IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH REPUBLIC INSURANCE COMPANY, Plaintiff, on behalf of itself and all others similarly situated, vs. THE UNITED STATES OF AMERICA, Defendant.	No. 1:16-cv-00259-MMS (Judge Sweeney)

PLAINTIFF HEALTH REPUBLIC INSURANCE COMPANY'S
OPPOSITION TO THE UNITED STATES' MOTION TO DISMISS

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page

Cases

Rules / Statutes

Other Authorities

PRELIMINARY STATEMENT

Defendant The United States of America (the "Government") does not dispute that it must pay qualified health plan ("QHP") issuers risk corridors amounts owed under the Affordable Care Act ("ACA"). It could not take that position because the statute unambiguously states the Government "shall pay" all such amounts for every class member in this case. The Government also does not dispute that it currently owes the putative class over $2.5 billion for the 2014 risk corridors program year, and that all indications are it will owe a similar or higher amount for the 2015 program year. This is therefore not a case about ***whether*** the Government must pay Plaintiffs the risk corridors payments at issue; it is about ***when***.

The Government contends that the Department of Health and Human Services ("HHS")[1] currently interprets the ACA to require full risk corridors payments at some point in the future (after 2017), and that this current interpretation should be controlling. Because, the Government argues, the amounts are not due at this time, this Court supposedly has no subject matter jurisdiction. Whether the funds are "presently due," however, is not the test for jurisdiction. Indeed, that has not been the test for over a decade—since the Federal Circuit handed down its opinion in *Fisher v. United States*, 402 F.3d 1167 (Fed. Cir. 2005). Moreover, even if it were the test, this Court need not defer to the Government's *post hoc* rationalization for its conduct.

The ACA risk corridors amounts are due annually. In asking this Court to defer to HHS's interpretation of the ACA, the Government fails to mention that its interpretation has changed. For example, HHS initially acknowledged with respect to risk corridors payments that "***QHP issuers who are owed these amounts will want prompt payment, and payment deadlines***

[1] Throughout this brief, Plaintiff refers to the Government when generally referencing the defendant in this action. However, most relevant actions were taken by HHS. This brief therefore refers to HHS where necessary to explain the actual party committing the acts in question.

should be the same for HHS and QHP issuers." Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012) (emphasis added). It was only in early 2014, amid debates over whether to fund the risk corridors and other ACA programs at all, that HHS issued a two-page guidance indicating that the Government might not make full risk corridors payments on an annual basis.

Not only was it HHS's original position that all parties (including the Government) must make full, annual risk corridors payments, that original position is the only one consistent with the ACA as a whole. Every aspect of the risk corridors program is annual in nature, and the program is expressly intertwined with two other premium stabilization programs—reinsurance and risk adjustment—that are similarly annual in nature. Commonly known as the "3Rs," these programs are meant to work together to help mitigate insurers' risk and uncertainty in the first several years of the new ACA health exchanges. As the Centers for Medicare and Medicaid Services ("CMS")—the agency within HHS responsible for administering the ACA—has explained, the 3Rs are designed "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance."[2] For the reinsurance and risk adjustment programs, HHS makes and requires full, annual payments. Payments from those other 3R programs are then factored into the calculations for the risk corridors payments, further demonstrating that risk corridors must be paid annually for the program to be viable. Indeed, HHS paid all that it had on hand and was able to distribute—12.6% of owed amounts for the 2014 plan year—when payments first came due in late 2015.

Another point demonstrating the ACA risk corridors program's annual nature is that it is

[2] CMS, "The Three Rs: An Overview" (Oct. 1, 2015) ("The Three Rs"), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html (last visited Aug. 15, 2016).

explicitly "based on" Part D of the Social Security Act ("Part D"), a risk corridors program enacted as part of Medicare in 2003.[3] Part D requires full, annual risk corridors payments "in the following payment year." By specifically requiring HHS to model the ACA program on Part D, Congress thus mandated risk corridors payments every year.

Notwithstanding these facts, the Government argues that HHS's new position on when risk corridors payments are due, as well as Congress's failure to appropriate funds to HHS to pay its risk corridors obligations, have somehow changed the meaning of the ACA. That is not the law. Such *ex post* developments have not modified the risk corridors program's payment requirements (and cannot), nor can they deprive this Court of jurisdiction over Plaintiff Health Republic Insurance Company's ("HRIC") claim, which it brings on behalf of itself and the other QHP issuers that continue to suffer billions in unpaid risk corridors amounts. Indeed, were the Government correct, it would completely undermine the purpose of the Tucker Act. *Slattery v. United States.*, 635 F.3d 1298, 1301 (Fed. Cir. 2011) (*en banc*) (noting the Government cannot avoid its monetary obligations by failing to appropriate sufficient funds to pay them).

Underscoring the importance of the Government's obligations is that its continuing failure to pay full, annual risk corridors amounts has already led to the widespread disruption of the ACA Exchanges the risk corridors were intended to help support and stabilize. While there were 23 CO-OPs at the ACA's first open enrollment period in 2013, only 7 of those CO-OPs have been able to survive since, a result linked to the Government's failure to pay full risk corridors amounts.[4] Numerous other insurers—including several of the nation's largest—have

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[3] *See* Section 1342(a) of the ACA: "Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act." 42 U.S.C. § 18062(a).

[4] *See* Louise Norris, *CO-OP health plans: patients' interests first*, HEALTHINSURANCE.ORG (Aug. 3, 2016) ("Patients' Interests First"), *available at* https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/ (last visited Aug. 15, 2016).

also indicated they will withdraw or minimize their presence in the ACA Exchanges because of massive, uncompensated losses covered by the risk corridors program. These empirical results alone demonstrate why the Government's proposed interpretation of the statute is contrary to law. "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter." *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015).

All of the above also explains why HRIC and the putative class claims for the 2014 program year are ripe. The claims for the 2015 program year are also ripe because the Government has affirmatively stated that it (a) will not appropriate funds to pay for the risk corridors program, and (b) will only pay out amounts on a prorated basis, with unpaid 2014 amounts taking priority over 2015 amounts. Given data and public disclosures indicating the compensable risk corridors payment due to class members in 2015 will likely be greater than the $2.5 billion still owed from 2014, HRIC and the putative class—which have complied with their obligations under the risk corridors program—presently have a case or controversy for 2015 as well.[5] In any event, during the pendency of the motion to dismiss, HHS will have specifically calculated for each class member the amount due to each class member under the risk corridors program, thereby mooting any distinction between the amounts due for 2014 and 2015.

HRIC respectfully requests that the Court deny the Government's motion to dismiss.

STATEMENT OF QUESTIONS PRESENTED

1. Whether HRIC has established this Court's subject matter jurisdiction pursuant to the test articulated in *Fisher v. United States*, 402 F.3d 1167 (Fed. Cir. 2005).

[5] Although not at issue in this motion, current indications are that QHP issuers will also suffer massive losses in the 2016 plan year. *See*, *e.g.*, Anna Wilde Mathews, *Aetna Joins Rivals in Projecting Loss on Affordable Care Act Plans for 2016*, WALL ST. J. (Aug. 2, 2016), http://www.wsj.com/articles/aetna-tops-views-stops-aca-expansion-plans-1470134736 (last visited Aug. 15, 2016).

2. Whether Plaintiffs that complied with all statutory requirements for payments under the risk corridors program for the 2014 and 2015 plan years have ripe claims for those plan years.

STATEMENT OF THE CASE

I. THE AFFORDABLE CARE ACT'S 3R PROGRAMS WERE DESIGNED TO REDUCE UNCERTAINTY FOR INSURERS AND TO STABILIZE PREMIUMS

Upon its enactment on March 23, 2010, the ACA created a series of programs and effectuated a number of health care reforms. The ACA was intended to increase competition in health insurance markets and to expand health insurance coverage to millions of uninsured Americans. Declaration of M. Kate Bundorf ("Bundorf Decl.") ¶¶ 7, 9. To this end, it established Health Insurance Marketplaces, also called "Health Benefit Exchanges" (the "Exchanges"). These Exchanges enabled insurers to sell individual and small group plans. The Federal Government would run the Exchange for a particular state unless that state decided to run its own Exchange. *See* ACA §§ 1311, 1312, 1313, 1321 (42 U.S.C. §§ 18031, 18032, 18033, 18041). For health plans issued through the Exchange, these plans were required to satisfy specific criteria. Such plans are known as "Qualified Health Plans," or "QHPs." *See* ACA § 1301 (42 U.S.C. § 18021).

A. The ACA Created the 3Rs to Work Together to Stabilize and Mitigate Risk

In the first few years of the Exchanges, experts anticipated that QHP issuers would face significant challenges and uncertainty in setting insurance premiums. A key driver behind an insurance company's profits is its ability to actuarially predict how much an average insured will need in terms of health coverage. Bundorf Decl. ¶ 6. These predictions are used to price the insurer's plan premiums. *Id.* Due to the ACA Exchanges' novel makeup, coupled with the ACA requirement for guaranteed issue, QHP issuers could not engage in medical underwriting before

providing insurance coverage and did not have any effective way to accurately predict the number and cost of the previously uninsured individuals who would be enrolling in their plans starting in 2014. *Id.* ¶ 7.

