Nos. 2019-1290, 2019-1302, 2019-1633

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.

COMMUNITY HEALTH CHOICE, INC.,
Plaintiff-Appellee,

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;
and Case No. 18-5C, Chief Judge Margaret M. Sweeney

REPLY BRIEF FOR APPELLANT

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INTRODUCTION

Plaintiffs offer a simple but unpersuasive proposition. Section 1402 of the Patient Protection and Affordable Care Act (ACA) required insurers to reduce cost sharing for eligible insureds and also provided that HHS "shall make periodic and timely payments to the issuer equal to the value of the reductions." Therefore, plaintiffs argue, they are entitled to damages whenever those payments are not made.

This argument requires the Court to disregard the rest of the ACA and the legal hurdles that any plaintiff must surmount to demonstrate that Congress created the right to monetary relief.

The ACA established both the cost-sharing program and the related tax credit program for subsidizing premiums. It provided a permanent appropriation for the tax credits. As plaintiffs recognize, however, the ACA did not provide a permanent appropriation for the cost-sharing program. Instead, it left it to future Congresses to determine whether and to what extent to fund such payments. In enacting these related provisions, Congress understood that if future Congresses chose not to provide cost-sharing funding, insurers would raise premiums to recoup their cost-sharing expenses. And, in that event, the impact of higher premiums on consumers would be mitigated by the increased tax credits permanently funded under the ACA.

That is exactly what happened. Plaintiffs' own actuarial memoranda show that they raised premiums for the specific purpose of recouping their cost-sharing

expenses in the absence of federal payments under the cost-sharing program. And the impact on consumers was generally offset by increased tax credits.

Plaintiffs' arguments underscore the errors of their position. Plaintiffs fundamentally misunderstand the legislative process when they assert that the enacting Congress could not have anticipated that future Congresses might not fund cost-sharing payments. The essence of the annual appropriations process is that it is discretionary. Congress fully understood that basic point when it established a permanent appropriation for tax credits and did not do so for cost-sharing payments.

Congress also fully understood that insurers would raise premiums if cost-sharing payments were not funded. As amicus Common Ground recognizes, there is "a *direct* relationship between the amount of an issuer's unpaid costs and its premiums." Br. 4. "Higher costs equal higher premiums." *Id.* Congress did not, as plaintiffs urge, create a scheme under which insurers would cover unpaid costs by raising premiums and also recover those costs in a damages suit.

ARGUMENT

I. Congress Did Not Give Insurers A Right To Damages For Cost-Sharing Payments That Congress Declined To Fund.

Plaintiffs cannot surmount either of the "two hurdles that must be cleared" to establish their Tucker Act claim. *United States v. Navajo Nation*, 556 U.S. 287, 290 (2009). To proceed under the Tucker Act, a claimant must identify a violation of "a substantive source of law that establishes specific fiduciary or other duties," and,

further, show that the substantive law "can fairly be interpreted as mandating compensation for damages sustained as a result of a breach of the duties [the governing law] impose[s]." *Id.* at 291. In combination, these two hurdles require that the claimant show both a "failure to perform an obligation undoubtedly imposed on the Federal Government" and "a right to monetary relief." *United States v. Bormes*, 568 U.S. 6, 15-16 (2012). As we demonstrate in Point B, HHS did not breach "an obligation undoubtedly imposed" by section 1402 of the ACA. *Id.* at 16. But even assuming that plaintiffs could make such a showing, they plainly cannot demonstrate that Congress intended to grant insurers a monetary remedy.

A. An Implied Damages Remedy Would Allow Insurers To Recoup Their Cost-Sharing Expenses Twice.

1. Section 1402 cannot "fairly be interpreted as mandating compensation" for the absence of cost-sharing payments. *Bormes*, 568 U.S. at 15. Plaintiffs invoke the "plain language" of section 1402, Sanford/Montana Br. 22, and urge the Court "to enforce the statute as written," Community Br. 20. But section 1402 contains no "plain language" that gives insurers a damages remedy, and the structure of the statute precludes any such inference.

Congress provided a permanent appropriation for tax credits but did not do so for cost-sharing payments. Plaintiffs observe that HHS previously made such payments from the permanent appropriation for tax credits, but they do not argue that this was a permissible use of the tax-credit appropriation. On the contrary,

Community recognizes (Br. 31) that "Congress did not intend for CSR payments to be funded by permanent appropriations." Sanford and Montana agree (Br. 40) that "Section 1401 contains a permanent funding source and Section 1402 does not."

