Nos. 18-1023, 18-1028 & 18-1038

IN THE

Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,
Petitioner,

v.

UNITED STATES,
Respondent.

[For Continuation of Caption see Reverse Side of Cover]

On Petition for a Writ of Certiorari to the United States Court of Appeals for the Federal Circuit

BRIEF FOR *AMICUS CURIAE* BLUE CROSS BLUE SHIELD ASSOCIATION IN SUPPORT OF PETITIONERS

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Petitioner,

v.

UNITED STATES,

Respondent.

BLUE CROSS BLUE SHIELD
OF NORTH CAROLINA,

Petitioner,

v.

UNITED STATES,

Respondent.

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NONPROFIT MUTUAL INSURANCE CORP.,

Petitioner,

v.

UNITED STATES,

Respondent.

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INTEREST OF *AMICUS CURIAE*[1]

The Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-six independent, community-based and locally-operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide healthcare coverage to nearly 106 million people—nearly one-third of all Americans—in every zip code in all fifty states, Washington D.C., and Puerto Rico.

The Blue Plans are regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") and have been the leading providers of health insurance coverage in the ACA markets ("Exchanges"). In the third quarter of 2018, they provided coverage to nearly 4.3 million enrollees through the Exchanges.

The question presented by this petition concerns the government's ability to abrogate its payment obligations under the ACA risk corridors program, which was intended to stabilize the Exchange markets when they were first established. Blue Plans are owed nearly 40% of all outstanding risk corridors payments totaling nearly $5 billion. BCBSA also has an interest in this petition because Blue Plans continue to partner with the government to offer

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[1] Pursuant to Rule 37.6, no counsel for any party authored this brief in whole or in part and no counsel or party made a monetary contribution intended to fund the preparation or submission of this brief. Counsel of record for all parties received timely notice of the intent to file this brief. All parties have consented to the filing of this brief.

coverage to beneficiaries of various government supported health insurance programs.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

In order for the healthcare markets created by the ACA to function, Congress needed health insurers to agree to offer affordable policies in the new Exchanges, despite the lack of historical data concerning the population they would be covering. To encourage issuers to accept this risk, Congress promised to share in it by making "risk corridors" payments to offset losses incurred by issuers whose costs exceeded their premiums. This arrangement is not unusual; the government routinely addresses public problems by facilitating private sector solutions, including by mitigating risk exposure. But when the time came for the federal government to make good on its commitment to issuers who participated in the Exchanges between 2014 and 2016, the government refused to do so—notwithstanding the astonishing sums of money that issuers had lost.

Blue Plans provided a disproportionate share of the coverage available on the Exchanges between 2014 and 2016—insuring between 6.4 and 8.1 million enrollees each year. Consequently, Blue Plans were disproportionately injured by the government's bait-and-switch. Of the $12.3 billion in risk corridors obligations that the government has failed to pay, 40%—or nearly $5 billion—is owed to Blue Plans.

The Federal Circuit agreed with Petitioners that the ACA obligates the federal government to make risk corridors payments. But it held that that com-

mitment was implicitly abrogated by the *legislative intent* underlying later-enacted appropriations riders that restricted the government's use of one source of funds to make risk corridors payments. The Federal Circuit's decision cannot be squared with this Court's long-standing precedent holding that a later-in-time statute does not amend an existing statute unless it contains "words that expressly, or by clear implication, modif[y] or repeal[] the previous law," *United States v. Langston*, 118 U.S. 389, 394 (1886). The Court should therefore grant certiorari and correct this clear error.

Further, certiorari is warranted due to the threat that the Federal Circuit's approach poses to future public-private partnerships in the healthcare sector and beyond. Blue Plans responded in good faith to the federal government's call to the insurance industry to help solve real issues in the nation's healthcare system. Many remained in the Exchanges even when it became clear that they would incur substantial losses. If these insurers had known that the federal government could renege on its commitments merely by passing a single line of ill-considered and opaque text, they may have acted differently, either by charging higher premiums or declining to participate in the Exchanges. Left standing, the message that the Federal Circuit's decision sends to all of the federal government's prospective private sector partners is clear: Think twice before relying on the U.S. government. That is a dangerous precedent, indeed. The Court should grant certiorari and reverse the Federal Circuit's erroneous decision.