Congress explicitly recognized that this uncertainty could lead insurers to increase premiums and cause instability in the market. This is precisely why the ACA included three inter-related "premium stabilization programs," *i.e.*, the 3Rs: reinsurance, risk corridors, and risk adjustment. ACA §§ 1341-1343 (42 U.S.C. §§ 18061-18063). The 3Rs targeted specific uncertainties in the new Exchange markets and, as CMS has explained, were designed "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance,"[6] particularly during the first few years of full ACA implementation. *See* Bundorf Decl. ¶¶ 8-9 (explaining the purpose and intended effect of each 3R program).

Discussing the risk corridors program specifically, CMS stated that "[d]ue to uncertainty about the population during the first years of Exchange operation, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted." March 2012 Regulatory Impact Analysis, at 44. The risk corridors program would thus "protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains." *Id.* at 43; *see also* Bundorf Decl. ¶¶ 9-11 (discussing how and why a risk corridors program provides such protection).

B. The 3Rs Depend on Timely and Predictable Payments

The Government has recognized that, without timely payments to QHP issuers, the 3R programs will not work as intended. For example, the Government previously admitted:

If issuers do not have ***confidence that risk adjustment will timely reimburse them*** for the

[6] CMS, The Three Rs, *supra* note 2; *see also* CMS, "Regulatory Impact Analysis," (Mar. 16, 2012) ("March 2012 Regulatory Impact Analysis"), at 38.

> risk they take on, they will face strong financial incentives to avoid the sickest enrollees, ***undermining the protections of the ACA***. This in turn could cause issuers to raise their rates to account for the uncertainty in receiving full and timely risk adjustment payments**.**
>
> ***Insurers depend on timely disbursements of risk adjustment payments, and a disruption of that process would concretely injure each insurer and the insurance market as a whole***.

Def.'s Opp'n to Pls.'s Mot. for Prelim. Inj. at 18, *Gerhart v. United States Dept. of Health and Human Servs., et al.*, No. 4:16-cv-00151 (S.D. Iowa June 21, 2016) ECF No. 38-1 (emphasis added) (internal citations omitted).

While the above admission does not specifically mention the risk corridors program, the Government's logic applies to that program as well. QHP issuers, like HRIC, depended on the timely disbursement of risk corridors payments and have been injured as the result of the Government's failure to pay. Compl. ¶¶ 42-45, 50. Indeed, the Government's failure to timely pay full amounts has driven numerous CO-OPs out of business and compelled other QHP issuers to withdraw from or reduce their exposure to ACA Exchanges. *Id.* This is directly counter to the intent of the ACA.

The Government's admission that risk adjustment payments must be timely also necessarily means that risk corridors payments must be timely because the 3Rs are intertwined. The ACA expressly provides that a QHP issuer's risk corridors payments (if any) depend on the amount that its "allowable costs" exceed its "target amount." "Allowable costs" expressly incorporate, and are modified by, risk adjustment and reinsurance payments. *See* 42 U.S.C. § 18062(c)(1)(B) ("allowable costs shall [be] reduced by any risk adjustment or reinsurance payments received"); 45 C.F.R. § 153.530(b)(1) ("allowable costs" are *increased* by any risk adjustment payments made or accrued).[7]

[7] As noted in Argument Section I.B *infra*, the Government is thus taking the position that it can collect risk adjustment payments annually without paying related risk corridors obligations

The Government has also recognized the importance of making annual cost-sharing payments to insurers under another ACA risk mitigation program. Specifically, it noted that a failure to make payments in a way that provided certainty about the "existence and amount of payments" would be "inefficient and destabilizing," and "would also inevitably lead to increased premiums—and correspondingly greater federal expenditures," even if Congress ultimately appropriated funds for the payments. Br. for Defs. at 23, *United States House of Representatives v. Burwell*, 2016 WL 2750934 (D.D.C. May 12, 2016) (No. 1:14-cv-01967), ECF No. 55-1.[8]

HRIC and the Government thus both recognize that the failure to make the 3R risk mitigation payments on a timely basis will disrupt the entire insurance market and cause insurers to raise rates to account for this uncertainty. *See also* Bundorf Decl. ¶¶ 10-11. Nevertheless, on this particular motion—when the issue impacts Tucker Act liability—the Government contends it is not obligated to pay full risk corridors amounts annually.

II. THE ACA RISK CORRIDORS PROGRAM IS ANNUAL IN NATURE

"The goal of the risk corridors program is to support the [Exchanges] by providing insurers with additional protection against uncertainty in claims costs during the first three years of the [Exchanges]." CMS, The Three Rs, *supra* note 2. "Issuers whose premiums exceed claims and other costs by more than a certain amount pay into the program, and insurers whose claims exceed premiums by a certain amount receive payments for their shortfall." *Id.*

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annually. That is inconsistent with the structure and text of the ACA.

[8] The Government has also admitted that portions of the ACA are "interdependent" and failing to implement some could lead to "skyrocketing premiums" or even "death spirals." *See* Br. for Resp't at 14-15, *King v. Burwell*, 135 S. Ct. 2480 (2015) (No. 14-114), 2015 WL 349885, at *14-15 (Jan. 21, 2015) ("the individual-coverage provision could not perform its market-stabilizing function in the absence of subsidies making coverage broadly affordable" and "[t]he denial of tax credits and the resulting loss of customers would thus have disastrous consequences for the insurance markets in the affected States"); Br. for Resp't at 26, *Nat. Fed'n of Indep. Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) (Nos. 11-393, 11-398, 11-400), 2012 WL 273133, at *26 (Jan. 27, 2012) ("without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals").

A. Mechanics of the ACA Risk Corridors Program

Section 1342(b) of the ACA mandates that the Secretary of HHS, for each of the first three years of full ACA implementation, must make risk corridors payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount":

> (b) PAYMENT METHODOLOGY. —
>
> (1) PAYMENTS OUT. — The Secretary shall provide under the program established under subsection (a) that if —
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (2) PAYMENTS IN.—The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

42 U.S.C. § 18062(b). Both "allowable costs" and "target amounts" are defined on a ***plan year*** basis. *See* 42 U.S.C. § 18062(c)(1)(A) (defining allowable costs as certain costs "of a plan for any year"); 42 U.S.C. § 18062(c)(2) (defining "target amount" as total premiums less

administrative costs "of a plan for any year").

If a plan's allowable costs are more than three percent above the total of the plan's premium revenue less the plan's administrative costs, the plan shall receive a payment equal to 50 percent or more of the plan's costs over that three percent threshold. The annual risk adjustment and reinsurance payments are part of the calculation of a plan's allowable costs. 42 U.S.C. § 18062(c)(1)(B); 45 C.F.R. §153.530(b).

B. Indicia of the ACA Risk Corridors Program's Annual Nature

Although Section 1342 does not specifically state that the Secretary must remit payment annually, everything about the statute, including its language, structure, and purpose, support that interpretation. For example, and as noted above, the allowable costs and target amounts used to calculate risk corridors amount are annual in nature, reset every year, and must take into account the QHP issuers' annual 3R risk adjustment and reinsurance payments or receipts. CMS regulations implemented these requirements in the final program. 45 C.F.R. § 153.510(a)-(d), (g). Similarly, QHP issuers must submit their risk corridors data annually, 45 C.F.R. § 153.530(d), and QHP issuers must remit risk corridors charges *to* the Government annually. 45 C.F.R. § 153.510(d) ("A QHP issuer must remit [risk corridors] charges to HHS within 30 days after notification of such charges"). This, of course, is consistent with the fact that, depending upon the calculations, QHP issuers must pay into the risk corridors programs under certain conditions just as the Government must pay out under certain conditions.

If the above were not alone enough, the Government has required or made full payments under the other 3R programs every year since their inception. *See* CMS, The Three Rs, *supra* note 2. This is telling because, just like the risk corridors program, the statutes and regulations creating the other 3Rs reference how to calculate and share payments—and, in the case of the reinsurance program, require either annual or more-than-annual payments from QHP issuers, 42

U.S.C. § 18061(b)(3)—but are silent regarding when payments out from the Government to QHP issuers must occur. *See* 42 U.S.C. § 18061(b)(1) (stating that the ACA reinsurance entity must only begin making payments in the "3-year period beginning January 1, 2014"); 42 U.S.C. § 18061(b)(4) (allowing the ACA reinsurance entity to pay out reinsurance amounts for current or previous plan years); 42 U.S.C. § 18063(b) (with respect to the risk adjustment program, permitting HHS to implement methods and criteria "utilized under part C or D of title XVIII of the Social Security Act" for similar premium stabilization programs). And even in the risk corridors context, the Government has made annual payments of the money it can pay—to date, just 12.6% of the 2014 risk corridors amounts owed. *See* Compl. ¶¶ 41, 45.

Prior to the spending bills that barred CMS from paying risk corridors obligations above and beyond those collected from QHPs, the Government recognized that payments should be annual and made contemporaneously with payments made by QHPs. For example, on July 15, 2011, HHS stated:

> HHS would make payments to QHP issuers that are owed risk corridor amounts from HHS ***within a 30-day period after HHS determines that a payment should be made to the QHP issuer***. We believe that QHP issuers who are owed these amounts will want prompt payment, and also ***believe that the payment deadlines should be the same for HHS and QHP issuers***.