In contrast to its provision for tax credits, the ACA left to future Congresses the policy choice whether and to what extent to provide funding for cost-sharing payments. If a future Congress appropriated no funds or inadequate funds, insurers would raise premiums to cover their costs. The objective of reducing premiums would not be fully realized, but the impact on consumers would generally be mitigated by the increased tax credits that the ACA permanently funded.

That is in fact what occurred, as reflected in the actuarial memoranda that plaintiffs used to justify their premium increases. The actuarial memorandum prepared for Sanford Health Plan explained that Sanford raised its 2018 premiums because it "assume[d] Cost Sharing Reduction (CSR) subsidy payments will not be funded by CMS in 2018." Milliman, *Part III Actuarial Memorandum, Unfunded Cost Share Reduction Subsidies, Sanford Health Plan Individual Rate Filing Effective January 1, 2018,* at 1 (Sept. 5, 2017).[1] The actuarial memorandum prepared for Montana Health CO-OP likewise relied on the absence of cost-sharing payments in justifying the "reasonableness of applicable rate increases" for 2018. Milliman, *Part III Actuarial Memorandum (Redacted), CSR Not Funded Scenario, Montana Health Co-Op Individual Rate*

[1] https://go.usa.gov/xyjJn

Filing Effective January 1, 2018, at 1, 3 (Oct. 16, 2017).[2] And the actuarial memorandum prepared for Community Health Choice indicated that Community raised its 2018 rates on the assumption that "CSRs will not continue to be reimbursed." Milliman, *Part III Actuarial Memorandum (Redacted), Community Health Choice Individual Rate Filing Effective January 1, 2018*, at 3 (Sept. 18, 2017).[3]

Plaintiffs made the same assumption (no cost-sharing payments) in the actuarial memoranda they used to justify their 2019 rates.[4] And they are presumably poised to do the same for 2020.

2. Nonetheless, plaintiffs have sued for damages for 2018 and reserved the right to do so for all future years in which Congress declines to fund cost-sharing payments. Chief Judge Sweeney awarded Community more than $60 million for 2018 despite Community's premium increase for that year. *See* Community Br. 16. Judge Kaplan declared that Sanford and Montana can recover damages despite their rate increases, *see, e.g.*, No. 19-1290, Appx11, and stayed their 2018 claims pending the

[2] https://go.usa.gov/xyjJV

[3] https://go.usa.gov/xEFjG

[4] https://go.usa.gov/xyjJ7 (Sanford) ("This Actuarial Memorandum assumes Cost Sharing Reduction (CSR) subsidy payments will not be funded by CMS in 2019."); https://go.usa.gov/xyjJt (Montana) ("As prescribed by Montana the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will remain unfunded."); https://go.usa.gov/xyjS3 (Community) ("As instructed by Community Health Choice, the premium rates developed and supported by this Actuarial Memorandum assume that Cost Share Reductions (CSR) will continue to not be funded.").

resolution of these appeals, *see Montana Health CO-OP v. United States*, No. 19-568C; *Sanford Health Plan v. United States*, No. 19-569C.

Contrary to the trial judges' premise, Congress did not enact a scheme under which insurers could raise premiums to cover increased costs and also assert a claim for monies that Congress declined to appropriate. There can be no "fair inference" that Congress authorized double recoveries.

Plaintiffs' arguments highlight the implausibility of their position. They argue that such double recoveries are warranted because Congress would not have "anticipated that insurers would use increased premiums to make up for lost CSR payments." Sanford/Montana Br. 44; *see* Community Br. 40 (describing this connection as "speculative"). That argument is flatly at odds with the fact that "there is unquestionably a *direct* relationship between the amount of an issuer's unpaid costs and its premiums." Common Ground Amicus Br. 4. As Common Ground (which represents a certified class of more than 90 insurers) stresses, "[h]igher costs equal higher premiums." *Id.*

It would thus have been extraordinary if Congress had assumed that premiums would remain constant if cost-sharing payments were not appropriated. And neither the language nor the structure of the statute permits that inference. Congress legislated against the backdrop of longstanding state insurance regulations that require insurers to set premiums high enough to cover their costs. *See* Office of the Assistant Secretary for Planning and Evaluation (ASPE), HHS, *ASPE Issue Brief: Potential Fiscal*

Consequences of Not Providing CSR Reimbursements, at 2 n.4 (Dec. 2015) (*ASPE Issue Brief*).[5] The ACA explicitly preserved that state regulatory authority. Section 1321(d) provides that "[n]othing" in Title I of the ACA, which includes the ACA's insurance regulations, "shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d). The express purpose of that provision was to ensure that there is "[n]o interference with State regulatory authority," *id.*, except in the event of a conflict with federal law. Congress thus specifically preserved the States' role in ensuring that premiums are set at rates high enough to cover an insurer's costs. Such costs include unreimbursed cost-sharing expenses, which is why States approved rate increases to compensate for the absence of cost-sharing payments.

