No. 17-1994

UNITED STATES COURT OF APPEALS
FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC,
Plaintiff-Appellee,

v.

UNITED STATES OF AMERICA,
Defendant-Appellant.

Appeal from the U.S. Court of Federal Claims,
Case No. 1:16-cv-00649-TCW, Judge Thomas C. Wheeler

BRIEF OF *AMICI CURIAE* THE ASSOCIATION FOR COMMUNITY AFFILIATED PLANS AND THE ALLIANCE OF COMMUNITY HEALTH PLANS IN SUPPORT OF REHEARING

FAEGRE BAKER DANIELS LLP
William L. Roberts
Jonathan W. Dettmann
Nicholas J. Nelson
Kelly J. Fermoyle
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402
Tel.: (612) 766-7000

Attorneys for Amici Curiae
The Association for Community Affiliated Plans and
The Alliance of Community Health Plans

August 13, 2018

CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, counsel for *amici curiae* the Association for Community Affiliated Plans and the Alliance of Community Health Plans certifies the following:

1. The full name of every party or *amicus* represented by one or more of the undersigned counsel is: Association for Community Affiliated Plans; Alliance of Community Health Plans.

2. The name of the real party in interest (if the party in the caption is not the real party in interest) represented by one or more of the undersigned counsel is: None.

3. All parent corporations and publicly held companies that own 10% or more of stock in the party: None.

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: The attorneys who have entered appearances are: William L. Roberts, Jonathan W. Dettmann, Nicholas J. Nelson, and Kelly J. Fermoyle of Faegre Baker Daniels, LLP.

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:

Federal Circuit

Land of Lincoln Mutual Health Insurance Co. v. United States, No. 17-1224

Blue Cross and Blue Shield of North Carolina v. United States, No. 17-2154

Maine Cmty. Health Options v. United States, No. 17-2395

Court of Federal Claims

Affinity Health Plan, Inc. v. United States, No. 18-110C (Kaplan, J.)

Alliant Health Plans, Inc. v. United States, No. 16-1491C (Braden, J.)

BCBSM, Inc. v. United States, No. 16-1253C (Coster Williams, J.)

Blue Cross and Blue Shield of Alabama v. United States, No. 17-347C (Campbell-Smith, J.)

Blue Cross and Blue Shield of Kanas City v. United States, No. 17-95C (Braden, J.)

BlueCross BlueShield of Tennessee v. United States, No. 17-348C (Horn, J.)

Blue Cross of Idaho Health Service, Inc. v. United States, No. 16-1384C (Lettow, J.)

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

Community Health Choice, Inc. v. United States, No. 18-5C (Sweeney, J.)

EmblemHealth, Inc. v. United States, No. 17-703C (Wheeler, J.)

Farmer v. United States, No. 17-363C (Campbell-Smith, J.)

First Priority Life Ins. Co. v. United States, No. 16-587C (Wolski, J.)

Health Alliance Medical Plans, Inc. v. United States, No. 17-653C (Campbell-Smith, J.)

Health Net, Inc. v. United States, No. 16-1722C (Wolski, J.)

Health Republic Ins. Co. v. United States, No. 16-259C (Sweeney, J.)

HPHC Ins. Co., Inc. v. United States, No. 17-87C (Griggsby, J.)

MDWise Marketplace, Inc. v. United States, No. 17-1958C (Coster Williams, J.)

Medica Health Plans v. United States, No. 17-94C (Horn, J.)

Minuteman Health Inc. v. United States, No. 16-1418C (Griggsby, J.)

Molina Healthcare v. United States, No. 17-97C (Wheeler, J.)

Montana Health CO-OP v. United States, No. 16-1427C (Wolski, J.)

Neighborhood Health Plan, Inc. v. United States, No. 16-1659C (Smith, J.)

New Mexico Health Connections v. United States, No. 16-1199C (Bruggink, J.)

Ommen v. United States, No. 17-712C (Lettow, J.)

Sanford Health Plan v. United States, No. 17-357C (Bruggink, J.)

Sendero Health Plans, Inc. v. United States, No. 17-2048C (Griggsby, J.)