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41930, 41943 (July 15, 2011). In 2012, exactly two years after the ACA was enacted (but before Congress declined to appropriate funds for the program), HHS again stated:

> While we did not propose deadlines in the proposed rule, we…suggested…that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. ***QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***

Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17220, 17238 (Mar. 23, 2012) (emphasis added).

HHS also admitted that no statute or regulation requires the risk corridors program to be "budget neutral"—*i.e.*, HHS uses only the funds provided by QHP issuers under the program to pay other QHP issuers owed under the program. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15410, 15473 (Mar. 11, 2013) ("The ***risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under 1342 of the Affordable Care Act***.") (emphasis added). While the Government now argues that HHS has "determined" that it need not pay the risk corridors payments on annual basis, that is a *post hoc* rationalization owed no deference by the Court. *Parker v. Office of Personnel Mgmt.*, 974 F.2d 164, 166 (Fed. Cir. 1992) ("[P]ost-hoc rationalizations will not create a statutory interpretation deserving of deference."). HHS did not "establish a three-year payment framework" as the Government contends in its Motion. (*See* Mot. at 16-17.) The only thing the 2014 HHS guidance established was that the risk corridors payments would, in fact, be annual to the extent HHS has the funds to pay its obligations. Simply put, the Government's changed interpretation of the statute four years after it was enacted has no bearing on the original intent of the statute. Rather, if any deference is owed, it is to HHS' original regulations and statements recognizing that full, annual payments are required—facts that are notably omitted from the motion to dismiss.

III. THE ACA RISK CORRIDORS PROGRAM IS BASED ON AN EARLIER PROGRAM THAT REQUIRES PAYMENT (AT LEAST) ANNUALLY

The ACA specifically provides that its risk corridors program is based on a prior risk corridors program: Part D of the Social Security Act. 42 U.S.C. § 18062(a) ("Such program ***shall be based*** on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act.") (emphasis added). Part D must, therefore, be considered when determining how the ACA risk corridors program is to be implemented.

There can be no doubt that Part D contemplates and requires annual risk corridors payments. For example, Part D makes clear that ***each plan year*** has a separate risk corridor. 42 U.S.C. § 1395w-115(e)(3)(A) ("For each plan year the Secretary shall establish a risk corridor for each prescription drug plan . . . ."); *see also* 42 C.F.R. § 423.336(a)(2)(i) ("For each year**,** CMS establishes a risk corridor for each Part D plan.").

Moreover, Part D contemplates that payments will be made ***at least*** annually. *See* 42 U.S.C. § 1395w-115(d)(1) ("The Secretary may establish a payment method by which interim payments of amounts under this section are made during a year based on the Secretary's best estimate of amounts that will be payable after obtaining all of the information."). The Part D regulations—which were in place at the time Congress enacted the ACA and thus acted as the explicit model for the ACA risk corridors program—require the Government to make risk corridors payments within "the following payment year" after the reported losses. *See* 42 C.F.R. § 423.336(c) ("***CMS makes payments after a coverage year*** after obtaining all of the cost data information in paragraph (c)(1) of this section necessary to determine the amount of payment. . . . CMS at its discretion makes either lump-sum payments or adjusts monthly payments ***in the following payment year*** . . . .") (emphasis added).

The Government has, in fact, made full payments annually under the Part D risk corridors program. *See e.g.,* HHS Office of Inspector General, *Medicare Part D Reconciliation Payments for 2006 and 2007*, at 14 (September 2009), *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf (last visited Aug. 15, 2016).[9]

[9] Since its inception, the Part D program receipts have exceeded its payouts, making the program net positive for the Government. Based on this success, HHS did assume that the ACA program would be similarly budget neutral ***in practice*** (which explains the limited statements it made to the Congressional Budget Office ("CBO") that it did not believe Congress would need to appropriate significant funds for the risk corridor program, *see* Mot. at 6-7).

In terms of policy, the Government's annual payments with respect to the Part D risk corridors program, as well as its initial indications that it would pay in full annually for the ACA risk corridors program, are consistent with the purpose and long-held understanding of how to make such programs effective. *See* Bundorf Decl. ¶ 11. A risk corridors program is most important in the first few years of a new health insurance marketplace, when the insurers providing plans know the least about the demographics of the insureds they will cover. *Id.* ¶ 9. Without such a program in place, insurers would necessarily need to price their premiums higher, which would in turn lead to lower adoption of the new plans and hinder growth of both insurers in the market, as well as the market itself. *Id.* Risk corridors help remedy this uncertainty and counteract the negative consequences of opening a new insurance market. *Id.* However, because the vast majority of health plans in the United States are annual in nature, the only way such a program works in practice is if the payments required under the program are annual in nature, and required in full every year. *Id.* ¶¶ 10-11. This is exactly what happened in the previous Part D program, and what was supposed to happen with the ACA. *Id.* ¶ 11.

IV. CONGRESS REFUSED TO APPROPRIATE FUNDS TO PAY HHS'S RISK CORRIDORS OBLIGATIONS FOR THE 2014 AND 2015 PLAN YEARS

On December 16, 2014, a year after QHP issuers already began offering insurance through the ACA-created Exchanges, Congress enacted the 2015 Spending Bill, which contained, among other provisions, a rider eliminating CMS/HHS's ability to make risk corridors payments from appropriated funds. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, 2491 (the "2015 Spending Bill") at 362. This was also over eighteen months after class member QHP issuers submitted proposed insurance premiums for regulatory approval. Compl. ¶ 36. Congress included a similar provision in the following year's appropriations bill, Pub. L. No. 114-113 (the "2016 Spending Bill"), this time

further specifying that special amounts appropriated to CMS and HHS in 2016 could not be used to fund the risk corridors program. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242, 2624-25. The 2015 and 2016 Spending Bills ***have not and cannot*** change the fact that the risk corridors provisions of Section 1342 of the ACA are money-mandating. *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (admitting the ACA still "requires the Secretary to make full [risk corridor] payments").

V. THE CONTINUING FAILURE TO MAKE FULL, ANNUAL RISK CORRIDORS PAYMENTS HAS HARMED HRIC, THE CLASS, AND THEIR INSUREDS

For the 2014 plan year, the Government paid QHP issuers only 12.6% of the more than $2.87 billion they were owed under the risk corridors program (Compl. ¶ 41), thereby causing significant damage to the ACA Exchanges the risk corridors provisions were intended to support and stabilize.

To date, for example, only 7 of the original 23 CO-OPs created pursuant to the ACA are still functioning as QHP issuers.[10] HRIC is one of the CO-OPs forced to exit the market and wind down its operations. In 2014 and 2015, HRIC priced its QHPs competitively, but responsibly, falling in the middle of the pack of the 10 carriers offering insurance on the Oregon exchange. Compl. ¶ 44.[11] HRIC's business plan was structured so that it only needed to receive half of its 2014 compensable risk corridors payments in order to meet cash flow and regulatory reserve requirements. *Id.* ¶ 45. Even with this conservative plan, however, HRIC was at risk of

[10] *See* Patients' Interests First, *supra* note 4.

[11] This was despite that the Government affirmatively tried to force HRIC to lower its premiums, or else lose its federal loans, because other insurers in Oregon had premiums more than 10% lower than those HRIC deemed reasonable for its business and the consumer pool it covered. In fact, the Government threatened to find HRIC in default of its loans if it were not priced that low. The Government rationalized this position by saying the 3Rs would protect HRIC from any losses it might suffer. However, as is evident from HRIC's own history, that was only true if the Government paid on an annual basis. When it failed to do so, HRIC also failed as a company and withdrew from the market. Declaration of Dawn Bonder ("Bonder Decl.") ¶ 11.

falling below statutory reserve requirements directly because of the Government's failure to pay its risk corridors obligation; when the Government paid only 12.6% of the amount it owed. *Id.* As a direct result of the Government's failure to pay this statutory obligation, HRIC was not able to participate as a QHP issuer for 2016. *Id.*

The Government's failure to pay its risk corridors obligations, however, has impacted many more insurers than just the CO-OPs, and it has caused widespread damage to the ACA Exchanges. For example, in several counties in Oregon, consumers seeking an individual health plan on the ACA exchanges now have much more limited choices because the other issuers were forced by the risk corridors non-payment to exit the market.[12] Another example is the nation's largest health insurer, UnitedHealth Group, which announced that it suffered approximately $650 million in losses on ACA exchanges as of the end of 2015 and would no longer offer QHPs after 2016 in the majority of the 34 states where it currently offered such plans.[13] Humana Inc. also announced plans to exit ACA exchanges in at least two states in 2017, and it is preparing to increase premiums to cover the higher-than-expected costs in the other states.[14] This decrease in competition is a result of the Government's failure to pay annual risk corridors payments and is at odds with the stated intent of the ACA as recognized by the United States Supreme Court.

Compounding the overall shortfall in risk corridors payments is that the National Association of Insurance Commissioners ("NAIC") issued guidance to state insurance

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[12] *See* Tara Bannow, *Final Oregon health insurance rates approved,* THE BULLETIN (Bend, Or.) (July 1, 2016), *available at* http://www.bendbulletin.com/home/4470743-151/final-oregon-health-insurance-rates-approved?referrer=fpblob (last visited Aug. 15, 2016).