The structure of the ACA reflects Congress's understanding that insurers would raise premiums in the absence of cost-sharing payments. As discussed, the statute provides protection for consumers in the event of increased premiums. 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 through the Exchange in their rating area. *See* 26 U.S.C. § 36B(b)(2)(B). As a result, an increase in silver-plan premiums triggers an increase in the amount of the tax

[5] https://go.usa.gov/xyjS2

credit. Notably, that increase in the tax credit is not limited to those individuals who enroll in silver plans, or whose cost sharing is reduced under section 1402. *See California v. Trump*, 267 F. Supp. 3d 1119, 1135 (N.D. Cal. 2017) (explaining that as a result of silver-loading, "the available tax credits rise substantially"—"[n]ot just for people who purchase the silver plans, but for people who purchase other plans too").

Two years before cost-sharing payments ceased, HHS anticipated that "if the federal government did not reimburse insurers for [cost sharing reductions (CSRs)], insurers would increase plan premiums to cover these costs." *ASPE Issue Brief* at 1. HHS further anticipated that, "[a]s a result of the ACA's structure, these higher premiums would translate into higher federal costs for Premium Tax Credits (PTCs)." *Id.* "Moreover, because many more people are eligible for PTCs than for CSRs, the result would be a substantial increase in total federal costs, compared to the current arrangement under which the federal government directly reimburses insurers for the CSRs they provide to eligible individuals." *Id.* HHS concluded that, "[i]n effect, the federal government would pay CSRs indirectly, through increased PTCs, at much greater total expense." *Id.* That is what happened when cost-sharing payments ceased. *See California*, 267 F. Supp. 3d at 1134-37.

Plaintiffs cannot supply the inference that Congress created a right to damages by asserting that the damages awards they seek "will help *reduce* premiums." Sanford/Montana Br. 51. Damages are a backward-looking remedy. By contrast, premiums are set in advance of a given benefit year based on anticipated costs for that

year, which reflect the costs associated with reducing cost-sharing as required by section 1402. *See* Community Br. 42. If an insurer "cannot, ahead of time, count on reimbursement for those costs, then it must also, by necessity, raise its premiums to cover them," Common Ground Amicus Br. 6, which is what plaintiffs did.

If the Congress that enacted the ACA had wanted to establish a permanent appropriation for cost-sharing payments, it would have done so directly—as the ACA did for tax credits and as Congress has done elsewhere for programs such as Medicare and Social Security. Congress would not have chosen the after-the-fact mechanism of Tucker Act litigation with eventual recourse to the permanent appropriation for final judgments.[6]

Plaintiffs' argument reduces to the proposition that the ACA impliedly authorized double recoveries by directing HHS to make cost-sharing payments. Plaintiffs seek to rely on Justice Scalia's dissenting opinion in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), which stated that "a statute commanding the payment of a

[6] Indeed, the points that Common Ground makes in its amicus brief were made in the *United States House of Representatives v. Burwell* litigation by America's Health Insurance Plans (AHIP)—which is the national trade association for health insurers—and the Blue Cross Blue Shield Association (BCBSA). *See* Amicus Brief of AHIP and BCBSA, *United States House of Representatives v. Burwell*, No. 16-5202 (D.C. Cir. Oct. 31, 2016). There, AHIP and BCBSA argued that the permanent appropriation for tax credits should be interpreted to encompass cost-sharing payments, so that HHS could make advance cost-sharing payments to insurers pursuant to the ACA. AHIP and BCBSA did not suggest that after-the-fact damages awards would be a viable alternative, and they have not filed an amicus brief in support of plaintiffs' position here.

specified amount of money by the United States impliedly authorizes (absent other indication) a claim for damages in the defaulted amount." 487 U.S. at 923 (cited at Community Br. 37; Sanford/Montana Br. 24). The majority did not adopt Justice Scalia's view, and instead held that the means for enforcing such a statute is an action against the agency under the Administrative Procedure Act (APA). *Id.* at 882-83, 905 n.42. Such an APA suit necessarily respects Congress's funding decisions, because a court cannot order an agency to spend money that Congress has not appropriated.

