford Health Plan, Plaintiff-Appellee in No. 19-1290, each timely submitted signed QHPIAs to CMS by the end of September 2016. In so doing, each committed to offer health insurance coverage on the exchanges for benefit year 2017. They made these commitments to participating in the marketplace in 2017 with the express understanding—based on the plain text of Section 1402 and consistent with the Government's payment of CSRs in previous benefit years—that the Government would continue to honor its statutory obligations to "make periodic and timely payments to the issuer equal to the value of the reductions."

From the start of the exchanges in January 2014, HHS had indeed made the monthly advance payments to reimburse insurers, including

Montana Health and Sanford, for their CSRs.[7] And HHS had continued to make these monthly payments, including to Montana Health and Sanford, for 45 months, until October 2017.[8]

On October 11, 2017—over a year after Plaintiffs-Appellees had committed to participate on the 2017 exchanges—the Attorney General concluded that the fund from which HHS had been making CSR payments (the same tax appropriation from which Section 1401 payments were made) was not proper for that purpose, leaving no

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[7] *See* CMS, Manual for Reconciliation of the Cost-Sharing Reduction Component of Advance Payments for Benefit Years 2014 and 2015 at 27 (Mar. 16, 2016), *available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS_Guidance_on_CSR_Reconciliation-for_2014_and_2015_benefit_years.pdf.

[8] In November 2014, the House of Representatives filed a lawsuit in federal district court arguing that HHS' payment of CSRs was unlawful because HHS lacked appropriated funds to make the CSR payments. *See* Complaint, *U.S. House of Representatives v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. No. 1 (D.D.C. filed Nov. 21, 2014). In a May 2016 decision, the district court agreed; but the court stayed its own injunction of CSR reimbursements pending appeal. *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 189 (D.D.C. 2016). That case was later settled; throughout, CSR payments continued to be processed.

appropriation from which HHS could continue to make CSR payments.[9] The next day, on October 12, 2017, HHS Acting Secretary Eric Hargan issued a memorandum to CMS stating that "CSR payments to issuers must stop, effective immediately," because no money had been appropriated to make the payments.[10] CMS ceased making CSR payments as of that date, leaving unpaid millions of dollars of CSR payments already accrued for 2017.

The Attorney General and Acting Secretary Hargan addressed only whether an appropriation existed to allow *HHS* to make the CSR payments. Neither addressed whether Section 1402 obligated the United States to make the payments notwithstanding the absence of an appropriation, and that question was not presented to the district court in the *Burwell* case (*see* n.8, *supra*).

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[9] *See* Oct. 11, 2017 Ltr. from Att. Gen. Sessions to Secretary of Treasury and Acting Secretary of HHS, *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

[10] *See* Oct. 12, 2017 Mem. from E. Hargan to S. Verma re: Payments to Issuers for Cost-Sharing Reductions (CSRs), *available at* https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf.

C. The Government Has Failed to Reimburse Plaintiffs-Appellees for the Cost-Sharing Reductions They Provided as Required By Section 1402.

The determination that HHS lacked available funding to make CSR payments left the Government owing Sanford $360,254 and Montana Health $1,234,058.79 in CSR payments for the final quarter of 2017.[11] Accordingly, Montana Health and Sanford each brought suit in the Court of Federal Claims under the Tucker Act seeking payment of the amount each is owed. Each moved for summary judgment in its respective case and the Government cross-moved to dismiss.

While it was clear enough that *HHS* could no longer make payments if Congress had not appropriated funds to do so, the Government took the position in the Court of Federal Claims that this was not a mere failure of appropriation. Instead, the Government argued that the underlying Section 1402 obligation was wholly unenforceable in the absence of an appropriation to support the payments. It argued, among other things, that by designating a

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[11] At the time they filed their complaints—and at the time judgment was entered in the trial court proceedings—Plaintiffs-Appellees did not yet have sufficient data to calculate the amount of their 2018 CSR claims. Accordingly, only unpaid CSR payments for benefit year 2017 are directly at issue in this appeal.

permanent appropriation to pay the Government's obligations under Section 1401, and not doing so under Section 1402, Congress had implied that Section 1402 payments were subject to Congress' discretion. As such, the Government argued, unless Congress appropriated money to make the payments, the payments need not be made.

Judge Kaplan rejected the Government's arguments and held that Section 1402 obligated the United States to make the CSR payments. Appx7-11, Appx19-23. She held, as longstanding case law required, that the statutory obligation to make CSR payments is established by the compulsory language of the Act ("shall make"). Appx8-9, Appx19-21. Section 1402 was a money-mandating statute that both established the Court of Federal Claims' Tucker Act jurisdiction and created a cause of action in favor of unpaid insurers.

Judge Kaplan reasoned that the lack of a specifically designated permanent appropriation for Section 1402 payments simply indicates that when it enacted the ACA, Congress anticipated that CSR payments would be funded through the annual appropriations process. Appx8-10, Appx19-22. Accordingly, Judge Kaplan held that the

existence of the obligations created by the compulsory language of the Act is not undercut by the fact that Congress may have left funding for the obligation to the annual appropriation process. Appx8-10, Appx19-22.

As Judge Kaplan explained, this Court in *Moda*, following precedent, had concluded that Section 1342 of the ACA, which employed similar "shall" language, had created an obligation of the Government that is enforceable by Tucker Act suit notwithstanding the absence of any specific appropriation. 892 F.3d at 1314. Congress' intention to create an obligation was clear from the mandatory payment language that Congress had used. It was not negated by the absence of an appropriation to support that payment obligation.

However, in *Moda*, this Court went on to construe the congressional intent underlying *subsequent* legislation, finding that the subsequent legislation revealed an intention to "suspend" the obligation set forth in Section 1342's "shall pay" mandate. The Government argued that a similar intent argument should prevail here. But, as Judge Kaplan correctly reasoned, the subsequent legislation that this

Court construed as signaling an intent to suspend the payment obligation in *Moda* is entirely absent in this case.

> 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*.

Appx10, Appx22. As such, she held that, as in *Moda*, the ACA created a clear obligation to make Section 1402 payments. But, unlike in *Moda*, there was no subsequent legislation to construe as intending to abrogate that obligation. The original "shall make" language of Section 1402 is controlling and requires the payments at issue here.

SUMMARY OF THE ARGUMENT

Section 1402 of the ACA requires insurers to provide cost-sharing reductions to eligible insureds and directs that the Government "shall make" payments to insurers to reimburse them for the CSRs they provide. 42 U.S.C. § 18071. Like the nearly identical ACA provision examined in *Moda*, Section 1402 is "unambiguously mandatory," and obligates the United States to make the required reimbursements. Section 1402 is thus a money-mandating statute that both confers

Tucker Act jurisdiction on the Court of Federal Claims for unpaid amounts, and, by the same token, creates a cause of action for recovery of the amounts due, but unpaid. *See Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005) (*en banc* in relevant part).