[13] *See* Carolyn Y. Johnson, *UnitedHealth Group to exit Obamacare exchanges in all but a 'handful' of states*, WASH. POST (April 19, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/04/19/unitedhealth-group-to-exit-obamacare-exchanges-in-all-but-a-handful-of-states/ (last visited Aug. 12, 2016).

[14] *See* Zachary Tracer, *Humana Echoes Obamacare Warning Following UnitedHealth Exits*, BLOOMBERG (May 5, 2016), *available at* http://www.bloomberg.com/news/articles/2016-05-05/humana-echoes-obamacare-warning-following-unitedhealth-exits (last visited Aug. 15, 2016).

commissioners recommending that, due to the uncertainty over when (and if) the Government would make its risk corridors payments, QHP issuers should not be permitted to admit risk corridors receivables as balance sheet assets.[15] As a consequence, QHP issuers cannot use owed risk corridors payments to meet regulatory reserve requirements. This inability to admit risk corridors amounts as assets caused many QHP issuers to become insolvent and/or to exit the QHP Exchange market. Compl. ¶¶ 11, 19, 43.

HHS's inability to pay the risk corridors amounts due (notwithstanding the statutory mandate to pay these amounts) has also caused insurance premiums to rise across the country.[16] This is precisely the kind of the "economic 'death spiral[s]'" the ACA (and the risk corridors program) was designed to prevent. *See King*, 135 S. Ct. at 2486 ("As premiums rose higher and higher, and the number of people buying insurance sank lower and lower, insurers began to leave the market entirely."). And, just as the above are some examples of a much broader problem in the ACA insurance markets, the problems can only be expected to increase for the QHP issuers within the putative class. All indications are that the losses for the 2015 plan year are at least, if not greater than, the losses collectively incurred in the 2014 plan year. *See, e.g.,* Deep Banerjee,

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[15] *See* NAIC, Interpretation of the Emerging Accounting Issues (E) Working Group, "INT 15-01: ACA Risk Corridors Collectibility," (Oct 19, 2015; Nov. 5, 2015), *available at* http://www.naic.org/documents/committees_e_app_eaiwg_related_int_1501_risk_corridors.pdf (last visited Aug. 15, 2016) (the NAIC working group "determined that risk corridors receivables for the 2015 and 2016 benefit years estimated in accordance with SSAP No. 107, paragraphs 56.b and 56e are nonadmitted 1) until such time that the prior benefit year is paid in full and 2) until additional proration amounts are confirmed by HHS or other information of a sufficient nature supports that collectibility is probable and reasonable").

[16] *See*, *e.g.*, Paul Demko, *Obamacare's sinking safety net*, POLITICO (July 13, 2016) (calling the risk corridors program "an unmitigated debacle" and blaming rising premiums on the government's nonpayment), http://www.politico.com/agenda/story/2016/07/obamacare-exchanges-states-north-carolina-000162 (last visited Aug. 15, 2016); Tara Bannow, *Final Oregon health insurance rates approved,* THE BULLETIN (Bend, Or.) (July 1, 2016), *available at* http://www.bendbulletin.com/home/4470743-151/final-oregon-health-insurance-rates-approved?referrer=fpblob (last visited Aug. 15, 2016); Louise Radnofsky & Anna Wilde Mathews, *Health Insurers Struggle to Offset New Costs*, WALL ST. J. (May 4, 2016), http://www.wsj.com/articles/health-insurers-struggle-to-offset-new-costs-1462404298 (last visited Aug. 15, 2016).

Caitlin Weir & James Sung, *The ACA Risk Corridor Will Not Stabilize The U.S. Health Insurance Marketplace in 2015*, STANDARD & POOR'S RATINGSDIRECT, at 2-3 (Nov. 5, 2015). Despite this—but due to the constraints imposed by the 2016 Spending Bill—the Government has stated that risk corridors amounts received from QHP issuers for the 2015 plan yearr will first be used to pay down the $2.5 billion shortfall from 2014 and, only after that shortfall has been paid in full, then be used for the 2015 shortfall. *See* CMS, "Risk Corridors and Budget Neutrality," (Apr. 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf (last visited Aug. 15, 2016). Given the massive losses incurred by QHP issuers, there is simply no way that any amounts collected for the 2015 plan year will be sufficient to pay ***either*** the 2014 shortfall or the 2015 shortfall, let alone both. Compl. ¶¶ 10, 15, 47-49.

ARGUMENT

I. HRIC HAS ESTABLISHED THIS COURT'S SUBJECT MATTER JURISDICTION OVER THIS DISPUTE

In order to invoke this Court's jurisdiction on the basis of a "money-mandating" statute, a plaintiff must identify a statute, regulation, and/or constitutional provision that (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (citations omitted). If the plaintiff also makes a "nonfrivolous assertion that it is within the class of plaintiffs entitled to recover under the money-mandating source, the Court of Federal Claims has jurisdiction. There is no further jurisdictional requirement that plaintiff make the additional nonfrivolous allegation that it is entitled to relief under the relevant money-mandating source." *Jan's Helicopter Serv., Inc. v. FAA,* 525 F.3d 1299, 1307 (Fed. Cir. 2008); *see also Albino v.*

United States, 104 Fed. Cl. 801, 813 (2012) (jurisdiction exists "if a statute is reasonably amenable to a reading that is money-mandating and the plaintiff falls within the class of plaintiffs entitled to recover under the statute").

As alleged in the Complaint, Plaintiffs' money damages are caused by the Government's failure to pay its risk corridors obligations under the ACA and relevant implementing regulations. The Government does not contest that the risk corridors program is "money-mandating"; instead, it admits that it is obligated to pay QHP issuers. Mot. at 15-16. Similarly, the Government does not contest that Plaintiffs (HRIC and the putative class) are the proper parties to sue for unpaid risk corridors amounts. HRIC therefore satisfies the *Fisher* jurisdictional test, and there is no dispute about Plaintiffs' personal standing to sue.

Instead, the Government seems to argue that the money-mandating risk corridors statutory provisions are not "reasonably amenable to the reading" that they require risk corridors payments to be "presently due" for the 2014 and 2015 plan years.

As an initial matter, the test the Government cites for determining this Court's subject matter jurisdiction is incorrect. The Government relies on *Todd v. United States*, 386 F.3d 1091 (Fed. Cir. 2004), and *Smith v. Sec'y of Army*, 384 F.3d 1288 (Fed. Cir. 2004), each of which denied jurisdiction because money damages were not "presently due" under the specific facts of those cases. However, in its subsequent *Fisher* opinion, the Federal Circuit clarified the rules surrounding this Court's jurisdiction, none of which include a "presently due" requirement. *Fisher*, 402 F.3d at 1173-74. Since then, this Court has repeatedly recognized that "presently due" is not the test for subject matter jurisdiction. *See*, *e.g.*, *House v. United States*, 99 Fed. Cl. 342, 347 (2011) (under *Fisher*, rejecting the Government's attempt to invoke a "presently due" jurisdictional step, and finding jurisdiction because the statute at issue was money-mandating);

Miller v. United States, 119 Fed. Cl. 717, 729 (2015) ("[T]he holding in *Smith* has been eroded by the Federal Circuit's more recent decision in *Fisher*."); *Tippett v. United States*, 98 Fed. Cl. 171, 179 n.10 (2011) (*Fisher* "altered the jurisdictional inquiry for Tucker Act suits").

Even if the proper jurisdictional test was "presently due" funds, however, the Government's argument still fails. Indeed, the case law relied upon by the Government (at 14-15) does not support its argument. For example, many of the claims held to be beyond the court's jurisdiction in the Government's citations sought non-monetary relief rather than money damages, the latter of which is a requirement for Tucker Act jurisdiction. *See Todd*, 386 F.3d at 1094 (no jurisdiction over lawsuit that effectively constituted a challenge to the Government's failure retroactively to change the status of an airport); *Smith*, 384 F.3d at 1297 (no jurisdiction to the extent challenge was to a promotion decision and did not give rise to a claim for damages); *Overall Roofing & Const. Inc. v. United States*, 929 F.2d 687, 687-88 (Fed. Cir. 1991) (no jurisdiction over lawsuit challenging Government contract termination without an accompanying claim for damages), *superseded by statute* 28 U.S.C. § 1491(a)(2), *as recognized in Alliant Techsystems, Inc. v. United States*, 178 F.3d 1260, 1268 (Fed. Cir. 1999); *United States v. Testan*, 424 U.S. 392, 407 (1976) (no Tucker Act jurisdiction over challenge to Government's employee classification decision). Another of the Government's primary "presently due" citations focused on a plaintiff that was not even statutorily eligible for payment for another eight years. *See Wood v. United States*, 214 Ct. Cl. 744, 745 (1977) (unpublished) (42-year-old Government employee sought a declaratory judgment or "$95,760.00 for the loss of his retirement benefits" even though he would not become eligible for a retirement program until age 50). And still other case citations clearly contradict the Government's contentions in its motion. *See*, *e.g.*, *United States v. Mitchell*, 463 U.S. 206, 228 (1983) (finding Tucker Act

jurisdiction because "the statutes and regulations at issue here can fairly be interpreted as mandating compensation").