BACKGROUND

A. Congress Intended for the Risk Corridors Program to be a Critical Feature of a Massive Public-Private Partnership

The ACA adopted "reforms designed to expand coverage in the individual health insurance market." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). "[T]he Act [further] require[d] the creation of an 'Exchange' in each state where people can shop for insurance, usually online." *Id*. at 2487. Congress intended for the Exchanges to "facilitate access of individuals and employers to a variety of choices of affordable, quality health insurance coverage." H.R. Rep. No. 111-299, at 402 (2009). In order for the Exchanges to achieve this central policy objective, Congress first needed to persuade insurers to participate in them. This was no easy task.

One of the most significant aspects of the insurance business is setting accurate premium rates. This process is challenging even under stable market conditions. Too high, and issuers price potential enrollees out of the market, drive up health costs, and may face regulatory scrutiny. Too low, and issuers cannot cover claims and could be forced into liquidation. *See, e.g.*, Iowa Code § 507C.17 (authorizing forced liquidation of insurer).

Issuers rely on current enrollee data to forecast who will buy insurance; what type of insurance enrollees will buy; and the medical history of enrollees. *See* U.S. Government Accountability Office ("GAO"), Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk, GAO-15-

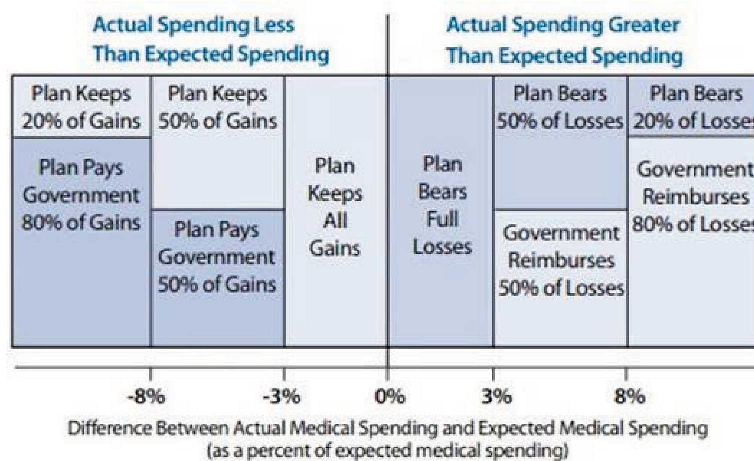
447, at 5-6 (Apr. 2015). In 2013, issuers that were considering marketing new plans on the Exchanges did not have this data for prospective insureds. It was therefore difficult for issuers to price accurately the insurance that Congress wanted them to sell, especially in light of other ACA provisions, including the "Guaranteed Issue" requirement, which prohibits issuers from denying coverage to high-risk individuals with difficult-to-predict losses. *See* 42 U.S.C. § 300gg-1–5; GAO-15-447, at 6-7.

Issuers could have responded to the uncertainty inherent to the new Exchanges by offering plans with high premiums or refusing to participate. *See* Am. Acad. of Actuaries, Issue Brief: Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act, at 3-4 (June 2011).[2] Both of these responses, however, would have frustrated Congress's aims in enacting the ACA—*viz.* to improve access to quality and affordable health insurance.

To address this problem, Congress created "a program of risk corridors" for the initial three years of the Exchange to "adjust[]" issuer payments "based on the ratio of allowable [plan] costs … to the plan's aggregate premiums." 42 U.S.C. § 18062(a). More specifically, § 1342 of the ACA provided that the government "shall pay" participating plans whose costs for Exchange-based policies *exceeded* 103% of premiums a partial reimbursement of their losses pursuant to a statutory formula. *Id.* § 18062(a); § 18062(b)(1). Conversely, § 1342 provided that participating plans whose claim-related costs were *less*

[2] https://tinyurl.com/y4q7rkfe

than 97% of received premiums "shall pay" the government a statutorily prescribed portion of their excess profits. *Id.* § 18062(b)(2). The American Academy of Actuaries ("AAA") explained the program with the following graphic:



AAA, Fact Sheet: ACA Risk-Sharing Mechanisms – The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained (Dec. 2013).[3]

In short, the risk corridors program formed a core part of a public-private partnership: the government encouraged issuers to offer affordable plans on the Exchanges by committing to mitigate the risk of undercharging insureds and penalizing issuers that overcharged insureds.