Moreover, under this Court's precedents (including *Moda*), the questions of whether a statute creates an obligation to pay and whether Congress has appropriated funds to make the payment are distinct. Thus, Congress' failure to appropriate funds to meet its obligation under Section 1402 cannot negate the obligation to make payments under that Section because "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt." *Moda*, 892 F.3d at 1321; *see Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892). The Government's Anti-Deficiency Act argument also fails because, as this Court confirmed in *Moda*, while the failure to appropriate money to an agency to pay an obligation absolutely bars the agency from making such payments, it does not negate the underlying payment obligation.

Congress' intent that Section 1402 payments be made is evident from the unambiguously mandatory words that Congress used in the

statute. Nonetheless, the Government seeks to attribute a contrary intent to Congress, which it conjures from whole cloth. None of the Government's arguments comes close to overcoming the plain language of the statute.

For example, from the fact that Congress left Section 1402 funding to the annual appropriations process, but made Section 1401's premium tax credits payable from the regular appropriation to the Treasury for tax refunds, the Government would have the Court conclude that Section 1402 obligations are not enforceable absent an appropriation. But no inference at all can be drawn from the fact that there were two different funding arrangements for two different programs. Indeed, it was entirely logical that Section 1401 tax credits, which are part of the Internal Revenue Code, would be financed through the Treasury's permanent appropriation for tax-related disbursements and treated differently than the CSRs, which are not tax-related.

The Government's argument that Congress could not have intended Section 1402 obligations to be enforceable because, following HHS' failure to pay under Section 1402, state regulators allowed insurers to raise their premiums to make up for the lost revenues, also

leads nowhere. That a party wrongly deprived of revenue from one source may try to recover it elsewhere does not negate that party's cause of action to recover what it was entitled to receive. And there is not the slightest indication that the Congress that enacted the ACA would have viewed the possibility of premium rate increases, dependent on approval by state regulators, as a viable alternative to the federal government complying with the mandatory payment obligation in Section 1402. Indeed, there is not the slightest indication that Congress even considered the possibility in the first place.

To the contrary, the Congress that enacted the ACA necessarily anticipated that the federal government would, in fact, meet its obligations under Section 1402 by appropriating funds that would allow HHS to do so. That is why it affirmatively used unambiguously mandatory language and, conversely, did not subject Section 1402 obligations to the discretion of a subsequent Congress, as it could have by saying that the payment obligation is "subject to appropriations," or something similar—the ordinary words of limitation that this Court has

recognized reflects an intent of Congress to peg its obligations to future decisions about appropriations.[12]

The Government's further argument that the Court should infer a congressional intent not to allow the Section 1402 obligation to be enforceable because the result of not paying CSRs is that premiums increase, and the federal government's ACA expense likewise increases, makes no sense. If, as the Government contends, the result of failing to make CSR payments would predictably be that premiums would increase, and the Government's ACA costs would increase, that would make it even more unlikely that the Congress that enacted the ACA would have made the Government's Section 1402 obligations optional and unenforceable. Indeed, on the Government's own reasoning, a decision by this Court affirming the decisions below and confirming that insurers will be reimbursed for the CSRs they provide will *reduce* premiums, and *reduce* the Government's overall ACA cost burden.

Of course, all this only highlights that the Government's invitation to this Court to attribute an intent to Congress that is

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[12] *See Prairie Cty. v. United States*, 782 F.3d 685, 687 (Fed. Cir. 2015) (noting that the statutory language "subject to the availability of appropriations" is generally interpreted as "restricting the government's liability to the amount appropriated by Congress").

contrary to the words of Section 1402, based on economic and policy arguments, takes the court into poorly charted territory. The central point here is that under the plain language of Section 1402, and established precedent, Plaintiffs-Appellees may insist that the Government meets its obligations under Section 1402.

Finally, the Government's argument that, simply by failing to appropriate money under Section 1402, Congress "suspended" the Government's payment obligation flies in the face of more than 100 years of binding precedent holding that mere failure to appropriate funds for payment does not obviate an existing statutory obligation to pay. Whereas a duly enacted, subsequent statute can repeal or "suspend" a previously enacted law, there was no such subsequent legislation here. The Government cannot equate subsequent congressional *inaction*—a failure to enact subsequent legislation or appropriate funds—with the kind of affirmative act of legislation that, under our constitutional framework, repeals, revokes, or "suspends" Section 1402's mandate.

ARGUMENT

The Court of Federal Claims decisions denying the Government's motions to dismiss and granting Plaintiffs-Appellees' cross-motions for summary judgment should be affirmed.

I. SECTION 1402, BY ITS TERMS, OBLIGATES THE UNITED STATES TO MAKE CSR REIMBURSEMENT PAYMENTS.

A. Section 1402 Creates an Enforceable Obligation to Pay.

1. The Plain Language of Section 1402 Mandates Payment.

Where, as here, a legal claim turns on the meaning of a statute, the first place to look for that meaning is the statute itself; if the statute is unambiguous, the inquiry also ends there. *See Star Athletica, L.L.C. v. Varsity Brands, Inc.*, 137 S. Ct. 1002, 1010 (2017); *McGee v. Peake*, 511 F.3d 1352, 1356 (Fed. Cir. 2008) (where "statutory language is clear and unambiguous, the inquiry ends with the plain meaning"); *Rosete v. OPM*, 48 F.3d 514, 517 (Fed. Cir. 1995). This principle is controlling here. Section 1402 is unambiguous in first imposing certain obligations on insurers by stating that insurers "shall reduce the cost-sharing under the plan," 42 U.S.C. §§ 18071(a)(1), (2). It is equally unambiguous in then imposing a reciprocal obligation on the Government to reimburse the insurer, dollar for dollar, for those

amounts:

> 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 added).

The statute means what it plainly says. Just last year, in *Moda*, this Court addressed a nearly identical provision of the ACA. In that case, the Court considered the meaning of Section 1342 of the ACA. The relevant text stated that, where insurers met certain predicate conditions, HHS "shall pay" an amount calculated under the statutory formula. This Court held that the "shall pay" language was "unambiguously mandatory" and imposed a legal obligation on the United States to make the promised payment. *See* 892 F.3d at 1320. The same is true of the Government's obligation under Section 1402, which requires in terms no less certain that HHS "shall make periodic and timely payments to the issuer equal to the value of the reductions."

As with the "shall pay" mandate construed by the Court last year in *Moda*, the "shall make" mandate places Section 1402 well within the heartland of money-mandating statutes that this Court has for decades

held to give rise to jurisdiction, and a cause of action for damages, under the Tucker Act.[13] *See, e.g., Greenlee Cty. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (holding that statute stating that "the Secretary of the Interior shall make a payment" to local governments to compensate them for losses due to the presence of tax-exempt federal land was money-mandating). "We have repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Id.* (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). *Accord Bowen v. Massachusetts*, 487 U.S. 879, 923-24 (1988) (Scalia, J., dissenting) (stating that "a statute commanding the payment of a specified amount of money by the United States impliedly authorizes (absent other indication) a claim for damages in the defaulted amount").

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[13] The money-mandating command of Section 1402 provides the basis for Tucker Act jurisdiction, which extends to claims for money damages where a statute "mandates a right of recovery in damages." *United States v. White Mountain Apache Tribe*, 537 U.S. 465, 473 (2003). The jurisdictional test is whether the statute "can fairly be interpreted as mandating compensation by the Federal Government for the damages sustained." *United States v. Mitchell*, 463 U.S. 206, 217 (1983). So long as the statute permits a "fair inference" that Congress provided a right of recovery in damages, Tucker Act jurisdiction will lie. *See White Mountain*, 537 U.S. at 473; *United States v. Bormes*, 568 U.S. 6, 15-16 (2012).