In any event, there are numerous reasons it is incorrect here to suggest the risk corridors program is not reasonably amenable to the interpretation that the Government must pay full, annual amounts. First, as more fully discussed in Statement of the Case Sections II & III *supra*, everything about the relevant regulations, policies, purposes, and structure support that interpretation that these statutorily-mandated payments must be made annually. Second, the allegations in the Complaint—including, *inter alia*, that the entire ACA exchange insurance market (including HHS itself) believed risk corridors payments were annual in nature and that the Government's failure to pay full risk corridors amounts caused substantial damage to the market the ACA intended to create and maintain (*see* Compl. ¶¶ 6, 10-11, 29-34, 44-45)—also support the point that the risk corridors statutory provisions are "reasonably amenable" to the interpretation that the Government owes full, annual risk corridors amounts. Third, controlling Supreme Court and Federal Circuit precedent on statutory interpretation (discussed further below) dictates that the Government's motion to dismiss must be denied. Finally, the Government's argument that CMS should not be required to pay on an "annual cycle" but instead should be permitted to pay sometime after the three-year "framework" (because that is allegedly the way CMS wants to administer the risk corridors program) is not an appropriate issue for a motion to dismiss because, for the Government to prevail, it would have to establish facts that are in dispute.

Put simply, the Government cannot prevail on its subject matter jurisdiction dismissal arguments because it does not identify why HRIC's interpretation is not "reasonably amenable" to the requirement that the Government pay full risk corridors amounts annually. Nor does it

explain why this issue is not, at worst, a disputed material fact.

A. Standards Governing Statutory Construction

When interpreting a statute, a Court must first look to the statute's plain language in order to "inquire whether Congress has clearly spoken on the subject" in dispute. *Bath Iron Works Corp. v. United States*, 27 Fed. Cl. 114, 125 (1992) (citing *Norfolk & W. Ry. Co. v. Am. Train Dispatchers Ass'n*, 499 U.S. 117, 128 (1991)). If the statute is plain on its face, that is the end of the inquiry. *Id.* Assuming there is an ambiguity in the statute's plain meaning, however, the next step is to look at "other extrinsic aids, such as legislative history." *Id.* (citing *Richards Medical Co. v. United States*, 910 F.2d 828, 830 (Fed. Cir. 1990)).

"Where a statute's text and legislative history are silent on an issue of statutory construction, the overriding purpose of the provision is highly relevant in resolving the ambiguity." *Augustine v. Dep't of Veterans Affairs*, 429 F.3d 1334, 1342 n.4 (Fed. Cir. 2005). To this point, "the court will not look merely to a particular clause …, but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give it such a construction as will carry into execution the will of the Legislature." *Warner–Lambert Co. v. Apotex Corp.,* 316 F.3d 1348, 1355 (Fed. Cir. 2003) (quoting *Kokoszka v. Belford,* 417 U.S. 642, 650 (1974)); *see also King*, 135 S. Ct. at 2490 (refusing to read portion of the ACA "out of context" with the broader Act, because it would render other provisions in the Act senseless or contradictory).

B. The ACA Requires Annual Risk Corridors Payments in Their Full Amounts

According to the Government, neither Section 1342 nor its implementing regulations impose any "temporal constraints on when HHS must pay risk corridors," therefore giving HHS complete discretion over when such payments may be made. Mot. at 15-16. This interpretation is incorrect based upon the plain language of the risk corridors provisions and ACA, incorrect

based upon the risk corridors provisions' legislative history, inconsistent with the very purpose and structure of the provisions and ACA, and contrary to the statutory construction rules established by the Supreme Court specifically in the context of the ACA.

1. The statute's plain meaning requires full, annual payments

"A court derives the plain meaning of the statute from its text and structure." *Norfolk Dredging Co. v. United States*, 375 F.3d 1106, 1110 (Fed. Cir. 2004) (citing *Alexander v. Sandoval*, 532 U.S. 275, 288 (2001)). "In construing a statute, courts should not attempt to interpret a provision such that it renders other provisions of the same statute inconsistent, meaningless, or superfluous." *Abramson v. United States*, 42 Fed. Cl. 621, 629 (1998). Thus, "when reviewing the statute at issue in this case, the court must construe each section of the statute in connection with each of the other sections, so as to produce a harmonious whole." *Id.*

(a) Section 1342 and the broader ACA provide for an annual risk corridors program

In the very first sentence of Section 1342, Congress mandated that HHS establish "a program of risk ***corridors*** for calendar years 2014, 2015, and 2016." 42 U.S.C. § 18062(a) (emphasis added). Absent contrary evidence, the use of the plural is deemed intentional, *see Dakota, Minnesota & Eastern R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) ("Congress's use of the plural is evidence of its intent"), which is revealing here because it indicates there are ***multiple*** risk corridors—one for each calendar year ("2014, 2015, and 2016")—and that there are separate payment obligations for each.

That there is a new risk corridor every year is no surprise, given that everything about the program is annual. The ACA mandates payment based on premiums and costs ***for each plan year*** from 2014-2016; all calculations are made on a plan year basis. *See* 42 U.S.C. §§ 18062(c)(1)(A) ("The amount of allowable costs of a plan for any year …."), 18062(c)(2) ("The

target amount of a plan for any year ….”); *see also* 42 U.S.C. § 18062(b) (calculating risk corridors “[p]ayments out” and “[p]ayments in” based on ratio of allowable costs to target amounts “for any plan year”). QHP issuers must submit their data to HHS annually for the preceding year, so that HHS may calculate annual risk corridors amounts based on that data. 45 C.F.R. § 153.530(d). All QHPs are certified for an Exchange just one year at a time. *See*, *e.g.*, 45 C.F.R. § 155.1045 (mandating that accreditation for QHPs occur before each year the QHP is offered). Payment into the risk corridors by QHP issuers is annual as administered by HHS; risk corridors payments out to QHP issuers are also annual to the extent HHS has money to make the payments. The other 3Rs (risk adjustment and reinsurance) are both paid annually even though neither program’s establishing statute mandates annual Government payments.

HHS has not made full, annual risk corridors payments because Congress specifically withheld the funds that would have allowed it to do so. In turn, the Government now contends HHS should be able to “administer” the mandatory risk corridors payment program by paying only what it can, when it can. But that was not HHS’ original understanding or position on the payment regime. In 2011, HHS admitted that “***QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***” Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17219, 17238 (Mar. 23, 2012) (emphasis added). QHP issuers are required to pay in their risk corridors amounts 30 days after the Government provides its final calculations. 45 C.F.R. § 153.510(d). HHS knows it should pay risk corridors amounts out at the same time, so it has paid what it can for 2014 (12.6% of the total owed amount) and will do the same for 2015 and 2016 unless and until the *status quo* changes. The Government, for its part, does not offer any real answer for how or when the mandatory payment will be made other than it is supposedly only due sometime

after 2017, at which time Congress will hopefully change its mind and appropriate the money so HHS can finally meet its payment obligations. That is no solution and certainly is not a basis to misread the relevant statutory provisions of the ACA, particularly because the entire point of the Tucker Act is to provide aggrieved plaintiffs the ability to obtain a judgment (from a permanent appropriation, *see* 31 U.S.C. § 1304) for a payment the government is statutorily obligated to make, but has not.

(b) The ACA risk corridors program is "based on" the Part D Medicare program, which requires full, annual payments

Supporting this interpretation is Part D, which Congress required HHS to use as the basis the ACA risk corridors program. *See* 42 U.S.C. § 18062(a). Part D specifically notes that each "risk corridor" is specific to the plan year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) ("***For each plan year*** the Secretary shall establish ***a risk corridor*** for each prescription drug plan and each MA–PD plan. The ***risk corridor for a plan for a year*** shall be equal to a range as follows . . . .") (emphasis added); 42 C.F.R. § 423.336(a)(2)(i) ("***For each year***, CMS establishes ***a risk corridor*** for each Part D plan. The ***risk corridor for a plan for a coverage year*** is equal to a range as follows . . . .") (emphasis added).

Part D also requires payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) ("CMS at its discretion makes either lump-sum [risk corridor] payments or adjusts monthly [risk corridor] payments ***in the following payment year*** ….") (emphasis added). Where "Congress adopts a new law incorporating sections of a prior law, Congress normally can be presumed to have had knowledge of the [administrative or judicial] interpretation given to the incorporated law, at least insofar as it affects the new statute."