Plaintiffs also disregard Justice Scalia's crucial qualification that a damages remedy can only be inferred "absent other indication." Here there is ample indication that no damages remedy may be inferred. Justice Scalia did not suggest that a damages remedy may be inferred when an agency's failure to make payments is the result of Congress's own funding decisions (which was not an issue in *Bowen*), let alone when that remedy would allow claimants to recoup the same expenses twice (also not an issue in *Bowen*).

Plaintiffs' reliance on Justice Scalia's dissent is, moreover, overtaken by the Supreme Court's later decision in *Bormes*, where the Court (per Justice Scalia) made clear that the existence of "an obligation undoubtedly imposed on the Federal Government," without more, does not entitle a plaintiff to money damages. 568 U.S. at 16. The Supreme Court held that "the test for determining whether . . . the failure to perform [such] an obligation" is "whether the statute can fairly be interpreted as mandating compensation by the Federal Government for the damage sustained." *Id.*

at 15-16. Plaintiffs contend that *Bormes* is inapposite because it held that the "detailed remedial scheme" of the Federal Credit Reporting Act precluded Tucker Act suits. *Id.* at 15. In so ruling, however, the Supreme Court explicitly clarified the test that governs whether Tucker Act relief is available. *See id.*

Community's reliance (Br. 47-49) on cases involving the antitrust and RICO statutes further underscores the errors in plaintiffs' position. The antitrust and RICO statutes include express causes of action for damages meant to penalize wrongdoers for violations of law. The question in the cases cited by Community was which party could invoke those express damages remedies. For example, in *Kansas v. Utilicorp United, Inc.*, 497 U.S. 199 (1990), the Supreme Court held that when suppliers violate the antitrust laws by overcharging a public utility for natural gas, and the utility passes on the overcharge to its customers, only the utility can sue under the treble damages provision in section 4 of the Clayton Act. And in *Carter v. Berger*, 777 F.2d 1173 (7th Cir. 1985), the Seventh Circuit held that the party directly defrauded by the defendant was the proper plaintiff in a RICO damages action, and dismissed claims brought by those indirectly injured.

Here, by contrast, section 1402 of the ACA does not expressly authorize damages. Moreover, unlike in the antitrust and RICO context, there is no wrongdoer to be penalized with a damages award. As discussed below, HHS's failure to make cost-sharing payments was not a breach of federal law but dutiful compliance with the dictates of the Anti-Deficiency Act. And the Congress that enacted the ACA could

not plausibly have intended HHS's faithful implementation of Congress's own future funding decisions—a lawful exercise of Congress's appropriations power—as a wrong in need of a damages remedy.

B. HHS Did Not Breach A Statutory Obligation.

1. Section 1402 states that "the Secretary [of HHS] shall make periodic and timely payments to the issuer equal to the value of the reductions" in cost-sharing that the insurer makes for its enrollees. 42 U.S.C. § 18071(c)(3)(A). Plaintiffs' argument presumes that this instruction binds the agency when Congress declines to provide necessary appropriations. But that contention requires the further assumption that Congress mandated that the agency make payments that would violate the Anti-Deficiency Act, 31 U.S.C. § 1341, which unambiguously forbids federal agencies from making payments unless Congress provides the necessary appropriation.

Read together, these two federal statutes (1) require HHS to make cost-sharing payments to the extent that Congress provides the necessary funding and (2) prohibit HHS from doing so to the extent that cost-sharing payments are unfunded or underfunded. Contrary to Community's assertion, reading these two statutes together does not make cost-sharing payments "optional rather than mandatory." Br. 39. The mandatory language in section 1402 means that HHS has no choice but to make cost-sharing payments *if Congress provides the necessary funding*.

The ACA did not provide a permanent appropriation for cost-sharing payments. Moreover, Congress pointedly refused the prior Administration's request

to include an appropriation for cost-sharing payments in HHS's fiscal year 2014 appropriations act, and has not included such funding in any subsequent appropriations act. "Deprived of funds to make additional payments, HHS had no choice but to cease reimbursing insurers for [cost-sharing reductions (CSRs)]." Sanford/Montana Br. 2. That is not a breach of a statutory duty.