This Court has declared in no uncertain terms that the money-mandating directive of a statute is "determinative both as to the question of the [Court of Federal Claims' Tucker Act] 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." *Fisher*, 402 F.3d at 1173 (*en banc* in relevant part). Thus, where a statute contains a money-mandating provision sufficient to ground jurisdiction, it will likewise be understood to reflect an intention to provide a damages remedy. The Section 1402 payment directive at issue here plainly satisfies both tests.

Ignoring Section 1402's money-mandating directive, the Government insists that a failure to establish an appropriation to finance CSRs demonstrates an intent not to obligate the United States, arguing (as it did in *Moda*) that there must be a source of funding before an obligation can fairly be deemed to come into existence. But as the long line of cases on which *Moda* relied demonstrates, this has never been the rule.[14] Indeed, this Court rejected that very argument in *Moda*, stating "it has long been the law that the government may incur

[14] *See Moda*, 892 F.3d at 1321-22 (citing cases).

a debt independent of an appropriation to satisfy that debt." 892 F.3d at 1321.

Beginning with *United States v. Langston*, 118 U.S. 389 (1886), the Supreme Court had recognized that the question whether a statute has created an obligation to pay is distinct from whether Congress appropriated funds to meet that obligation. *See Moda*, 892 F.3d at 1320-22. Obligations "persist independent of the appropriation of funds to satisfy that obligation." *Id.* at 1321. As this Court has explained, a failure to appropriate funds does not absolve the government of its statutory obligation to pay amounts owed. *See Slattery v. United States*, 635 F.3d 1298, 1303, 1321 (Fed. Cir. 2011) (en banc).

Indeed, distinguishing between a statutory obligation, on the one hand, and the existence of an appropriation to fund the obligation, on the other, is a cornerstone of Tucker Act adjudication. As the Court of Claims said in *Gibney* long ago:

> The judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them. Neither is a public officer's right to his legal salary dependent

> upon an appropriation to pay it. Whether it is to be paid out of one appropriation or out of another; whether Congress appropriate[s] an insufficient amount, or a sufficient amount, or nothing at all, are questions which are vital for the accounting officers, but which do not enter into the consideration of a case in the courts.

Gibney v. United States, 114 Ct. Cl. 38, 52 (1949).[15]

Thus, while Congress' failure to appropriate funds for Section 1402 reimbursements restricted HHS' ability to remit those payments to insurers, it did not negate the obligations created by Section 1402. *See Ferris*, 27 Ct. Cl. at 546 ("An 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***, nor defeat the rights of other parties") (emphasis added). Just as this Court held with respect to the risk corridors provision at issue in *Moda*, this

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[15] *See also id.* (stressing that an appropriation "limitation upon the power of the Secretary does not extend to the court; the real question before the court is that of the claimant's legal right to receive the pay" to which the controlling statute entitled him); *Collins v. United States*, 15 Ct. Cl. 22, 35 (1879) ("***This court***, established for the sole purpose of investigating claims against the government, ***does not deal with questions of appropriations, but with the legal liabilities incurred by the United States*** under contracts, express or implied, the laws of Congress, or the regulations of the executive departments.") (emphases added); *New York Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966).

Court should hold that the nearly identical language in Section 1402 obligated the United States to make the payments described therein.

As it did in *Moda*, the Government also invokes the Anti-Deficiency Act, 31 U.S.C. § 1341, in support of its view that this Court ought not recognize an obligation to pay absent an appropriation to support it. But as this Court held in *Moda*, the fact that the Anti-Deficiency Act bars HHS—the federal government's agent—from making payments absent an appropriation for those payments says nothing about whether the government, as whole, owes that obligation. The Anti-Deficiency Act constrains the ability of government officials to take actions in the absence of funds available to them, but does not negate the statutory obligations of the government itself. This is clear from the plain language of the Anti-Deficiency Act and the cases construing it.

As this Court explained:

> It is 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. That Act provides that "[a]n officer or employee of the United States Government . . . may not . . . make or authorize an expenditure . . . exceeding an amount available in an appropriation . . . for

> the expenditure." 31 U.S.C. § 1341(a)(1)(A). But the Supreme Court has rejected the notion that the Anti-Deficiency Act's requirements somehow defeat the obligations of the government. *See Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 197 (2012). The Anti-Deficiency Act simply constrains government officials. *Id.*

Moda, 892 F.3d at 1322. Just as with any other debtor, the failure to pay, or to designate funds for payment, does not negate the obligation to pay.

The Government says that *Moda* got it wrong. It says that in *Prairie County v. United States*, 782 F.3d 685 (Fed. Cir. 2015), this Court characterized *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182 (2012), as resting on contract law and, therefore, its holding does not extend to statutory claims. Govt. Br. at 25-26. Here again—and quite apart from the fact that *Moda* is the controlling precedent on this point—the Government's arguments miss the mark. While *Salazar* was indeed a contract case, the relevant point was not grounded on contract law. To the contrary, it was grounded on the distinction stressed in *Ferris*—on which it relied—that the creation of an obligation, and the funding of that obligation, are distinct actions.

And nothing in *Prairie County* is to the contrary. *Prairie County*, like *Greenlee County*, concerned the Payment in Lieu of Taxes Act, or PILT. 782 F.3d at 690. In *Greenlee County*, this Court held that PILT was money-mandating, but denied the plaintiff's claim for damages for amounts that exceeded the Secretary of Interior's appropriation to pay its PILT claims because PILT's "shall make" promise of payment was *expressly* conditioned on available appropriations. 487 F.3d at 878-79 ("Amounts are available only as provided in appropriation laws"). *See* 31 U.S.C. § 6906. As the Court observed in *Greenlee County*, this language of limitation has long been seen as restricting the obligation to the amount of the appropriation. 487 F.3d at 878-79. No such language is part of Section 1402—and the availability of such language to limit payments in the absence of appropriations only highlights that Section 1402 created a payment obligation not limited to appropriations.

The question in *Prairie County* was whether *Salazar* altered the law to now allow broad obligations to be created by the Government's agents even where the statute expressly provided that the payment obligation was subject to appropriations. It did not. *Salazar* had construed the Indian Self-Determination and Education Assistance Act

("ISDA"), and contracts entered into with the Government under ISDA. Although ISDA provides that federal funding for ISDA contracts are "subject to the availability of appropriations," the Supreme Court held that once the federal government enters into a contract, traditional contracting principles apply. *Salazar*, 132 S. Ct. at 2189. Accordingly, the federal government cannot back out of a fully formed contract and avoid damages to the contractor on the basis that Congress did not appropriate sufficient funds. *See id.* at 2191. Because the obligation ran to the United States, the mere fact that the agency was restricted by the Anti-Deficiency Act in its ability to pay claims only to the amount of the appropriation did not negate the obligation of the United States. *See id.* at 2193 (citing *Ferris*, 27 Ct. Cl. at 546).