Dated: August 13, 2018

/s/ William L. Roberts
William L. Roberts

TABLE OF CONTENTS

Page

CERTIFICATE OF INTEREST ii

IDENTITY AND INTEREST OF AMICI CURIAE 1

ARGUMENT 2

I. The Panel Abandoned The Presumption Against Repeal-By-Appropriation. 3

II. The Panel's Rule Would Harm Vital Governmental Interests. 5

1. The executive branch will be forced to guess how much to pay and to whom. 6

2. Congress must have a clear understanding of what proposed legislation will do. 8

III. Abandoning The Presumption Against Repeal-By-Appropriation Would Devastate Many Insurers. 9

CONCLUSION 11

CERTIFICATE OF COMPLIANCE 13

CERTIFICATE OF SERVICE 14

TABLE OF AUTHORITIES

Page(s)

FEDERAL CASES

Building & Constr. Trades Dep't v. Martin,
961 F.2d 269 (D.C. Cir. 1992), *cert. denied*, 506 U.S. 915 (1992) 3

Calloway v. Dist. of Columbia,
216 F.3d 1 (D.C. Cir. 2000)....................................4

Minis v. United States,
40 U.S. (15 Pet.) 423 (1841) 3

New York Airways, Inc. v. United States,
369 F.2d 743 (Ct. Cl. 1966) 4

Robertson v. Seattle Audubon Society,
503 U.S. 429 (1992) 4

Tennessee Valley Auth. v. Hill,
437 U.S. 153 (1978) 4

Unites States v. Mitchell,
109 U.S. 146 (1883) 4

FEDERAL STATUTES

Affordable Care Act....................................1

Affordable Care Act § 1342....................................3

38 U.S.C. § 117....................................4

42 U.S.C. § 1395g 4

OTHER AUTHORITIES

Amend the Affordable Care Act: Hearing on H.R. 3812, 113th Cong. H137-
06 (2014) 8

Authorization of Appropriations: Procedural and Legal Issues, Cong. Res. Serv.
(Nov. 30, 2016) 3, 4

Marco Rubio, *No Bailouts for ObamaCare*, Wall Street J., Nov. 20, 2013 8

R. XXI(1)(b), *Rules of the House of Representatives*, 114th Cong. (2015) 8

Risk Corridors Payment and Charge Amounts for Benefit Year 2014, Dept. of Health & Human Servs., Nov. 19, 2015 6

S. 1726, 113th Cong. (2013) 8

Standing Rules of the Senate, S. Res. 16, 113th Cong. (2013) 8

IDENTITY AND INTEREST OF *AMICI CURIAE*

The Association for Community Affiliated Plans ("ACAP") is a national trade association representing community-based not-for-profit health plans, many of whom participate in health-insurance marketplaces under the Affordable Care Act ("ACA").[1] Collectively, ACAP's 62 Medicaid, Medicare, and Marketplace plans serve more than 21 million enrollees in 29 states. Many enrollees are among the nation's poorest and sickest people who lack access to other health insurance. In contrast to many other insurers, ACAP member health plans primarily participate in the low-margin Medicaid market and rarely participate in the higher-margin large group employer market.

The Alliance of Community Health Plans ("ACHP") is a national leadership organization whose members are not-for-profit, community-based, and regional health plans or subsidiaries of not-for-profit health systems. ACHP's member health plans provide coverage and care for more than 21 million Americans across 32 states and the District of Columbia. These organizations focus on improving the health of the communities they serve and are on the leading edge of innovations in affordability and quality of care.

Amici's members are owed an estimated $1.88 billion under the risk corridors program. These unpaid debts will have severe impacts on community-based health

---

[1] All parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, and no person other than *amici*, their members, and their counsel contributed money intended to fund preparing or submitting this brief.

insurers and their insureds. *Amici* submit this brief to highlight the legal and practical problems the panel decision will cause, absent reversal by the full Court.

ARGUMENT

The United States and its citizens have a crucial interest in understanding to whom the government owes money—and how much and when. When the U.S. Code mandates a government payment, courts have consistently refused to imply a change to that obligation from an appropriations enactment, unless language in the appropriation clearly manifests such intent.

Any other rule would lead to serious problems. Citizens relying on payments under a federal statute who fail to guess that the payments have been implicitly repealed would face financial hardship. The executive branch would be left guessing whether Congressional orders to pay money had been implicitly rescinded. And Congress would find that its statutory promises of payment trigger little response from private citizens, because few would believe them.

The panel decision leads the law down this rough road. The U.S. Code orders that the government "shall make" risk corridors payments to insurers according to a specific formula. But the panel abandoned the presumption against repeal-by-appropriation, holding that appropriations riders implicitly slashed the statutory payment obligation to almost nothing even though the riders' language manifests no such intent. This exposes insurers who relied on the statutory promise of payments to severe hardship or even financial ruin. It pulls the rug out from under the executive

branch, which had been making payments up to its funding limits and logging remaining unpaid amounts as outstanding legal obligations of the Government, only to now have the statute deemed implicitly changed so that, under the panel's reasoning, millions of dollars may have gone to the wrong insurers for the wrong program year. And it cripples Congress's ability to legislate in the future: people are unlikely to act on statutory promises of payment that the courts may later decide were illusory.