[3] https://tinyurl.com/y2j6hucr

B. Congress and HHS Understood that the Risk Corridors Program Was Not Budget Neutral

From its inception, Congress, HHS, and issuers understood that the risk corridors program was not budget neutral, that is, that the government's obligation to reimburse issuers for excess losses was not limited to the amount that the government recouped in excess premiums.

Congress expressly based the ACA risk corridors program on a similarly-named Medicare Part D program, which the government concedes is not budget neutral. *See* 42 U.S.C. § 18062(a) (establishing Medicare Part D risk corridors program); Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) (acknowledging that Medicare Part D risk corridors program is not budget neutral). Congress established the Part D program in response to the same concerns that prompted Congress to create the ACA program. Part D was intended to expand prescription drug coverage for Medicare beneficiaries by encouraging issuers to make such plans available. Issuers, however, lacked sufficient information about what it would cost to provide the benefits that the government wanted them to offer. By committing to have the federal government share issuers' risk, 42 U.S.C. § 1395w-115(e), the Medicare Part D risk corridors program is credited with encouraging issuers to offer Part D plans at cheaper rates than the gov-

ernment anticipated. *See* Timothy Stoltzfus Jost, Stabilizing Forces, The Actuary (Oct./Nov. 2016).[4]

HHS also recognized the federal government's obligation to compensate issuers for all risk corridors losses. For instance, in a 2013 rulemaking, a plan asked HHS how it "plan[ned] [to] … fund[] the risk corridors in the event that payments exceed receipts." Letter from Charles E. Metz, Geisinger Health Plan, to Marilyn Tavenner, CMS re: Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 – CMS-9964-P (Dec. 31, 2012). HHS responded that the program "is not statutorily required to be budget neutral" and that "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013); *see also*. The final rule further explained that under the program, the "Federal government and certain participating plans" would "shar[e] in gains or losses" caused by "inaccurate rate setting from 2014 through 2016." 79 Fed. Reg. 13,744, 13,746 (Mar. 11, 2014) (emphasis added).[5]

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[4] https://theactuarymagazine.org/stabilizing-forces/

[5] HHS has recognized that other ACA programs designed to mitigate issuer risk *are* budget neutral. *See* 45 C.F.R. § 153.230(d) (reinsurance program); 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (risk adjustment program).

C. After 2014 Rates Were Set, HHS Undermined Plans' Actuarial Predictions, Effectively Ensuring that Exchange Plans Would Incur Losses

Relying on the risk corridors program, issuers submitted to state insurance regulators in the spring of 2013 proposed rates for 2014 benefit year ("BY") Exchange plans. *See* Center for Consumer Information and Insurance Oversight ("CCIIO"), CMS, Letter to Issuers on Federally-Facilitated and State Partnership Exchanges, at 20 (Apr. 5, 2013). After receiving state regulatory approval that summer, issuers executed formal agreements with the federal government to offer Exchange plans in September 2013. *Id.*[6]

Two months later and after open enrollment started, the federal government announced a "transition policy" that permitted issuers to renew policies that existed prior to 2014 but that did not comply with certain ACA requirements, including the costly community ratings provision. *See* CMS Letter to State Insurance Commissioners (Nov. 14, 2013) (the "Transition Policy"). In doing so, HHS all but ensured that the generally healthier segment of the public that had health insurance that did not satisfy the ACA's requirements would retain their existing coverage rather than switch to an Exchange plan, disrupting issuers' assumptions about the relevant

[6] HHS followed similar timelines in 2015 and 2016. *See* CCIIO, CMS, 2015 Letter to Issuers on Federally-Facilitated Marketplaces, at 11-12 (Mar. 14, 2014); CCIIO, CMS, FINAL 2016 Letter to Issuers on Federally-Facilitated Marketplaces, at 16-17 (Feb. 20, 2015).