Construing *Salazar*, this Court held in *Prairie County* that the decision did not alter the Court's interpretation of PILT. Because there was no separate contract, *the terms of the statute would control*—and the statute at issue there plainly limited the Government's obligation to the extent of available appropriations. 782 F.3d at 690. That made all the difference: *Prairie County* makes clear (as did *Greenlee County*) that Congress can obligate the United States by statute, but that the

extent of the obligation depends on whatever limitations are placed in the statutory text. The decisive point here is that in the case of Section 1402, Congress placed no restriction on the obligation to pay CSR reimbursements. Thus, as in *Moda*, the obligation is the full amount of the unpaid claims, precisely as the statute states. *See id.*

The Government nonetheless argues that this Court should not construe Section 1402 to have directed government officials to violate the Anti-Deficiency Act, and that "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." Govt. Br. at 24. But there is nothing to harmonize because there is no tension between Section 1402 and the Anti-Deficiency Act. It "has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt." *Moda*, 892 F.3d at 1321. And there was every reason to believe that the Congress that enacted the ACA expected that subsequent Congresses would, in the ordinary course, provide the appropriations that would allow the Government to satisfy its statutory obligations under Section 1402. That Congress did not do

so did not cancel the underlying obligation. Refusing to pay a debt does not cancel the debt.

2. The First Half of *Moda* Is Not Dictum.

The Government contends that the portion of *Moda* addressing the obligation created by Section 1342 of the ACA—the first holding—"was not necessary to the Court's decision and is thus not binding precedent." Govt. Br. at 25. This argument falls flat for two reasons. First, *Moda*'s holding (that a statutory payment obligation exists independent of a corresponding appropriation) was not dictum. Second, *Moda* did not break new ground in this holding, but instead followed binding precedent spanning more than a century.

There were two "holdings" in *Moda*, as that term is used and understood. Indeed, this Court could hardly have reached the question on which it ultimately decided *Moda* in the Government's favor (concerning the effect that subsequent legislation had on the original obligation) without first determining that Section 1342 imposed an obligation on the United States to pay insurers according to its statutory formula, and was not intended to be "budget neutral."

It is well recognized that an appellate decision can contain multiple holdings that, in combination, are necessary to the final result. *See Seminole Tribe of Fla. v. Fla.*, 517 U.S. 44, 67 (1996) ("When an opinion issues for the Court, it is not only the result but also those portions of the opinion necessary to that result by which we are bound."); Bryan A. Garner, The Law of Judicial Precedent 115 (2016) ("When the record presents several questions, and the court considers and deliberately decides each one, the case is precedential for them all."). *E.g.*, *DaimlerChrysler Corp. v. United States*, 361 F.3d 1378, 1385 (Fed. Cir. 2004) (applying *Seminole Tribe*, stating "[w]e read the Supreme Court's analysis [regarding the part of the case that the Government portrayed as dicta] not as dicta, as the government suggests, but as necessary to the Court's analysis such that we are bound by it"). The same is true of *Moda*.

Indeed, the rule that a considered decision of the Court relevant to its ultimate decision must be deemed holding, not dictum, is especially clear in *Moda*. The first half of the *Moda* decision construes the statute to impose an obligation to pay according to the statutory formula, rejects the notion that the absence of an appropriation affected the

meaning of the statute, and rejects the Government's Anti-Deficiency Act theory. These determinations are all predicates to the ruling in the second half of the decision. This Court could not have held that each of the subsequent yearly appropriation riders "suspended" the obligation to pay each year unless it had first determined that there was, in fact, a statutory obligation to pay. And indeed, *Moda*'s holding that the existence of the underlying statutory obligation to pay (which was not intended to be "budget neutral," as the Government contended) has independent significance because of its implications for further congressional action: It clarifies that Section 1342, which remains in the statute books, creates an obligation to pay according to the statutory formula, and that Congress need only provide funding to lift the "suspension" and ensure that the risk corridor payments, under the statutory formula, will be made.

B. The Government Cannot Avoid the Mandate of Section 1402.

1. The Government Ignores the Intent Reflected in the Plain Language of Section 1402.

The Government literally ignores the plain text of Section 1402. The "shall make" mandate of Section 1402 does not garner a single mention in its Argument section. Rather, the Government's theory is

that it is not the language of the statute that is controlling but rather Congress' intent. Where the language of the statute is clear, that is itself a debatable proposition.

But even on its own terms, the Government's argument ignores the self-evident proposition that the best evidence of Congress' actual intent is the words it chose to use in a statute to communicate that intent. And equally importantly, even if, in theory, the Court could elevate "intent" over the plain language of the statute, the Government offers no persuasive basis to do so here. Rather, it seeks to conjure an intent that contradicts the plain language of the statute from a host of strained arguments none of which are supported by any direct evidence of the actual intent of Congress, in the form of legislative history or contemporaneous statements or understandings by the legislators. The kind of speculation that the Government cites as the source of its view of intent is frequently illogical and inconsistent with the precedent of this Court and the Supreme Court.

Indeed, the Government's newly proposed "intent-based" interpretation of Section 1402 is precisely contrary to its own reading of Section 1402 just a few years ago in *U.S. House of Representatives v.*

Burwell. In *Burwell*, the Government squarely acknowledged that the ACA "requires the government to pay cost-sharing reductions to issuers," and explained to the district court that "[t]he absence of an appropriation would not prevent the insurers from seeking to enforce that statutory right through litigation." Defs.' Mem. ISO Mot. for Summ. J., *U.S. House of Representatives v. Burwell*, Case No. 1:14-cv-01967-RMC, Dkt. No. 55-1 (D.D.C. filed Dec. 2, 2015) at 20. The Government further acknowledged that prevailing insurers "can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund . . . ." *Id*.

2. *Bormes* Has No Application Here and Does Not State any Contrary Rule.

In this Court, the Government cites *United States v. Bormes*, 568 U.S. 6 (2012), in support of its position that this Court may ignore Section 1402's statutory directive in favor of a search for unexpressed congressional intent. But *Bormes* provides no support for the Government's invitation that this Court ignore the language of the statute in favor of an unconstrained exploration of congressional intent.

Bormes, unlike this case, did *not* involve a money-mandating statute directing the government to make payments, thus giving rise to

both Tucker Act jurisdiction and a cause of action. The issue in *Bormes* was whether a separate "judicially enforceable" remedial scheme provided by the Fair Credit Reporting Act ("FCRA") "displaced" the Court of Federal Claims' Tucker Act jurisdiction. *See* 568 U.S. at 12-13. As the Supreme Court stated:

> The Tucker Act is displaced . . . when a law assertedly imposing monetary liability on the United States contains its own judicial remedies. In that event, the specific remedial scheme establishes the exclusive framework for the liability Congress created under the statute.

Id. After examining the *judicially enforceable* remedy created by the FCRA, the Court held that it displaced any more general remedy that might otherwise be available under the Tucker Act. *See id.* Missing here, of course, is any suggestion that Congress created an alternative, judicially enforceable, remedial scheme that Plaintiffs-Appellees could avail themselves of in lieu of Tucker Act remedies.