2. Sanford and Montana argue (Br. 42-43) that there is "no indication that the enacting Congress anticipated that a future Congress would not appropriate Section 1402 funds." But there is every reason to conclude that Congress was aware of that possibility. The essence of the annual appropriations process is that it is discretionary. As the Government Accountability Office (GAO) has explained, "[d]iscretionary spending . . . refers to budget authority that is provided in and controlled by appropriations acts." GAO, *Federal Budget, Government-Wide Inventory of Accounts with Spending Authority and Permanent Appropriations, Fiscal Years 1995 to 2015* at 7 (Nov. 2018).[7] "During the annual appropriations process, Congress may choose to appropriate the amount in the President's budget request, increase or decrease those levels, eliminate proposals, or add other programs." *Id.* That, of course, is how Congress exercises its power of the purse.

HHS did not violate the law when it complied with the Anti-Deficiency Act and Congress's entirely lawful exercise of its appropriations power. That the agency's

[7] https://www.gao.gov/assets/700/695730.pdf

action was lawful is confirmed by *Highland Falls-Fort Montgomery Central School District v. United States*, 48 F.3d 1166 (Fed. Cir. 1995), in which (as discussed in our opening briefs), this Court interpreted a statutory directive to an agency to make payment in light of the Anti-Deficiency Act. In *Highland Falls*, the amounts earmarked in annual appropriations acts were insufficient for the Department of Education to pay school districts the full amount to which they were entitled under the substantive legislation. This Court concluded that, by making *pro rata* reductions in the amounts paid, the agency properly "harmonized the requirements of [the substantive statute] and the appropriations statutes with the requirements of" the Anti-Deficiency Act. *Id.* at 1171. The Court emphasized that "[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." *Id.* (quoting *Morton v. Mancari*, 417 U.S. 535, 551 (1974)).

Sanford and Montana fail even to reference *Highland-Falls*. Community mentions the case (Br. 34) but does not acknowledge this Court's reliance on the Anti-Deficiency Act.

Instead of coming to grips with this precedent, plaintiffs rely on dicta from *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), that, our opening brief explained, rested on a misunderstanding of the Supreme Court's decision in

Salazar v. Ramah Navajo Chapter, 567 U.S. 182 (2012).[8] Citing *Ramah*, the *Moda* opinion stated that "the Anti-Deficiency Act's requirements" do not "defeat the obligations of the government." *Id.* at 1322. That observation was unremarkable in *Ramah*, a contract case in which the Supreme Court concluded that "the Government's obligation to pay contract support costs should be treated as an ordinary contract promise." 567 U.S. at 189. *Ramah* emphasized that "Congress expressly provided in [the Indian Self-Determination Act] 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.

Ramah recognized that "the Appropriations Clause does not permit plaintiffs to recover money for Government-caused injuries for which Congress 'appropriated no money'" when—as here—"'the express terms of a specific statute'" do not establish "'a substantive right to compensation' from the Judgment Fund." *Ramah*, 567 U.S. at 198 n.9 (quoting *Office of Personnel Management v. Richmond*, 496 U.S. 414, 424, 432 (1990)). And in *Prairie County v. United States*, 782 F.3d 685, 687 (Fed. Cir. 2015), this Court held that *Ramah* rested on contract principles that do not apply to statutory claims.

[8] On June 24, 2019, the Supreme Court granted the insurers' petitions for a writ of certiorari in *Moda* and related risk-corridors cases. *See* Nos. 18-1023, 18-1028, 18-1038.

Interpreting statutory directives without regard to the Anti-Deficiency Act would effectively transform such statutes into contracts that bind future Congresses, reversing the Supreme Court's presumption against treating a statute as a contract. Plaintiffs explicitly adopt this reasoning, asking this Court to treat the statutory language in section 1402—which is an instruction to HHS to make cost-sharing payments—as if it were a "statutory promise" that binds future Congresses to appropriate funding. Sanford/Montana Br. 49; Community Br. 26. They thus urge the Court to treat Congress's later decisions not to fund cost-sharing payments as if they were a failure by Congress itself to "follow through on its promises." Sanford/Montana Br. 43 n.18.