The full Court should grant rehearing and reinstate the long-settled presumption against repeal-by-appropriation.

I. The Panel Abandoned The Presumption Against Repeal-By-Appropriation.

Appropriations bills are strongly presumed ***not*** to repeal or amend substantive legislation such as Section 1342. Our constitutional tradition distinguishes between permanent "authorizing" legislation and appropriations laws. *See, e.g., Building & Constr. Trades Dep't v. Martin*, 961 F.2d 269, 273 (D.C. Cir. 1992) (citing *Minis v. United States*, 40 U.S. (15 Pet.) 423 (1841)). Authorizing legislation tells government agencies what to do, while appropriations provide the funds to carry out those instructions. *See Authorization of Appropriations: Procedural and Legal Issues,* Cong. Res. Serv. (Nov. 30, 2016). In general, authorizing legislation is enacted only once and becomes a permanent part of the U.S. Code; by contrast, appropriations are made yearly and not codified. This allows Congress to enact a permanent statute mandating yearly

payments, while leaving funding for those payments to future appropriations bills. Congress has chosen this arrangement for major government programs such as Medicare and veterans' benefits. 42 U.S.C. § 1395g; 38 U.S.C. § 117.

If a later Congress does not appropriate enough money to make the full payment required by the authorizing legislation, does the government still owe the money? The courts have established the rule: "[w]hile appropriation acts are 'Acts of Congress' which can substantively change [authorizing] law, there is a very strong presumption that they do not." *Calloway v. Dist. of Columbia*, 216 F.3d 1, 9 (D.C. Cir. 2000) (citation omitted); *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 189-90 (1978); *Robertson v. Seattle Audubon Soc'y*, 503 U.S. 429, 440 (1992). Thus, when authorizing legislation creates a "statutory obligation [that] concerns an entitlement to funds," the strong presumption is that Congress does not repeal that obligation through appropriations acts. Cong. Res. Serv., *supra*, at 10. Instead, Congressional "failure to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in the Court of Claims." *New York Airways, Inc. v. United States*, 369 F.2d 743, 747 (Ct. Cl. 1966).

Whether the presumption has been overcome "depends on the intention of [C]ongress as expressed in the statutes." *Unites States v. Mitchell*, 109 U.S. 146, 150 (1883). The focus must be on the language of the appropriations enactment.

Here, the panel majority abandoned this well-established rule of law. The panel did not ask whether the appropriations riders at issue clearly manifested an intent to repeal or amend the Government's obligation to pay. Instead, the panel majority waded into the murky waters of legislative history and wondered aloud, "What else could Congress have intended?" Panel Op. at 25. Its reasoning—essentially that because Congress limited the funds available to CMS to make payments, it must have intended to eliminate the legal obligation to make any payments beyond the amount appropriated —defies the presumption against repeal-by-appropriation. The whole point of the presumption is to assure that, unless Congress speaks clearly in the appropriation that the statutory payment obligation is changed, the obligation remains intact notwithstanding an appropriation inadequate to fund it.

The appropriations riders at issue contain no language addressing the statutory obligation, nor do they change or replace the statutory formula for determining amounts due. They only limit availability of funds. Accordingly, the presumption mandates that they be construed *not* to have changed the statutory obligation established in U.S. Code Section 1342.

II. The Panel's Rule Would Harm Vital Governmental Interests.

If government payment obligations become a guessing game, vital governmental interests will be harmed.

1. The executive branch will be forced to guess how much to pay and to whom.

The ACA enacted a mathematical formula for calculating the annual amount due to each individual insurer for each program year. A given insurer's risk corridors payment would change from year to year—and many insurers were entitled to payments only in one or two years of the program. The annual appropriations riders did not change the statutory formula. At most, they only limited the funds available to CMS for risk corridors payments during the applicable year. When the funding in 2015 fell short of the amounts due for the 2014 program year, CMS acted consistently with the presumption against repeal-by-appropriation: it paid what it could, and logged the rest of the 2014 amounts as outstanding obligations of the government. *See* Appx27 n.13; *Risk Corridors Payment and Charge Amounts for Benefit Year 2014*, Dept. of Health & Human Servs., Nov. 19, 2015. When additional funds became available in 2016 and 2017, CMS continued paying down its obligations from program year 2014. Since the available funds did not come cover even those obligations, CMS has never paid any 2015 or 2016 risk corridors amounts—although it has recognized that it still owes this money.