And *Bormes* does not support any notion that, when faced with clear money-mandating language creating jurisdiction and an apparent right to payment, the Court should seek out gleanings of some contrary intent from speculative sources. To the contrary, the Supreme Court and Federal Circuit precedents addressing remedial schemes displacing

Tucker Act jurisdiction all concern "judicially enforceable" alternative remedies. *See Alpine PCS, Inc. v. United States*, 878 F.3d 1086, 1092-93 (Fed. Cir. 2018) (citing cases). *Bormes* certainly offers no support for the notion advanced by the Government that this Court should not construe Section 1402 to provide a basis for payment simply because insurers could make up their losses by raising premiums instead.[16]

3. Nothing About Section 1401 Reveals an Intention That Section 1402 Not Create Enforceable Obligations.

In this Court, the Government (at 18) makes only passing mention of what was one of its central arguments in the Court of Federal Claims. The Government argued that Congress' decision to support Section 1401 premium tax credits with the existing permanent appropriation for tax refunds under 31 U.S.C. § 1324, but to leave Section 1402 to the yearly appropriations process, demonstrated Congress' intent that Section 1402 not be an enforceable obligation absent an appropriation. *See* Appx10, Appx21-22 (rejecting that argument below).

[16] Indeed, the Government did not even cite *Bormes* in the Court of Federal Claims in connection with either of the cases at hand.

But that argument begins on the false premise that there is something noteworthy about Congress creating an obligation and leaving the funding of that obligation to the yearly appropriation process. *Moda* squarely addressed and refuted such a connection. Obligations and appropriations are distinct issues and Congress is free to create an obligation that it will fund, year to year, through the annual appropriations process.

The Government emphasizes the proximity of Section 1401 to 1402 within the ACA. Govt. Br. at 18. But the proximity of the two sections means nothing more than what is apparent on the face of the ACA: both provisions relate to subsidies for plan enrollees. The Supreme Court has routinely dismissed arguments that proximity matters where the argument is not supported by anything in the text itself. *See*, *e.g.*, *Sebelius v. Auburn Regional Medical Ctr.*, 133 S. Ct. 817, 819-20 (2013) (rejecting proximity-based argument); *Gonzalez v. Thaler*, 565 U.S. 134, 146 (2012) (same).

Indeed, if an explanation were needed why Section 1401 contains a permanent funding source and Section 1402 does not, that explanation is right at hand. Section 1401 addresses tax credits. It was

enacted as an amendment to the Internal Revenue Code itself and is part of the tax code. 26 U.S.C. § 36B. It was therefore perfectly natural for Congress to fund it through the standing appropriation from which the Treasury makes tax-related payments. 31 U.S.C. § 1324.

Section 1402 rests on an entirely different footing. It does not involve taxes. And it was therefore perfectly natural for Congress to leave its funding to the annual appropriations process, as many other parts of the ACA are funded.

4. Insurers' Potential to Increase Their Premiums Provides No Basis for Ignoring the Mandate of Section 1402.

As its final effort to avoid the plain text of Section 1402 by invoking a hypothesized congressional intent, the Government proposes to connect any government cutoff of Section 1402 CSR payments with the ability of insurers to raise premiums to make up for lost revenue. In the Government's view, "Congress had no reason to provide a damages remedy [to allow insurers to recover the Section 1402 owed but unpaid] because insurers—which could recoup their costs by raising premiums—would not be injured." Govt. Br. at 19. As such, the Government reasons that, contrary to what Congress said, Congress did

not mean for insurers to be able to insist on the Government's performance of its Section 1402 obligations.[17] Indeed, the Government explains that any such premium increase would, and did, result in increased government payments under Section 1401, above and beyond what the Government would owe if had simply appropriated the funds required to meet its CSR obligations under Section 1402.

a. The Government's Argument Has No Basis in the Statutory Text.

The Government's argument ignores what has already been pointed out above: In directing that the Government "shall make" the Section 1402 CSR reimbursements, Congress spoke unambiguously. Those unambiguous statements reflect the intention and expectation of the Congress that enacted the ACA that the government would, in fact, make the Section 1402 payments that the statute directs. There is no

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[17] To the extent that the Government is trying to connect this argument about hypothetical intent with the inquiry into congressional intent outlined in *Bormes*, it is sufficient to say that *Bormes* was concerned with the clear inferences to be drawn from Congress' affirmative creation of alternative, "judicially enforceable" remedies. 568 U.S. at 13. *See also Alpine*, 878 F.3d at 1092-93 (citing cases). Nothing in *Bormes* suggests that opportunities for self-help "remedies" (as by trying to raise premiums) in the face of a government-failure to pay militates against enforcing the clear language of a statute that unambiguously creates an obligation to pay.

indication that the enacting Congress anticipated that a future Congress would not appropriate Section 1402 funds (despite a statute that clearly required HHS to make payments), and therefore, that insurers might have to raise premiums to mitigate the consequences of a future Congress arbitrarily deciding not to fund its Section 1402 obligations.[18] The connection that the Government hypothesizes between Section 1402 non-payment and premium increases is—as a theory of "intent"—a pure fiction.

The Government identifies nothing in Section 1402 as anything but mandatory and definite. Section 1402 lacks any of the language—*e.g.*, "subject to appropriations"—that Congress uses to make payment obligations contingent on the appropriation actions of a subsequent Congress. *See Greenlee Cty.*, 487 F.3d at 878-79; *Prairie Cty.*, 782 F.3d at 690. There is likewise nothing in the statute that suggests that Congress viewed the CSR payment framework of Section 1402 as interchangeable with the premium tax credits it provided in 1401. They

[18] It is, of course, always possible that Congress might not follow through on its promises. But it would be strange to deem the mere possibility of a future Congress not appropriating funds as evidence that Congress intended to make optional what Section 1402 designates as mandatory.

are not presented as alternative programs but rather as separate and distinct mandates, each with a distinct function, and both of which operate at the same time. And it identifies no legislative background materials—debates, reports, or discussions—that make such a connection. Indeed, while the Government, in passing, uses language in its brief suggesting that Congress actually anticipated that insurers would use increased premiums to make up for lost CSR payments, as if it that had always been the intended "remedy" for any non-payment of CSR reimbursements, *see* Govt. Br. at 10, 18-19, the Government ultimately confesses that there is no evidence to support any such connection.

In fact, after asserting that Congress had no reason to provide a damages remedy in light of insurers' ability to raise premiums, the Government turns to the notion of "silver loading," *i.e.*, concentrating the increase in premiums specifically on silver plans since it is for silver plans that a premium increase generally triggers a dollar-for-dollar tax credit. *See* 26 U.S.C. § 36B. But even the Government concedes that the potential interplay between Section 1401 and 1402 is not one Congress would have likely appreciated when it enacted the ACA in

2010. Govt. Br. at 21 ("To be sure, Congress may not have specifically contemplated that insurers would engage in the particular practice of 'silver loading' . . . ."). [19] As a matter of congressional intent, the connection between Section 1401 and Section 1402 that the Government posits is hypothetical at best.

b. Sections 1401 and 1402 Are Distinct Mandates.