Lorillard v. Pons, 434 U.S. 575, 580-81 (1978).[17] Thus, the ACA required HHS (just as Part D does) to establish a program to make and receive payments in the year following each risk corridor. HHS clearly understood this requirement as it applies to QHP issuers, who must provide an annual QHP on the Exchanges, submit their risk corridors data for that QHP by the following July 31, and then pay any owed amounts based on that data 30 days after notification of any charges owed to the Government. 45 C.F.R. § 153.510(d).[18]

(c) The Government identifies no plain language in any statute supporting its "three-year payment framework"

The Government's primary counter-position relies on the assumption that payments for each risk corridor may be collectively spread across the three-year length of the ACA risk corridors program, and/or set off against payments and charges from other risk corridors years. Mot. at 16. For this interpretation, however, the Government identifies no actual statutory language permitting such a result, nor any reason that (in light of risk corridors' clear annual purpose and structure) such a payment framework would be consistent with the statute's plain meaning. (*Id.*) There is non. Notably, while Section 1342 of the ACA does allow for reductions that can affect a QHP issuer's risk corridors amounts related to the annual calculations of the other 3R programs (demonstrating the interrelatedness of these annual programs), it does not provide for risk corridors payment reductions or increases based on risk corridors amounts from

[17] *See also Am. Fed. of Gov't Employees, AFL-CIO v. United States*, 46 Fed. Cl. 586, 599-600 (2000) (applying interpretation given to statute with "the same purposes" as statute at issue in the present case); *Leroy v. Sec. of Dep't of Health and Human Servs.*, 2002 WL 31730680, at *14 (Fed. Cl. Oct. 11, 2002) (applying definition of specific statutory term from previous Act that was referenced in newer Act, the latter of which did not define the term); *James v. Santella*, 328 F.3d 1374, 1377-78 (Fed. Cir. 2003) (applying interpretation given to language from previous statute that was incorporated into newer statute); *Cohen v. United States*, 105 Fed. Cl. 733, 752-53 (2012) (analyzing and applying interpretations of Copyright Act provisions regarding minimum statutory damages that were incorporated into amendments to the Patent Act).

[18] For the 2014 plan year, the Government notified QHP issuers of their charge amounts on November 19, 2015, thus requiring them to pay those charges by December 19, 2015. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), at 1.

other plan years. *See* 42 U.S.C. § 18062(c)(1)(B) (reducing allowable costs "by any risk adjustment and reinsurance payments received under section 18061 and 18063 of this title").

The Government next argues that the 2015 and 2016 Spending Bills somehow indicate HHS has the discretion to set a three-year payment schedule because the Bills prohibit HHS from making payments above the amounts it receives directly from the risk corridors program. Mot. at 17. While it is correct that HHS lacks the ability to pay all the money it owes to class members now because of the Spending Bills, Congress's *ex post* restriction on appropriations for the risk corridors program is not relevant to the interpretation of the underlying statute and does not absolve the Government of its payment obligations. The Tucker Act ***prohibits*** such activity and provides jurisdiction to this Court to remedy it for aggrieved plaintiffs. *See*, *e.g.*, *Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (*en banc*) ("[T]he jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid."). Indeed, the Government's own cited authorities negate the position that the post-ACA 2015 and 2016 Spending Bills provide any insight into the statute's original meaning. *See*, *e.g.*, *Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005) (cited in Mot. at 17) ("The significance of appropriations bills is of course limited and the associated legislative history even more so. . . . [P]ost-enactment legislative history is not only oxymoronic but inherently entitled to little weight.").[19]

Furthermore, absent an evident statutory purpose to the contrary, courts read statutes and

[19] The Government's citation to *Schism v. U.S.*, 316 F.3d 1259 (Fed. Circ. 2002) (*en banc*), is instructive. (*See* Mot. at 17-18.) In *Schism*, the Federal Circuit held *en banc* that Congress did ***not*** ratify an agency's actions through an appropriations bill because there were no specific statements authorizing the specific conduct at issue. *Id.* at 1289-1294. Furthermore, from a logical standpoint, law on ratification-through-appropriations has no application here, because it addresses situations in which Congress assumes the burden of an agency's previously-unauthorized, affirmative acts by appropriating funds for those acts. In this case, HHS refrained from abiding by its monetary obligations to the Plaintiffs. By law, Congress cannot ratify such acts because they violate the Tucker Act. *Slattery*, 635 F.3d at 1321.

regulations to preserve common law principles. *See United States v. Texas*, 507 U.S. 529, 534 (1993). It is axiomatic under the common law that, in the absence of a specific timetable, payments must be made within a reasonable time. *Goodman v. Praxair, Inc.*, 494 F.3d 458, 465 (4th Cir. 2007) (observing, in context of statute of limitations discussion, that the elapse of a "commercially reasonable time for payment" is one event that could establish a breach of contract); *see also Eden Isle Marina, Inc. v. United States*, 113 Fed. Cl. 372, 493 (2013) (when there is not a specified timetable for performance, performance must occur within a reasonable time). The Government has identified nothing suggesting it is reasonable to pay out owed amounts at some undefined point after three years for a risk corridors program that all agree is crucial to stability and risk mitigation in the early years of the ACA Exchanges.

2. The legislative history demonstrates that HHS must make full, annual risk corridors payments

While there is little legislative history on the ACA,[20] the risk corridors program of the ACA is, as noted above, required by statute to be "based on" Part D. 42 U.S.C. § 18062(a) ("Such program shall be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act [42 U.S.C. 1395w–101 et seq.]."). Therefore, Part D's statutory language, implementing regulations and legislative history are relevant to the present dispute. *See*, *e.g.*, *Cohen*, 105 Fed. Cl. at 753 (analyzing older law's legislative history when interpreting new law that incorporated portions of the older law); *Am. Fed. of Gov't Employees, AFL-CIO*, 46 Fed. Cl. at 598-600 (same).

In the legislative history of Part D, Congressional testimony provided as follows: "The Federal Government has large-scale experience with the use of risk corridors," and that such a

[20] "Congress wrote key parts of the Act behind closed doors, rather than through 'the traditional legislative process.'" *King*, 135 S. Ct. at 2492 (citation omitted).

program "can limit both the downside risk and upside gain for an insurance organization." Expanding Coverage of Prescription Drugs in Medicare: Hearing before the Committee on Ways and Means, House of Representatives, 108th Congress, 2003 WL 23996388, at *115 (Apr. 9, 2003) (Statement of Cori E. Uccello and John M. Bertko, American Academy of Actuaries). This testimony identified ***annual*** risk corridors. *Id.* at *116-17. Following debate, Congress reported that it agreed to enact a risk corridors program that proceeded in phases, with the first risk corridors in 2006-2007 and then a subsequent phase from 2008-2011, in which the corridors would be broadened and plans would be at full risk for a greater portion of their gains and losses. 149 Cong. Rec. H. 11877, 12000 (Nov. 20, 2003) (H.R. Rep. No. 108-391 (2003) (Conf. Rep.)). Just as with the ACA, all amounts for these risk corridors calculations were annual. *Id.* HHS then demonstrated its understanding of Congress's intent with respect to the Part D risk corridors program by requiring annual payments from all parties. 42 C.F.R. § 423.336(c). It is this history that informed Congress when enacting the ACA and further supports the fact that the risk corridors program only works if it is annual in nature.

3. The purpose of the risk corridors program is to prevent exactly what has now occurred due to the Government's failure to pay

The risk corridors program's purpose (as demonstrated by Section 1342 and the ACA's other interrelated provisions) also supports the conclusion that risk corridors amounts must be paid annually. As the Government admits, the 3Rs are meant to provide "premium stabilization" in the highly risky, early years of the ACA exchanges. Mot. at 4. If risk corridors amounts are not paid annually, then the program will fail—as it has to date, because of the deferred payments—to provide any stabilization at all.

Insurance premiums are set annually. *See* 42 U.S.C. § 18031(c)(6)(B) (providing for "annual open enrollment periods" in advance of "calendar years" for plans on the Exchanges); 42

U.S.C. § 18031(e)(2) (providing for review of premiums for certification of Exchange plans). As previously discussed, the demographics in the new ACA Exchange markets were so uncertain that health policy experts expected rational QHP issuers to charge higher premiums for their plans in order to account for the potential of pricing errors. Bundorf Decl. ¶ 9.

The risk corridors program was meant to counteract the effects this uncertainty had on premiums and insurance coverage by providing risk mitigation to QHP issuers during the first few years of the Exchanges, when the market demographics were least understood. Profits and losses for each year are restricted to a narrow "corridor" so that issuers can learn the market pricing models and to build up capital reserves, which will "assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance."[21] Compl. ¶¶ 25-26; Bundorf Decl. ¶¶ 8-10. Key to this approach is ensuring that any misjudgments in setting premiums one year do not impact a QHP issuer too heavily in the next. *See* March 2012 Regulatory Impact Analysis, at 43 (the risk corridors program is meant to "protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains"); Bundorf Decl. ¶¶ 9-11. If the risk corridors payment is not made in the following year, this non-payment will cause insurers to create the exact conditions for the "economic death spirals" the ACA was designed to avoid. Compl. ¶¶ 11-12, 42-43; Bundorf Decl. ¶ 11. This is particularly true given that insurers must include risk corridors amounts in their annual assumptions when setting premiums. *See* Declaration of Janice Finley ("Finley Decl.") ¶¶ 5-7 (noting that HRIC's annual premiums by necessity included estimates of the company's risk corridors payments); Bundorf Decl. ¶ 10.

* * * * *

[21] CMS, The Three Rs¸ *supra* note 2.

Given this annual structure and purpose, there is no reasonable interpretation that permits anything other than risk corridors must be paid in each year following the plan year. *See King*, 135 S. Ct. at 2492-93 ("the statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market . . . , and likely create the very 'death spirals' that Congress designed the Act to avoid").