This argument runs headlong into the Supreme Court's admonition 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." *National R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985) (*Atchison*) (emphasis added). There is no statutory language that overcomes that presumption here or binds future Congresses to provide discretionary appropriations. Section 1402 "is a directive from the Congress to the [agency], not a promise" to insurers. *Hanlin v. United States*, 316 F.3d 1325, 1329 (Fed. Cir. 2003). Plaintiffs' actual contract claims are meritless, and their contract rhetoric has no proper place in the analysis of their statutory claims.

3. To the extent that *Moda* suggested otherwise, the conclusion was "unnecessary to the decision in the case" and thus "not precedential." *National Am. Ins. Co. v. United States*, 498 F.3d 1301, 1306 (Fed. Cir. 2007). Although Sanford and Montana declare (at 33) that *Moda* "followed binding precedent spanning more than a century," they do not identify any case that awarded damages as a statutory remedy for Congress's own funding decisions. Even *United States v. Langston*, 118 U.S. 389 (1886)—which is the sole statutory case in which the Supreme Court ruled in a claimant's favor despite inadequate appropriations—did not award damages. Instead, the judgment in Langston's favor was paid because Congress chose to enact legislation that appropriated the necessary funds. *See* Act of August 4, 1886, ch. 903, 24 Stat. 256, 275, 281-82.[9]

Moreover, the Supreme Court limited *Langston* to its facts seven years later when it decided *Belknap v. United States*, 150 U.S. 588 (1893), where the Court held acts appropriating less than the claimant's full salary precluded his demand for the full amount. The Supreme Court in *Belknap* admonished that *Langston*'s ruling in the claimant's favor expressed "the limit in that direction." *Id.* at 595.

Plaintiffs cannot plausibly analogize the facts of these cases to the facts of *Langston*. As our opening briefs explained, the context of the appropriations acts at issue in *Langston* indicated that Congress had not deliberately meant to underfund the

[9] Community denies that the judgment in *Langston* was hortatory, *see* Br. 26 n.6, but the Supreme Court did not, of course, direct Congress to enact an appropriation.

claimant's salary, which Congress had funded in full for many years. Under those circumstances, the Supreme Court stated that it would not infer that Congress intended to deny the claimant the salary for which he had worked. Here, by contrast, plaintiffs do not contend that Congress's funding decisions with respect to cost-sharing payments were inadvertent. It is undisputed that the ACA "left Section 1402 funding to the annual appropriations process." Sanford/Montana Br. 18. It is undisputed that Congress refused the prior Administration's request to include an appropriation for cost-sharing payments in HHS's annual appropriations act. And it is undisputed that, ever since that time, Congress has declined to include such funding in HHS's annual appropriations acts.

The annual legislation that appropriated funds for various HHS programs but not section 1402 is not "Congressional inaction." Sanford/Montana Br. 52. Indeed, plaintiffs acknowledge that those appropriations acts would foreclose their claims if Congress had *underfunded* cost-sharing payments. *See id.* at 55 (acknowledging that the annual acts underfunding the claimant's salary in *Belknap* foreclosed his demand for full payment). The result does not change simply because Congress decided to appropriate *zero dollars* for cost-sharing payments. Inferring a right to damages in the face of that decision would undermine the plenary control over appropriations that the Constitution vests in Congress.

Our opening briefs explained that "[a] damages award in the circumstances presented here would, to our knowledge, be unprecedented." Gov't Br. 28

(Sanford/Montana); Gov't Br. 29-30 (Community). Plaintiffs make no contrary argument. Instead, they rely on contract cases (such as *Ferris v. United States*, 27 Ct. Cl. 542 (1892), and *New York Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (per curiam)); cases in which the government prevailed (such as *Moda* and *Greenlee County v. United States*, 487 F.3d 871 (Fed. Cir. 2007)); and cases that addressed jurisdiction rather than the merits (such as *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)). Although Sanford and Montana assert (Br. 25) that the jurisdictional and merits inquiries are identical, they disregard the contrary reasoning of *Greenlee County*. There, this Court concluded that it had jurisdiction to consider a claim under a statute that directed an agency to make payment, but ruled on the merits that there was no right to payment beyond the amounts that Congress appropriated.[10] In short, there is no precedent for plaintiffs' statutory claims.

4. Unable to identify a precedent that awarded damages as a statutory "remedy" for Congress's own funding decisions, plaintiffs note that some statutory provisions state that an express authorization of appropriations is "subject to the availability of appropriations" (or words to that effect). Community Br. 26-27;

[10] In light of *Greenlee*, the government's district court briefs in *United States House of Representatives v. Burwell* acknowledged that the absence of appropriations would not preclude jurisdiction over Tucker Act claims for cost-sharing payments, but did not concede that such claims would have merit.