As explained above, there is no statutory text or legislative history supporting the notion that Congress conceived of a possible trade-off between payments under Section 1401 and Section 1402, and that this supports the notion that Section 1402 was to be unenforceable. At least as a matter of "intent," the proposed trade-off is more imagined than actual. To the contrary, the nature of the programs demonstrates that both were intended to be mandatory and run in parallel.

These two programs provide distinct and separate forms of subsidy. Each affords a distinct set of benefits, serving somewhat different populations, and each with a distinct payment structure for affected insurers. The premium tax credit set forth in Section 1401

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[19] The Government concedes that in approving premium increases, States could engage in "silver-loading" irrespective of whether CSRs were, or were not, paid. Govt. Br. at 11.

assists eligible insureds in purchasing insurance coverage by subsidizing the cost of the premiums. Section 1402 reduces the ongoing out-of-pocket costs of a different class of eligible insureds. In short, Section 1401 provides a means for acquiring insurance while Section 1402 provides a means for utilizing that insurance, by reducing out-of-pocket costs, on a day-to-day basis.

Both programs were deemed important, which was why the Congress that enacted the ACA used mandatory language that required both programs to be implemented. The Congress that enacted the ACA would not have anticipated that some subsequent Congress would simply choose not to fund its Section 1402 obligations, and thus could not have "intended" that the ability to raise premiums would negate insurers' right to insist that the Government meet its obligations under Section 1402.

What is more, as the Government acknowledges (at 5), insurers' ability to raise premiums ultimately rests with state insurance regulators, and any premium increase is filtered through the state regulatory process. Even in practice, the Government concedes that not every state allowed insurers to raise their premiums even after the

federal government stopped making CSR reimbursement payments. *See* Govt. Br. at 11 n.7. And while the loss of CSR revenues would be taken into account in setting premiums, Judge Kaplan observed that there is no suggestion of any direct linkage between the premiums charged by insurers, and allowed by state regulators, and Section 1402 reimbursement. *See* Appx10, Appx22-23. Premiums are set by state regulators taking a number of factors into account, the possibility of CSR reimbursements being just one. There is no suggestion of any one-to-one connection between premium increases allowed by the regulators and the loss of CSR revenues.

This very case highlights that the connection between the potential for premium increases, and unpaid Section 1402 benefits, is indefinite and uncertain at best. As Judge Kaplan observed, in these cases, the Government offers no suggestion as to how Plaintiffs-Appellees would have been able to raise their premiums to counteract the 2017 shortfalls (at issue here) resulting from HHS' cutoff of CSR payments for that year.

c. The Government's Argument Proves Too Much.

The Government's "double recovery" theory proves far too much. Any commercial entity, deprived of one source of revenue, may seek to modify its pricing to recover the lost revenue in another way. But those limitless possibilities have never been thought of as precluding a cause of action for breach of an obligation owed that entity. For example, PILT states that the Government "shall make" payments to local governments for the loss of tax revenue for federal enclaves. *See* 31 U.S.C. §§ 6901, 6902(a)(1). Of course, the local government could make up the lost revenue by raising property taxes on other entities. And, of course, to the extent it successfully did so, and was also able to recover under the Tucker Act, it would for that period realize more revenue than it might otherwise have realized. But this Court rejected the Government's argument that PILT was not a money-mandating statute, and thus not a source of a cause of action against the United States under the Tucker Act. *See Greenlee Cty.*, 487 F.3d at 877.

There are no "double recoveries." Whatever insurers are collecting in premiums is, as noted, a function of state regulation. Premium receipts are not a "recovery"; they are a source of business revenue

necessary for the business to remain actuarially sound. CSR reimbursements, in contrast, are a statutory promise of the United States, in return for insurers reducing the cost-sharing expenses of their plan enrollees in the first instance. Premium receipts and CSR reimbursements are distinct sources of revenue. Obtaining both does not "double" anything.

d. That the Result of Not Enforcing Section 1402 May Be Increased Premiums and Government Expense Confirms That the Congress That Enacted the ACA Would Want to Ensure That the Government Meets Its Section 1402 Obligations.

The Government notes that the result of withholding appropriations for the CSRs was that many state regulators allowed insurers to increase their premiums. And as a result of those premium increases, the Government has paid out more under Section 1401 than it would have paid if it had, in fact, made timely payments under Section 1402 as the statute required. To add insult to injury, the Government complains that many state regulators found ways to maximize the federal government's expense. *See* Govt. Br. at 11. Rather than simply allow insurers to make up for lost CSR revenues through increases in all metal levels of plan, including gold and

platinum levels, the premium increases in some states were concentrated in silver plans—so called "silver-loading—which provides the measure for Section 1401 premium tax credits.

If all this is true, that is simply a consequence of what, in the Government's view, has apparently turned out to be a short-sighted failure to appropriate money to allow HHS to fulfill the Government's Section 1402 obligations. But avoidance of bad policy results flowing unintentionally from congressional inaction has never been solid ground on which to interpret a statute in a manner at odds with its plain text. *See*, *e.g.*, *Fla. Dep't of Revenue v. Piccadilly Cafeterias, Inc.*, 554 U.S. 33, 52 (2008) ("it is not for us to substitute our view of . . . policy for the legislation which has been passed by Congress." (citations and quotations omitted)).

Moreover, the Government's further suggestion that the Court should infer a congressional intent that Section 1402 not be enforceable because the result of not paying CSRs is that premiums increase and the federal government's ACA expense likewise increases, makes no sense. *See* Govt. Br. at 11 (noting that the "pattern of increased government spending . . . is expected to continue as long as Congress

declines to fund cost-sharing payments and silver loading is permitted."). If, as the Government contends, the result of failing to make CSR payments would predictably be that premiums would increase, and the Government's ACA costs would increase, that would make it even more unlikely that the Congress that enacted the ACA would have "intended" the Government's Section 1402 obligations to be optional and unenforceable. Indeed, the logical upshot of the Government's own reasoning is that a decision by this Court affirming the decisions below, and confirming that insurers must be reimbursed for the CSRs they provide, will help *reduce* premiums—itself an objective of Congress—and *reduce* the Government's overall ACA cost burden.

Of course, all this only highlights why the Government's invitation to this Court to attribute a hypothetical intent to Congress, based on economic and policy arguments, takes the court into poorly charted territory, and provides no proper basis to depart from Section 1402's mandate. The central point for this Court should remain that under the plain language of Section 1402, and established precedent, Plaintiffs-Appellees may properly insist that the Government meets its

obligations under Section 1402, and bring suit in the Court of Federal Claims to do so.

5. The Government's Theory That the Failure to Appropriate "Suspended" the Statute Is Inconsistent With Precedent.

In the end, the Government stops arguing about the intent of the Congress that enacted the ACA in 2010, and says that this Court should infer a congressional intent to legally suspend Section 1402 payments from the failure of *subsequent* Congresses to appropriate funds for those payments. *See* Govt. Br. at 29-32. In making this argument, the Government invokes the second part of the *Moda* decision, where this Court interpreted the significance of subsequent legislation—specific appropriations riders—that barred HHS from using certain funds for the risk corridor program at issue there.

But, as Judge Kaplan pointed out, in contrast with the facts at issue in *Moda*, there is no subsequent legislation for this Court to interpret with respect to the Section 1402 CSR program. All we have is a bare failure to appropriate money. Congressional inaction, in the form of a failure to do something—to appropriate money—cannot repeal or "suspend" an existing statutory obligation.