C. HHS's "Three-Year Payment Framework" is Not Owed Any Deference

To the extent the Government argues (at 16-18) that the Court should defer to HHS's decision to implement a three-year payment framework, this is also incorrect. *See Fisher*, 402 F.3d at 1175 (noting that a Tucker Act plaintiff need not be one the government has decided it must pay, because "[i]f the Government official's determinations under the [money-mandating] statute are in error, the court is there to correct the matter"). Presumably, the Government is invoking the "*Chevron* deference" doctrine, which affords heightened deference to an agency's positions "if Congress either leaves a gap in the construction of the statute that the administrative agency is explicitly authorized to fill, or implicitly delegates legislative authority, as evidenced by 'the agency's generally conferred authority and other statutory circumstances.'" *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352, 1361 (Fed. Cir. 2005) (quoting *United States v. Mead Corp.,* 533 U.S. 218, 229 (2001)).[22]

The ACA did not specifically grant HHS unfettered discretion to make risk corridors

[22] Where the *Chevron* doctrine does not apply, Courts may still apply a lower standard of deference to an agency's actions under the *Skidmore* doctrine. *W.E. Partners II, LLC v. U.S.*, 119 Fed. Cl. 684, 691 (2015). "The application of *Skidmore* deference depends upon the circumstances of the case and requires courts to give some deference to informal agency interpretations of ambiguous statutory dictates." *Id.* (internal quotations omitted). However, the exact level of deference—which varies from "great respect . . . to near indifference", *id.*—depends "upon the thoroughness evident in its consideration, the validity of its reasoning, its consistency with earlier and later pronouncements, and all those factors which give it power to persuade, if lacking power to control." *Id.* For the reasons discussed at length above, the Government's current interpretation of the statute is inconsistent with its earlier positions and is invalid based on the statute's plain meaning and inherent purpose.

payments in any amount it wants, whenever it wants.[23] Indeed, the agency's failure to pay full risk corridors amounts has destabilized the ACA Exchanges the 3Rs were designed to protect. This is important as to *Chevron* deference because the Supreme Court, in the context of the ACA, declined to apply the doctrine where the interpretation implicated "the [Affordable Care] Act's key reforms, involving billions of dollars in spending each year and affecting the price of health insurance for millions of people." *King*, 135 S. Ct. at 2489. As in *King*, this is "a question of deep 'economic and political significance' that is central to this statutory scheme," and "had Congress wished to assign the question to an agency . . . it surely would have done so expressly." *Id.* (quoting *Utility Air Regulatory Group v. EPA*, 134 S. Ct. 2427, 2444 (2014)). Thus, the Government cannot invoke the "explicit authorization" path to *Chevron* deference.

Nor does the statute implicitly allow HHS to pay risk corridors on whatever schedule it prefers. The only proper interpretation (for the reasons discussed at length above) is that Congress mandated full, annual risk corridors payments to and from QHP issuers. HHS's current "three-year payment framework" predictably ***de***stabilized the ACA Exchanges, which makes the Government's proposed interpretation of the risk corridors provisions incompatible with the rest of the ACA and of the same type expressly rejected by the Supreme Court in *King v. Burwell*. "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter." *King*, 135 S. Ct. at 2496. In *King*, the petitioners proposed an interpretation of the ACA (based upon the "plain language" of the statute) that would limit tax credit eligibility to only those persons in states with state-operated exchanges. *Id.* at 2495-96.

[23] The Government contends in its brief that Congress did not say ***anything*** about when to pay risk corridors amounts, (*see* Mot. at 15-16), which highlights why the *Skidmore* doctrine is—at best—the only deference doctrine potentially applicable here.

The Supreme Court rejected this interpretation, holding that ACA provisions must be interpreted in a manner "that is compatible with the rest of the law." *Id*. at 2492. Similarly, in this case, the Court should not interpret the risk corridors provision in such a way as to continue the "death spiral" for QHP issuer participation in the individual insurance market. *See id*. at 2492-93 ("the statutory scheme compels us to reject petitioners' interpretation because it would destabilize the individual insurance market . . . , and likely create the very 'death spirals' that Congress designed the Act to avoid").

HHS's position is thus owed no deference under the "implicit authorization" prong of the *Chevron* doctrine. Rather, to the extent any deference should be given, it should be to HHS's original position that it make risk corridors payments on an annual basis, on the same timeframe as payments to HHS from QHPs. *See e.g.*, Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17219, 17238 (Mar. 23, 2012). HHS's revised interpretation is merely a *post hoc* rationalization apparently motivated by the difficult position in which Congress put the agency with the 2015 and 2016 Spending Bills. It is not entitled to deference. *See Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2167 (2012) ("And [*Chevron*] deference is likewise unwarranted when there is reason to suspect that the agency's interpretation does not reflect the agency's fair and considered judgment on the matter in question. This might occur when the agency's interpretation conflicts with a prior interpretation[.]") (internal citations and quotations omitted). Finally, and in any event, any ambiguity on this issue establishes a merits issue for later in the case. *See Fisher*, 402 F.3d at 1173-74; *Cathedral Candle*, 400 F.3d at 1361.[24]

[24] The Government's reliance on *McCarthy v. Madigan* and *Contreras v. United States* is misplaced. Mot. at 16. In *Contreras*, the statute at issue stated the "agency *may* pay a cash award." 64 Fed. Cl. 583, 592-93 (2005) (emphasis added) ("Unlike the use of 'shall' or 'must,' which very obviously connotes mandatory action, laws employing 'may' have been held on

D. The Government Currently Owes Risk Corridors Amounts for the 2014 and 2015 Plan Years

With the correct interpretation of the statute and implementing regulations thus established, the unavoidable conclusion is that HRIC and the putative class have a live case or controversy for the 2014 and 2015 plan years.[25]

For the 2014 plan year, HRIC and the vast bulk of its fellow QHP issuers collectively suffered over $2.87 billion in compensable risk corridors losses, only 12.6% of which were paid by the Government. Compl. ¶ 41. This resulted in a $2.5 billion shortfall in premium stabilization payments that forced many issuers, such as HRIC, to wind down their business; forced other issuers into receivership; and, for certain "lucky" issuers, only caused massive losses to their ACA insurance businesses that remain significantly in the red. Compl. ¶¶ 19, 42-43, 48.[26] The Government is currently delinquent on these payments—which were scheduled for 2015—thus rendering them "presently due" and establishing subject matter jurisdiction here.

For the 2015 plan year, risk corridors amounts are also presently due. HRIC and the other QHP issuers each set their target amounts and allowable costs for 2015, and each provided

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occasion to admit of some ambiguity."). Here, the ACA states the Secretary "*shall* establish and administer a program of risk corridors," which "*shall* be based on the program for regional participating provider organizations under part D of title XVIII of the Social Security Act." *See* 42 U.S.C. §18062(a) (emphasis added). *McCarthy* is similarly inapposite because it only addresses whether a prisoner must exhaust his administrative remedies before bringing a *Bivens* action. 503 U.S. 140, 141-45 (1993). The case did not involve a Tucker Act claim nor an analysis of whether a statute was money-mandating. *Id.* Moreover, the Supreme Court determined the plaintiff prisoner *did not* have to exhaust the agency's administrative procedures. *Id.* at 156.

[25] Although the Court of Federal Claims is an Article I tribunal, it generally adheres to traditional justiciability standards applicable to Article III courts. *See, e.g., Weeks Marine, Inc. v. United States,* 575 F.3d 1352, 1359 (Fed. Cir. 2009).

[26] *See also* Carolyn Y. Johnson, *UnitedHealth Group to exit Obamacare exchanges in all but a 'handful' of states*, WASH. POST (April 19, 2016), https://www.washingtonpost.com/news/wonk/wp/2016/04/19/unitedhealth-group-to-exit-obamacare-exchanges-in-all-but-a-handful-of-states/ (reporting UnitedHealth expects to lose $650 million in the ACA exchanges in 2016) (last visited Aug. 12, 2016).

insurance services for that plan year. Compl. ¶¶ 40, 50-51. As the Complaint alleges, market analyses, HRIC's individual losses, and reports regarding public QHP issuers' SEC filings all indicate that the 2015 plan year will result in a huge amount of compensable losses for QHP issuers (likely equal to or more than the 2014 plan year). Compl. ¶¶ 16, 47-48. HRIC and its fellow class members thus know that (a) they have substantial claims to payment under the risk corridors program; (b) HHS is forbidden by the 2016 Spending Bill from using any appropriations this year to fund the risk corridors program; (c) there will be insufficient funds collected from the 2015 plan year to pay off outstanding 2014 risk corridors amounts; and (d) due to the "2014 first" regime, ***no*** 2015 risk corridors amounts will be paid this year (as required). Compl. ¶¶ 17-18, 46-49. Such a scenario establishes a live case or controversy regarding the 2015 risk corridors amounts. *See Thomas v. Union Carbide Agr. Prods. Co.*, 473 U.S. 568, 581 (1985) ("One does not have to await the consummation of threatened injury to obtain preventive relief. If the injury is certainly impending, that is enough.").