Sanford/Montana Br. 31. Plaintiffs contend that the Anti-Deficiency Act should be ignored unless such qualifying language appears in substantive legislation.

Plaintiffs again misunderstand the appropriations process and the Anti-Deficiency Act, and, since they fail to come to grips with *Highland Falls,* they do not attempt to reconcile their position with the absence of any such language in the statute in that case. In the ACA, Congress explicitly authorized appropriations for certain programs, and included language that qualified those authorizations. That was the case in the provisions cited by plaintiffs. *See, e.g.*, ACA § 5303 ("[T]here is authorized to be appropriated $30,000,000 for fiscal year 2010 and such sums as may be necessary for each of fiscal years 2011 through 2015."). Congress did not authorize appropriations in section 1402, so it is unsurprising that Congress did not include the qualification that often follows such an explicit authorization. More generally, even if the Anti-Deficiency Act makes such qualifying language "surplusage," Community Br. 32, the Supreme Court has admonished that the "preference for avoiding surplusage constructions is not absolute" and that it is not "a particularly useful guide" in interpreting the ACA. *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015).

Indeed, plaintiffs' own position would result in surplusage. As this Court noted in *Prairie County*, 782 F.3d at 691, Congress has used specific language when it intends to make a payment directive an obligation of the government without regard to appropriations. For instance, the statute that directs HHS to make payments under

Medicare Part D specifies that it "represents the obligation of the Secretary to provide for the payment of amounts provided under this section." 42 U.S.C. § 1395w-115(a). The ACA likewise used such language in providing for a psychiatric demonstration project. *See* ACA § 2707(e)(1)(B) (stating that the provision "represents the obligation of the Federal Government to provide for the payment of the amounts appropriated under that subparagraph."). Plaintiffs cannot rely on "the canon against superfluity," which "assists only where a competing interpretation gives effect to every clause and word of a statute." *Microsoft Corp.* v. *i4i Ltd. P'ship*, 564 U.S. 91, 106 (2011). The most that can be said is that the canon against surplusage is not "a particularly useful guide" to the interpretive question presented here. *King*, 135 S. Ct. at 2492. It is certainly not license to disregard the actual language of the Anti-Deficiency Act.

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

Plaintiffs' contract claims fail because there are no implied-in-fact contracts for cost-sharing payments. Our opening briefs explained that plaintiffs cannot derive an implied contract from the text of section 1402. This Court has recognized 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) (quotation marks omitted). 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." *Id.* at 630-31 (quoting *Atchison*, 470 U.S. at 466).

Here, as in *Moda*, "the statute contains no promissory language from which" the Court could find an intent by Congress to bind the government in contract. 892 F.3d at 1329. Plaintiffs' reliance on *Radium Mines, Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), fails for the reasons that *Moda* set out. The regulations at issue in *Radium Mines* established "guaranteed minimum prices" for uranium delivered to the Atomic Energy 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, section 1402 has no such language. Section 1402 does not "offer to make CSR payments to health insurers" that "reduced cost sharing for eligible individuals." Sanford/Montana Br. 60. Section 1402 *requires* that qualified health plans sold on Exchanges reduce cost sharing for eligible individuals. That requirement is no different in kind from the host of other regulations that the ACA imposed on insurers as an exercise of Congress's Commerce Clause power, such as the requirement that plans sold on the Exchanges provide essential health benefits.

To the extent that the ACA's various requirements impose costs on insurers, they can generally recoup the costs by raising premiums. Although Community now characterizes the two parts of section 1402 as imposing "reciprocal obligations," Br. 54, insurers have never claimed that Congress's refusal to fund cost-sharing payments is a repudiation of a contract that excuses them of their obligation to reduce cost sharing. On the contrary, Community admits that "Section 1402 does not excuse insurers from providing CSRs if the government fails to pay for them." Br. 10. In other words, there is no quid pro quo. Insurers that choose to sell plans on the Exchanges must comply with the requirement to reduce cost sharing regardless of whether they are reimbursed, and they may build the costs of compliance into their rates.