Indeed, that is the very basis of lawmaking. It requires the majority vote of each House of Congress, and the concurrence of the President (or the override of his veto) to enact legislation. That was the constitutional process that produced the Affordable Care Act. To repeal or suspend that Act would require the same constitutional process. Congressional inaction, by one or both Houses of Congress, cannot repeal or suspend an existing law.[20]

That is also the central lesson of *United States v. Langston*, 118 U.S. 389 (1886), a case that is flatly at odds with the Government's position, and on which this Court relied in *Moda*. In *Langston*, the Supreme Court determined that where the minister to Haiti was promised a fixed salary by statute, the fact that Congress in later years appropriated less than the full amount to pay the salary did not negate the United States' liability for the full amount of the statutory obligation. The Supreme Court held that "a bare failure to appropriate

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[20] *See also Pension Benefit Guar. Corp. v. LTV Corp.*, 496 U.S. 633, 650 (1990) ("Congressional inaction lacks 'persuasive significance' because 'several equally tenable inferences' may be drawn from such inaction . . . ." (quoting *United States v. Wise*, 370 U.S. 405, 411 (1962)); *Schneidewind v. ANR Pipeline Co.*, 485 U.S. 293, 306 (1988) ("This Court generally is reluctant to draw inferences from Congress' failure to act.").

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." 118 U.S. at 394.

That is also true here, which is why the court below held that "[t]his case clearly falls into the same category as *Langston*." Appx10, Appx22. The Government contrasts *Langston* with *Belknap v. United States*, 150 U.S. 588 (1893), a case which it portrays as cabining *Langston*. *See* Govt. Br. at 30. But *Belknap* did no such thing. It too involved a claim for damages stemming from 10 consecutive salary appropriations that fell short of the amount set by the original statute. The Supreme Court said it "was not questioning at all the *Langston* case" and that the "whole question depends on the intention of Congress as expressed in the statutes." 150 U.S. at 594-95. It went on to find, after scrutinizing the successive legislative acts, that Congress intended to adjust the salary as reflected in the yearly appropriations acts. *Id.* at 595.

Belknap gets the Government nowhere in this case. Its analysis was a precursor to the very analysis that this Court conducted in *Moda* in ruling for the Government. In *Moda*, after holding in the first part of

the opinion that Section 1342 was "unambiguously mandatory" and thus created an obligation of the United States notwithstanding the lack of an appropriation, *see* 892 F.3d at 1320, the Court construed three successive pieces of legislation, in the form of appropriations riders, as "suspending" the obligation, and thus—for those operative years—negating the obligation. *See id.* at 1322-29. But there is no such subsequent legislation to construe in this case, so *Belknap*, and the second part of *Moda* (and kindred cases on which it relied), has no application here.

As in *Langston*, the "bare failure [of Congress] to appropriate funds" is not probative evidence of an intent of Congress to negate the obligation after the fact (or confirmation of Congress's original intent in 2010). Consequently, Congress' failure to appropriate funds to support its Section 1402 obligations cannot negate those obligations.

II. THE GOVERNMENT BREACHED AN IMPLIED-IN-FACT CONTRACT.

The Court of Federal Claims did not pass on the Plaintiffs-Appellees' claims for breach of an implied-in-fact contract, deeming it unnecessary to do so in light of the favorable decision on the statutory claim. Appx6, Appx18. The Government nonetheless addresses the

claim, perhaps wanting to get a jump on future appeals from other Court of Federal Claims decisions that have ruled against the Government on this very claim. Although the Court need not address it in this case since it was not passed on by the court below, Plaintiffs-Appellees will respond to the Government's brief.

A. The Government Breached Implied-in-Fact Unilateral Contracts With Plaintiffs-Appellees.

Implied-in-fact contracts require: (1) mutuality of intent; (2) unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the government contracting representative or subsequent ratification. *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995). In these consolidated cases, all elements of an implied-in-fact contract are met. The government held out a unilateral offer of CSR payments to insurers that provided insurance on the exchanges and reduced cost-sharing amounts for eligible insureds. Plaintiffs-Appellees accepted by performing. HHS' failure to uphold its side of the bargain is a contractual breach.

1. There Was Mutuality of Intent to Contract.

The Government contracts when its conduct or language "allows a reasonable inference" that it intended to do so. *ARRA Energy Co. I v.*

United States, 97 Fed. Cl. 12, 27 (2011). The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[21] The combination of Section 1402, HHS' implementing regulations, and the Government's own conduct support that the "conduct of the parties show[s], in the light of the surrounding circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996) (citations omitted).

This application of that longstanding test is best illustrated in *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957). In that case, the court found that a regulation establishing a guaranteed minimum government purchase price for uranium was not "a mere invitation to the industry to make offers to the Government," but instead expressed an intent to contract, because the regulation's

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[21] *See, e.g.*, *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 468 (1985); *U.S. Trust Co. of New York v. New Jersey*, 431 U.S. 1, 17-18 (1977) (although the statute did not expressly state an intent to contract, it was "properly characterized as a contractual obligation" when considering the purpose of the agreement and the fact that the Government "received the benefit they bargained for"); *Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (an implied-in-fact contract "is not created or evidenced by explicit agreement of the parties, but is inferred as a matter of reason or justice from the acts or conduct of the parties").

purpose was to "induce persons to find and mine uranium." *Id.* at 405-06. In other words, the case focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[22] The Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[23] *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

Applying this precedent, it is clear that, by requiring insurers on the exchanges to reduce cost sharing for eligible insureds while at the same time promising the insurers that the Government would reimburse them for the amount of those CSRs, one obvious purpose of

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[22] *See also Wells Fargo Bank, N.A. v. United States*, 26 Cl. Ct. 805, 810 (1992), *aff'd*, 88 F.3d 1012 (Fed. Cir. 1996) (""There is ample case law holding that a contractual relationship arises between the government and a private party if promissory words of the former induce significant action by the latter in reliance thereon.' Thus, where a unilateral contract is at issue, the fact that only one party has made a promise does not imply that a contract does not exist. A contract comes into existence as soon as the other party commences performance.") (quoting *Nat'l Rural Utils. Coop. Fin. Corp. v. United States*, 14 Cl. Ct. 130, 137 (1988) (internal citations omitted)).

[23] That *Radium Mines* involved a purchase contract for uranium that met the regulatory qualifications is irrelevant, as the crux of *Radium Mines* is that "the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001) (citations omitted).

the CSR program was to minimize new costs for insurers as further *inducement* to them to participate on the exchanges. The CSR program's promissory nature evidences the Government's intent to enter into a binding contract to make full CSR payments to insurers that did what Section 1402, and the remainder of the ACA, required them to do.

In *New York Airways*, the predecessor to this Court described a mandatory statutory payment as creating an implied contract once the plaintiff satisfied the requirements for payment. 369 F.2d at 752 (holding that the actions of the parties support the existence of a contract implied in fact where the agency's order was "in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer"). When the Government includes "numerous requirements . . . to receive the payments," those payments are "compensatory in nature," and one can accept such offer for payment through satisfaction of the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F.2d 518, 521 (5th Cir. 1948). Here, the ACA requires insurers to reduce cost sharing for

eligible insureds, and when the insurers satisfied that requirement, the mutuality of intent formed an implied-in-fact contract, obligating the government to pay the insurers.