Exchange enrollee population. Acknowledging that the policy "was not anticipated by health insurance issuers when setting rates for 2014," HHS restated its commitment to the risk corridors program, assuring issuers that any losses suffered due to this untimely shift in policy would be "ameliorate[d]," in part, by the risk corridors program. *Id.* at 3.

D. The Government Reneged on the Promise it Made to Issuers With Disastrous Consequences for the Healthcare Market

1. Like other parts of the ACA, the risk corridors program was politically contentious. Before the program started, several legislators introduced bills to make it a budget-neutral program among issuers or repeal it altogether. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (striking § 1342); Obamacare Taxpayer Bailout Protection Act, S. 2214, § 2, 113th Cong. (2014) (proposing to make § 1342 budget neutral). These efforts at transparent lawmaking failed.

On December 16, 2014, however, with the threat of a government shutdown looming and open enrollment for the 2015 BY underway, opponents of the risk corridors program proposed and Congress passed, a continuing resolution to fund the government that prohibited HHS from using appropriated funds and funds from other specifically enumerated sources to make risk corridors payments. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (Dec. 16, 2014) ("FY 2015 CR"). The FY 2015 CR provided that "[n]one of the funds made available by this Act from" several sources, including CMS's general pro-

gram fund, "may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridor)." *Id.* § 227, 128 Stat. 2491.[7]

Tellingly, even the sponsors of the FY 2015 CR did not construe it to eliminate the federal government's obligation to make risk corridors payments. After the adoption of the FY 2015 CR, these legislators continued to introduce bills to repeal the program or amend it to be budget neutral. *See, e.g.,* Taxpayer Bailout Protection Act, H.R. 724, § 2, 114th Cong. (2015); Obamacare Taxpayer Bailout Prevention Act, S. 147 § 2, 115th Cong. (2017).

2. HHS also continued to assure issuers that the federal government's obligation to make complete risk corridors payments remained intact. *See, e.g.,* 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("HHS recognizes that the [ACA] requires the Secretary to make full payments to issuers."); CMS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) (same)[8]; CCIO, CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) (same).[9]

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[7] Identical language appears in appropriations riders for the subsequent two years. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (Dec. 18, 2015); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135, 543 (May 5, 2017) (collectively with the FY 2015 CR the "Appropriations Riders").

[8] https://tinyurl.com/y4cyclp6

[9] https://tinyurl.com/y6qqam6h. To this day, the HHS website refers to the risk corridors program as an initiative through which the "*Federal government* share[s] risk in losses and gains." The Center for Consumer Information & Insurance

Still more, in the summer of 2015, HHS instructed state insurance commissioners that were reviewing issuers' proposed 2016 BY rates that they should assume that issuers would receive full risk corridors payments—thereby impeding issuers' ability to raise premiums to compensate for the possibility that the government would renege on its obligation. *See* Letter from Kevin Counihan to State Insurance Commissioners (July 21, 2015) ("CMS … recognizes that the [ACA] requires the Secretary to make full [risk corridors] payments to issuers …. [W]e ask that you consider these findings as you work to finalize rates for the 2016 [BY].").

3. Exchange plans incurred massive losses over the three years in which the risk corridors program was intended to operate. This was hardly surprising.

As explained *supra*, when issuers developed 2014 BY rates in the spring of 2013, they lacked data about the individuals who would participate in Exchange plans and were unaware that the federal government would adopt the Transition Policy that depleted the Exchange plans' expected risk pool. A recent GAO literature survey concluded that in the first year of the Exchanges, claims costs were 6 to 10 percent higher than issuers expected, and in one state, some issuers saw claims that were 50 to 100 percent more than premiums. *See* GAO, Health Insurance Exchanges: Claims Costs and Federal and State Policies Drove Issuer, Participation, Premi-