Like the insurers in *Moda*, Sanford and Montana assert (Br. 59, 61) that the ACA's various statutory benefits should be treated as a contractual "inducement" for insurers to participate on the Exchanges. As in *Moda*, the argument has no grounding in statutory text or economic reality. Insurers have strong business incentives to sell plans on the Exchanges, which are the only commercial channel through which insurers can market their plans to the millions of Americans who receive tax credits. *See King*, 135 S. Ct. at 2493 (noting that in 2014, approximately 87 percent of people who bought insurance on a federally facilitated Exchange did so with tax credits). Insurers that want to take advantage of the business opportunities presented by this

massive new customer base must comply with all of the ACA's requirements, and may price their plans accordingly.

Plaintiffs' contention that a contract may be implied from the conduct of HHS is equally baseless. HHS had no authority to enter into contracts to make unfunded cost-sharing payments and did not purport to do so. "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). Plaintiffs do not contend that any statute gave HHS authority to contract for cost-sharing payments "in excess of an appropriation." 31 U.S.C. § 1301(d). Sanford and Montana ignore section 1301(d), which their brief does not cite. Community notes (Br. 59-60) that in the *California* litigation, the States took the position that the requirement of section 1301(d) was met, on the theory that the permanent appropriation for tax credits was legally available for cost-sharing payments. Community does not defend the States' position: on the contrary, Community admits that "Congress did not intend for CSR payments to be funded by permanent appropriations." Br. 31. Community's reliance on the States' (unsuccessful) argument is thus unavailing.

III. Any Damages Must Be Reduced By The Increased Tax Credits An Insurer Receives As A Result Of The Cessation Of Cost-Sharing Payments.

For the reasons already discussed, insurers do not have either a statutory damages remedy or a contract for unfunded cost-sharing payments. Assuming the Court were to disagree, however, any damages should be reduced by the increased tax credits an insurer receives as a result of the cessation of cost-sharing payments. Damages require a showing of injury. For the reasons discussed above and in our opening briefs, there is every reason to conclude that plaintiffs will end up better off financially as the result of the cessation of cost-sharing payments, even taking into account the three-month period in late 2017 in which rates did not yet reflect the absence of cost-sharing payments.

Although Community vaguely asserts that "[m]arket competition" can serve as a "barrier to price increases," Br. 44, Community does not deny that it raised its silver-plan premiums for 2018 and 2019 to compensate for the absence of cost-sharing payments, as indicated in the actuarial memoranda discussed above.

Nor does Community deny that those silver-plan premium increases trigger substantially increased tax credits. Although Community declares that no "record evidence" shows that it will "receive more in increased tax credits than the government withholds in CSR payments," Br. 51, Chief Judge Sweeney ruled as a matter of law that Community may recover damages for unfunded cost-sharing payments despite its increased tax credits. *See Community Health Choice, Inc. v. United*

States, 141 Fed. Cl. 744, 764 (2019) (stating that the court was "not convinced" by the "concern that allowing insurers to both obtain greater premium tax credits and obtain a judgment for their lost cost-sharing reduction payments would provide an unwarranted windfall for insurers").

Chief Judge Sweeney did not question the findings that were made by Judge Chhabria after an evidentiary hearing in the *California* case. Those findings contradict Community's contention that the cessation of cost-sharing payments may result in "lost sales, lost market share, and disruption to the ACA exchanges." Br. 52. For example, although Community suggests that its silver-plan increases may have resulted in "a significant drop in silver plan sales," Br. 52, Community "omit[s] the fact that the premium increases . . . cause tax credits to increase in a corresponding amount, leaving so many people (especially lower-income people) better off or unharmed." *California*, 267 F. Supp. 3d at 1138. Furthermore, "the widespread increase in silver plan premiums will qualify many people for higher tax credits, and that the increased federal expenditure for tax credits will be far more significant than the decreased federal expenditure for CSR payments." *Id.* at 1139.

Apparently recognizing that its claims of economic harm will not be substantiated, Community declares that "courts need not delve into complex questions surrounding the impacts of the government's stoppage of CSR payments." Br. 53. We agree, because Congress did not give insurers a damages remedy. But if the Court were to disagree on that legal issue, then the proper disposition would be to

remand so that plaintiffs can attempt to show whether and to what extent the cessation of cost-sharing payments will cause them economic injury.

CONCLUSION

The judgments of the trial court should be reversed.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on July 12, 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.

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CERTIFICATE OF COMPLIANCE

This brief complies with the volume limit of Federal Circuit Rule 32(a) because it contains 6433 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.

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