Under the panel's reasoning, CMS has been doing it all wrong. The panel reasons that the appropriations riders implicitly changed not just the amount that CMS could pay each year, but also the amount that the government actually owed for each year. Thus, once CMS paid out all available funds in 2015, it owed nothing further for that year's risk corridors payments. Funds that became available in 2016

should have gone to insurers who were entitled to risk corridors payments due *that* year, not to pay down unmet 2014 program year obligations. The same would be true for 2017, according to the panel's reasoning.

Absent further review, the panel ruling will leave a mess. CMS's partial, pro-rata payments of 2014 program year obligations using 2015, 2016 and 2017 funds may need to be revisited. Reallocations will need to be debated. So will the question whether a pro-rata allocation is the correct approach of dealing with the disconnect between (1) the amounts due according to the statutory formula; and (2) the funds available to make those payments.

No answer to these questions is contained in the panel's ruling, the appropriations riders, and certainly not in the authorizing statute. The statute's formula for calculating amounts due is unambiguous, mandatory, and unchanged. The appropriations riders say nothing on the matter. The panel majority also does not explain how the money should be apportioned. The courts will have to improvise some method of apportionment, because CMS has never paid anything for program years 2015 or 2016.

Honoring the presumption against repeal-by-appropriation will avoid not only this mess but also inevitable confusion in future appropriations cycles. Without the presumption, each year's budget may involve a guessing game: is the legislative history behind this appropriations act clear enough to wipe out a spending obligation?

Different administrations may decide differently, causing federal spending to be turned on and off unpredictably.

2. Congress must have a clear understanding of what proposed legislation will do.

Congress's own rules reflect its reluctance to implicitly amend the U.S. Code. In both the House and the Senate, amendments that change existing law are out of order in appropriations bills and subject to being stricken. R. XXI(1)(b), *Rules of the House of Representatives*, 114th Cong. (2015); *Standing Rules of the Senate*, S. Res. 16, 113th Cong. (2013).

That is especially relevant here, where Congress repeatedly and prominently considered whether to repeal or amend the risk corridors program. Senator Rubio, for instance, introduced repeal legislation to "eliminate the risk corridor provision." Marco Rubio, *No Bailouts for ObamaCare*, Wall Street J., Nov. 20, 2013; *see also* S. 1726, 113th Cong. (2013). Numerous other bills would have had similar effect. *E.g., Amend the Affordable Care Act: Hearing on H.R. 3812*, 113th Cong. H137-06 (2014). But these bills did not pass.

The votes were not there in Congress for repealing or amending the risk corridors program. Congress was able to pass the partial measure of an appropriations rider as part of its annual omnibus appropriations enactment. But the presumption against repeal-by-appropriation should have allowed members of Congress and the public to remain confident that while the riders did limit the funds available to CMS

to make risk corridors payments (thereby protecting the CMS budget), the riders did not alter the government's obligation to make the statutorily mandated payments.

By contrast, the panel's rule would obscure the difference between a repeal and an insufficient appropriation. Under the panel's rule, members would be left to guess whether proposed appropriations bills would do implicitly what they had voted against doing expressly.

III. Abandoning The Presumption Against Repeal-By-Appropriation Would Devastate Many Insurers.

The presumption against repeal-by-appropriation allows parties to rely on the U.S. Code when it says the government will pay them. That is exactly what insurers did with respect to the risk corridors program.

The ACA created new "exchanges" to sell insurance to many people who previously had no coverage. Little data was available to estimate health-care costs for these new insureds. And the ACA prohibited insurers from using many of their ordinary pricing tools for managing risk, instead requiring insurers for the first time to offer standardized plans at standardized prices to every patient, regardless of risk profile.

Normally, insurers would approach such unknowns cautiously—perhaps by selling only a few policies in such new markets, or by setting rates high to avoid losses. But that would have frustrated the ACA's purpose of extending affordable coverage to the exchange customers.

Congress's solution was the risk corridors program. If insurers lost too much money in the early years of the exchanges, the risk corridors would cushion the blow. The program lasted only three years, after which insurers would have more data to set exchange premiums.