2. The Government Held Out a Unilateral Offer That Plaintiffs-Appellees Accepted Through Performance.

With Section 1402, this Government made a clear and unambiguous offer to make CSR payments to health insurers, including Plaintiffs-Appellees, who reduced cost sharing for eligible individuals on the exchanges. If further confirmation were necessary, the Government provided it through HHS' implementing regulations, its promises of advance payments to insurers that reduced cost sharing, the Government's actions in making CSR payments for benefit years 2014, 2015, 2016 and nine months of 2017, all implemented by agency officials with authority to bind the Government regarding its obligation to make CSR payments.

Plaintiffs-Appellees accepted the offer by performing.[24] Specifically, they accepted the offer by complying with the numerous

[24] In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral contract" as "[a] contract in which only one party makes a promise or undertakes a

administrative requirements, providing health insurance coverage, and reducing cost-sharing amounts for eligible individuals, as defined by Section 1402 and its implementing regulations. As such, the Government's offer became irrevocable—and the Government's counter-performance came due.

3. There Was Consideration.

Consideration at the time of contract formation flowed both ways. In order for Congress to see the exchanges succeed, it needed insurers to step up to provide the insurance. Insurers agreed to participate on the exchanges subject to the many conditions that the ACA placed on coverage only because of the statutory promises to help mitigate certain costs, including by reimbursing cost-sharing reductions for low- and moderate-income individuals that Section 1402 required them to provide. When Plaintiffs-Appellees agreed to offer plans on the exchanges and reduce cost sharing, they committed to an intricate set of specific, reciprocal obligations. The Government benefitted from Plaintiffs-Appellees' participation on the exchanges in compliance with

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performance."); *Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize).

the many conditions that the ACA placed on coverage, including the requirement to reduce cost sharing for certain insureds. In exchange, Plaintiffs-Appellees received consideration because HHS (and the ACA itself) committed that ***only*** issuers that actually reduced cost sharing would receive CSR payments, and that HHS would make advance CSR payments. *Ace-Fed. Reporters, Inc. v. Barram*, 226 F.3d 1329, 1332 (Fed. Cir. 2000) (Government buying from "between two and five authorized sources," to the exclusion of others, was "consideration" with "substantial business value").

4. The Secretary of HHS Had Actual Authority to Contract.

Actual authority can be express or implied—either is sufficient to bind the Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). Agency heads have contract-making authority "by virtue of their position." FAR 1.601(a) (contractual authority in each agency flows from the Agency Head to delegated officials).[25]

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[25] *Accord United States v. Winstar Corp.*, 518 U.S. 839, 890 n.36 (1996) ("The authority of the executive to use contracts in carrying out authorized programs is . . . generally assumed in the absence of express statutory prohibitions or limitations.") (quoting 1 R. Nash & J. Cibinic, Federal Procurement Law 5 (3d ed. 1977)); *H. Landau*, 886 F.2d at 324

Section 1402's instruction that the Secretary "shall establish" the CSR program and "shall make" CSR payments, along with the Secretary's broad obligation to administer and implement the Act,[26] gives the Secretary the express (or at least implied) authority to enter into binding QHPIAs to implement the Act. *See Winstar Corp.*, 518 U.S. at 890 n.36; *H. Landau*, 886 F.2d at 324. Coverage through the exchanges, and the obligation to reduce cost sharing, is carried out exclusively through plans offered by private insurers, and the ability to contract with private insurers is "integral" to the Secretary's ability to effectuate his statutory duty to implement the CSR program. *See H. Landau*, 886 F.2d at 324. Indeed, where contracts have been inferred from statutes promising payment, the Government's authority to contract is clear. *See, e.g.*, *Radium Mines*, 153 F. Supp. at 405-06; *N.Y. Airways*, 369 F.2d at 751-52.

(authority to bind the Government "is generally implied" where such authority is integral to execute program duties).

[26] *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d).

B. The Government's Arguments Against a Unilateral Contract Are Not Persuasive.

The Government argues that nothing in Section 1402 supports an implied-in-fact contractual relationship with Plaintiffs-Appellees. In particular, it points out that this Court rejected an implied-in-fact contract argument posed in *Moda* because the risk corridors scheme was simply part of an incentive structure that lacked the indicia of a Government "offer."

But Section 1402 provides for a different type of program than was at issue in *Moda*, and thus requires separate consideration by this Court. The CSR program directs insurers to reduce the cost-sharing requirements of their enrollees in exchange for a promise of dollar-for-dollar reimbursement from the United States. This is precisely the type of "traditional quid pro quo" that signals an implied contract. *Id.* at 1330. In *Maine Community Health Options*, Chief Judge Sweeney examined the Section 1402 program and summarized the point nicely, distinguishing *Moda* and finding an implied contract, holding:

> The risk corridors program differs from the [CSR] program in one significant manner: in the risk corridors program, insurers receive payments as an incentive to lower their premiums, while in the [CSR] program, insurers are reimbursed by the government for [CSRs] that they are

> statutorily required to make. In other words, the [CSR] program is less of an incentive program and more of a quid pro quo. Accordingly, that aspect of Moda Health Plan's analysis is inapplicable in this case.

142 Fed. Cl. 53, 75 (2019).

The Government is also incorrect in asserting that nobody at HHS had authority to bind the Government in contract. As explained above, HHS officials—in particular, the Secretary of HHS had actual, or at least implied, authority to bind the Government. And, in any event, the fact that HHS continued to receive the benefits of Plaintiffs-Appellees' performance on the exchanges would give rise to a finding of implied or institutional ratification, even if actual authority were lacking in the first instance.

CONCLUSION

The decisions below should be affirmed.

May 1, 2019

/s/ Stephen J. McBrady
Stephen J. McBrady
(Counsel of Record)
Crowell & Moring LLP
1001 Pennsylvania Ave., NW
Washington, DC 20004-2595
Tel: (202) 624-2547
Fax: (202) 628-5116
SMcBrady@crowell.com

Attorney for Plaintiffs-Appellees Sanford Health Plan and Montana Health CO-OP

CERTIFICATE OF SERVICE

I hereby certify that on May 1, 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.

May 1, 2019

/s/ Stephen J. McBrady
Stephen J. McBrady

CERTIFICATE OF COMPLIANCE

This Brief complies with the type-volume limitation of Federal Rule of Appellate Procedure ("Fed. R. App. Proc.") 32(a)(7)(B) and Federal Circuit Rule 32(a): it contains 12,910 words, excluding the portions exempted by Fed. R. App. Proc. 32(f) and Federal Circuit Rule 32(b).

This Brief complies with the typeface requirement of Fed. R. App. Proc. 32(a)(5) and the type style requirement of Fed. R. App. Proc. 32(a)(6): It has been prepared in a proportionally-spaced typeface using Microsoft Word 2010 in 14 point size.

May 1, 2019

/s/ Stephen J. McBrady
Stephen J. McBrady