The Government's response is to claim that 2015 risk corridors amounts are not "presently due" because HHS did not begin to calculate them until August 1, 2016. Mot. at 15. That argument, however, misses the point. The Government already owes risk corridors amounts for 2015 and has stated that it will not pay those amounts in accordance with its obligations. The exact ***amount*** of those damages—which the Government is currently calculating—is a factual question for discovery inappropriate for a motion to dismiss. *See BMY-Combat Sys. Div. of Harsco Corp. v. United States*, 26 Cl. Ct. 846, 850 (1992) ("[T]he precise quantum [of damages] is a question of fact to be determined later in the proceedings."). In any event, this will be a moot point by the time the Court resolves the motion to dismiss, as HHS is

currently calculating the exact amount due to each class member for the 2015 plan year.[27]

II. RISK CORRIDORS CLAIMS ARE RIPE FOR THE 2014 AND 2015 PLAN YEARS

The Government's next argument is that HRIC's claims are not ripe because HHS has not "consummated its decisionmaking process" regarding the total risk corridors amounts for 2014-2016. Mot. at 20-21. As an initial matter, this presumes that the Government need not pay full risk corridors amounts annually, which, for the reasons discussed above, is incorrect. However, the Government's argument also fails because it misapplies the law on ripeness.

As the Federal Circuit instructs:

> Whether an action is "ripe" requires an evaluation of "both the fitness of the issues for judicial decision and the hardship to the parties of withholding court consideration." As to the first prong, an action is fit for judicial review where further factual development would not "significantly advance [a court's] ability to deal with the legal issues presented." As to the second prong, withholding court consideration of an action causes hardship to the plaintiff where the complained-of conduct has an "immediate and substantial impact" on the plaintiff.

Caraco Pharm. Labs., Ltd. v. Forest Labs., Inc., 527 F.3d 1278, 1294-95 (Fed. Cir. 2008) (internal citations omitted). "These two prongs are typically [and respectively] referred to as fitness and hardship." *CBY Design Builders v. United States*, 105 Fed. Cl. 303, 331 (2012).

With respect to fitness, the facts (both as alleged in the Complaint and as further supported here) demonstrate that HRIC and its putative co-class members suffered massive compensable risk corridors losses for both the 2014 and 2015 plan years they have not received in full, and will not receive. The Government does not actually contest these facts or their implications. Mot. at 18-21. Instead, the Government simply argues that it has not yet

[27] As previously noted, although not at issue in this motion, current indications are that QHP issuers will also suffer massive losses in the 2016 plan year. *See*, *e.g.*, Anna Wilde Mathews, *Aetna Joins Rivals in Projecting Loss on Affordable Care Act Plans for 2016*, WALL ST. J. (Aug. 2, 2016), http://www.wsj.com/articles/aetna-tops-views-stops-aca-expansion-plans-1470134736 (last visited Aug. 15, 2016).

calculated the exact scope of the 2015 losses and does not know whether HHS will have enough money by the end of 2017 to pay back all that it owes. Mot. at 20. But these arguments do not change that HRIC and the putative class ***already suffered*** their compensable risk corridors losses, that HRIC and the putative class members have ***already complied*** with their statutory obligations for both 2014 and 2015 by submitting their data to the Government in accordance with the risk corridors program (*e.g.* 45 C.F.R. § 153.530(d)), that the Government ***already owes*** the risk corridors amounts for 2014 and 2015 (even if it has not finally calculated the latter), and that HHS is ***forbidden from using appropriations*** to pay these amounts.

Thus, no "further fact development"—including hypothetical "contingent future events" the Government cannot identify, (*see generally* Mot. at 20-21)—might eliminate the putative class's current claims nor affect the Court's ability to deal with the legal issues presented. This renders the claims ripe. *See*, *e.g.*, *Inter-Tribal Council of Arizona, Inc. v. United States*, 125 Fed. Cl. 493, 504 (2016) (plaintiffs' breach of trust claim ripe because government's attempts to secure sufficient collateral to secure payment obligations did not change initial failure to obtain sufficient collateral); *Neal v. Shimoda*, 131 F.3d 818, 825 (9th Cir. 1997) (Section 1983 challenge to law making it more difficult for sex offender-prisoners to be granted parole was ripe even though plaintiffs had not yet been denied parole).

HRIC and the putative class similarly satisfy the hardship prong. The Government owes HRIC tens of millions of dollars and collectively owes the putative class several ***billion*** dollars. Compl. ¶¶ 10, 16. That is, in and of itself, more than enough to establish hardship. *See Coalition for Common Sense in Gov't Procurement v. Sec. of Veteran Affairs*, 464 F.3d 1306, 1316 (Fed. Cir. 2006) (finding claim ripe where government would lose "hundreds of millions of dollars" annually if currently-pending stay continued, and plaintiff would have to pay "millions"

if stay was lifted). However, the Government's failure to pay owed risk corridors amounts and its insistence on keeping the program "budget neutral" also has more systemic, ongoing, negative consequences. As previously noted, NAIC—which oversees HRIC and the other QHP issuers—recommended that state insurance commissioners forbid QHP issuers from admitting risk corridors amounts on their financial statements due to the uncertainty over their repayment. *See supra* at 16-17. This, in turn, caused significant damage for QHP issuers, in some cases enterprise-threatening damage, which continues to this day. HRIC, for example, had to stop participating in the ACA Exchanges beginning with the 2016 plan year because it did not receive enough of the risk corridors amounts necessary for its capital reserves. Compl. ¶ 19. Other QHP issuers have faced similar harm, and still others have chosen to exit the ACA exchanges (partially or completely) because they could not justify sustaining further uncompensated losses resulting from the Government's failure to satisfy its risk corridors payment obligations. Compl. ¶¶ 42-43, 47; *see also supra* at 16-17. Finally, insureds have suffered, and continue to suffer, in the forms of higher annual premiums and reduced competition and consumer choice, which the risk corridors were designed to prevent. *See supra* at 17-18.

The Government incorrectly contends that the Administrative Procedure Act's "final agency action" requirement is also necessary for Tucker Act ripeness. (*See generally* Mot. at 18-21.) Under the APA, a plaintiff may seek a remedy for agency actions that are "final." *See* 5 U.S.C. § 704 ("Agency action made reviewable by statute and final agency action for which there is no other adequate remedy in a court are subject to judicial review."). If the action is not "final," then the APA claim is not ripe. *See Plaintiffs in Winstar-Related Cases v. United States*, 37 Fed. Cl. 174, 182 (1997) ("final agency action" is a ripeness requirement for "suits brought pursuant to the Administrative Procedure Act"). As this Court has previously observed,

however, the only portion of the APA incorporated into the Tucker Act is a standard for assessing the propriety of certain types of award. *See CBY*, 105 Fed. Cl. at 336. But that standard is incorporated into 28 U.S.C. § 1491***(b)***, which is not at issue in this case. *Id.*; *see also* Compl. ¶¶ 14, 59-63 (stating claim for relief under 28 U.S.C. § 1491(a)).

"Final agency action" law under the APA therefore has nothing to do with this Tucker Act claim. A plaintiff's Tucker Act claim is ripe when they choose to treat the Government's affirmative repudiation of its contractual (or, in this case, statutory) obligations as a present breach. *See*, *e.g.*, *Barlow & Haun, Inc. v. United States*, 118 Fed. Cl. 597, 615-16 (2014). Given that the Government (a) already failed to pay amounts owed for the 2014 plan year, and (b) affirmatively repudiated its obligation to pay full amounts owed for the 2015 plan year, HRIC's and the putative class's claims are ripe. *Id.*; *see also* Compl. ¶¶ 10, 16-18, 33, 41, 49.

III. HRIC AND THE CLASS ARE ENTITLED TO POST-JUDGMENT INTEREST

In appropriate cases, this Court may award post-judgment interest against the Government. *See* 28 U.S.C. § 2516(b); 28 U.S.C. § 1961(c); *see also* 31 U.S.C. § 1304(b)(1)(B) (permitting interest to be paid "on a judgment of the Court of Appeals for the Federal Circuit or the United States Court of Federal Claims under section 2516(b) of title 28 . . ."). The Government's only citation addressing post-judgment interest—*Ulmet v. United States*, 19 Cl. Ct. 527, 536 (1990)—acknowledged that post-judgment interest is permissible by statute and simply held that there had not yet been a "final judgment" in that case sufficient to begin running the post-judgment interest period. *Id.* at 536.

CONCLUSION

For the foregoing reasons, HRIC respectfully requests that the Court deny the Government's motion to dismiss.

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Respectfully submitted,

QUINN EMANUEL URQUHART & SULLIVAN, LLP

/s/ Stephen Swedlow

Stephen Swedlow
stephenswedlow@quinnemanuel.com
500 W. Madison Street, Suite 2450
Chicago, Illinois 60661-2510
Telephone: (312) 705-7400
Facsimile: (312) 705-7401

J.D. Horton
jdhorton@quinnemanuel.com
Adam B. Wolfson
adamwolfson@quinnemanuel.com
865 S. Figueroa Street
Los Angeles, California 90017
Telephone: (213) 443-3000
Facsimile: (213) 443-3100

Attorneys for Plaintiff Health Republic Insurance Company and the Class

CERTIFICATE OF SERVICE

I certify that on August 15, 2016, a copy of the attached Opposition to the United States' Motion to Dismiss was served via the Court's CM/ECF system on Defendant's counsel Charles Edward Canter.

/s/ Stephen Swedlow
Stephen Swedlow