Relying on the risk corridors program, members of *amici* ACAP and ACHP participated in the individual exchanges. Some started from scratch, or expanded into new business lines, specifically to serve patients on the exchanges. This would not have occurred without the backstop of risk corridors payments.

The insureds on the exchanges did turn out to be sicker than most insurers expected—and thus had higher medical costs. Consider "Plan A," an ACHP member. When Plan A set rates for policies sold on the exchanges, it projected that exchange patients would suffer serious injuries or illnesses 30-50% more often than other patients. Plan A knew that this was just a best guess, and that the reality could prove much worse—but it felt that it could still participate because the risk corridors program was there to prevent disaster. The reality did prove much worse: the actual morbidity increased by 100%, with all the attendant medical costs. Many other insurers had similar experiences and collectively lost billions of dollars. This meant that many individual insurers were owed millions of dollars under the risk corridors program, but it also meant that millions more people were insured, which was a central focus of the ACA.

Insurers are required by law to maintain adequate capital reserves to cover their customers' anticipated medical costs, and many state regulators prohibit insurers from raising rates in future years to make up for past losses. As a result, the lack of risk corridors payments puts serious strain on insurers' ability to stay in business. To remain viable, some ACAP and ACHP members have already had to shut down their exchange operations. Others have coped by raising rates 15% to 20%, or by limiting benefits under their plans, or by limiting the geographical scope of their exchange offerings.

If the panel's ruling stands, this case will become a cautionary tale against relying on government promises of payment—even those enshrined in the U.S. Code. Hundreds of insurers saw a federal statute that says the United States "shall make" certain payments, made financial investments in reliance on those payments, and entered into contracts based on the promise of those payments. Absent reversal, they will have been severely damaged. If this can happen to insurance companies in this context, businesses regardless of industry will not trust future government promises of payment. The result will be a state of affairs, as Judge Wheeler put it, "hardly worthy of our great nation." Fed. Cl. Op. at 39.

CONCLUSION

For all these reasons, the Court should grant rehearing.

Dated: August 13, 2018

Respectfully submitted,

/s/ William L. Roberts
William L. Roberts
William.Roberts@FaegreBD.com
Jonathan W. Dettmann
Jon.Dettmann@FaegreBD.com
Nicholas J. Nelson
Nicholas.Nelson@FaegreBD.com
Kelly J. Fermoyle
Kelly.Fermoyle@FaegreBD.com
FAEGRE BAKER DANIELS LLP
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
Telephone: (612) 766-7000
Fax: (612) 766-1600

Counsel for Amici Association for Community Affiliated Plans and Alliance of Community Health Plans

CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g), the undersigned hereby certifies that this brief complies with the type-volume requirements in Federal Rule of Appellate Procedure 32 and Federal Circuit Rule 32. According to the word count function of the word-processing system used to prepare this brief, it contains 2,558 words, excluding the parts exempted by Federal Rule of Appellate Procedure 32(f) and Federal Circuit Rule 32(b). This brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6). This brief has been prepared in proportionately spaced typeface using Microsoft Word 2010 in 14-point, Garamond.

Dated: August 13, 2018

Respectfully submitted,

/s/ William L. Roberts

William L. Roberts
William.Roberts@FaegreBD.com
Jonathan W. Dettmann
Jon.Dettmann@FaegreBD.com
Nicholas J. Nelson
Nicholas.Nelson@FaegreBD.com
Kelly J. Fermoyle
Kelly.Fermoyle@FaegreBD.com
FAEGRE BAKER DANIELS LLP
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
Telephone: (612) 766-7000
Fax: (612) 766-1600

Counsel for Amici Association for Community Affiliated Plans and Alliance of Community Health Plans

CERTIFICATE OF SERVICE

The undersigned hereby certifies that on this 13th day of August, 2018, a copy of the foregoing was filed electronically with the Court's Electronic Case Filing ("ECF") system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

Dated: August 13, 2018

Respectfully submitted,

/s/ William L. Roberts
William L. Roberts
William.Roberts@FaegreBD.com
Jonathan W. Dettmann
Jon.Dettmann@FaegreBD.com
Nicholas J. Nelson
Nicholas.Nelson@FaegreBD.com
Kelly J. Fermoyle
Kelly.Fermoyle@FaegreBD.com
FAEGRE BAKER DANIELS LLP
2200 Wells Fargo Center
90 South Seventh Street
Minneapolis, MN 55402-3901
Telephone: (612) 766-7000
Fax: (612) 766-1600

Counsel for Amici Association for Community Affiliated Plans and Alliance of Community Health Plans