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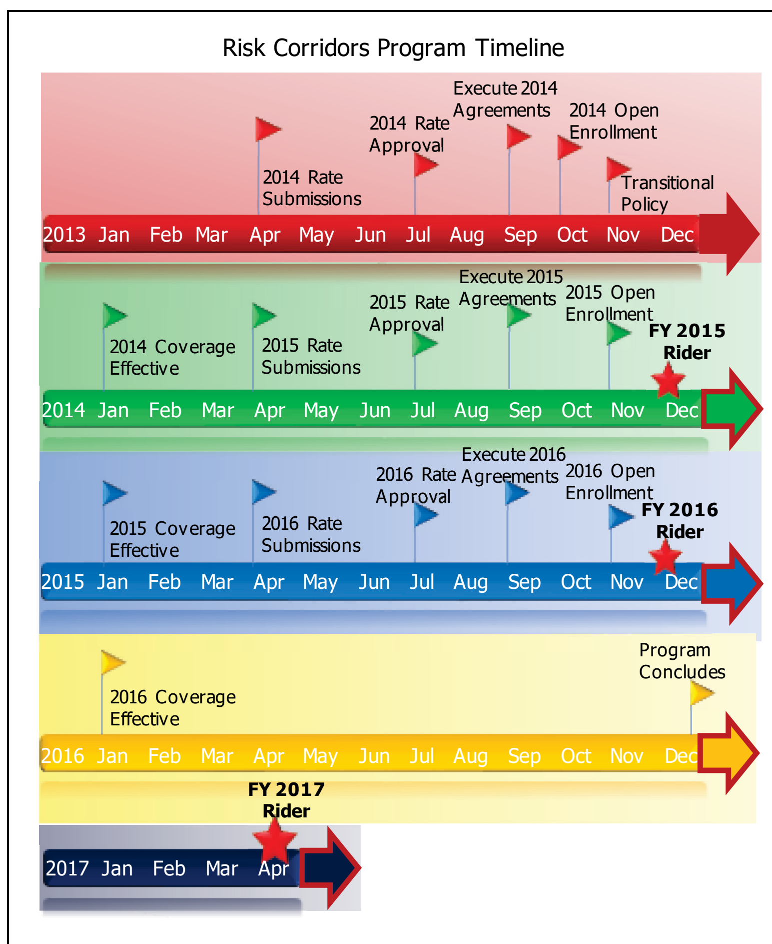
Oversight, Premium Stabilization Programs, https://tinyurl.com/y52ta7n5 (last visited Mar. 6, 2019).

ums, and Plan Design, GAO-19-215, at 10 (Jan. 2019).

Issuers faced similar challenges when setting rates for 2015 in the spring of 2014. At that time, issuers did not know how their plans would perform in the 2014 BY that had just commenced and Congress had not yet passed the FY 2015 CR. Finally, while issuers proposing premiums for the 2016 BY in the spring of 2015 had access to financial results from the 2014 BY and knew about the FY 2015 CR, losses in the 2016 BY were still all but certain. Without access to 2015 BY data, issuers had difficulty assessing whether 2014 losses were caused by the composition of the Exchange enrollee population or other anomalies, like the Transition Policy. *Id.*

Issuers' ability to avoid future losses in 2016 was further constrained by state regulators, some of whom refused to approve the full rate increases that issuers sought. For instance, in August 2015, the Kansas Insurance Commissioner reported that his office's review process had decreased issuers' proposed rate increases from 39% to between 9.4% and 25.4% above 2015 rates. *See* Jim McLean, Kansas Insurance Commissioner Reduces Proposed Obamacare Rate Increases, KCUR (Aug. 26, 2015).[10] These efforts all but guaranteed additional issuer losses. *See* John Holahan et al., 2016 Premium Increases in the ACA Marketplaces: Not Nearly As Dramatic As You Think, at 3, Urban Institute (Nov. 2015) (average rate increase for the 2016 program year 4.3 percent).

[10] https://tinyurl.com/y36e8u3h



4. Despite advising state insurance regulators in July 2015 that the federal government was committed "to mak[ing] full [risk corridors] payments to issuers," Letter from Kevin Counihan to State Insurance Commissioners, at 2 (July 21, 2015), when the payments were due in the fall of 2015, HHS made only pro rata payments. On October 1, 2015, HHS announced that for fiscal year 2014, issuers had requested $2.87 billion in risk corridors payments, but

HHS would only pay the $362 million that it had collected in risk corridors charges. CMS, Risk Corridors Payment Proration Rates for 2014, at 1 (Oct. 1, 2015).[11] Due to this shortfall, HHS indicated it would remit only 12.6% of each issuer request.

On November 18, 2016, HHS announced that issuers had made $5.9 billion in risk corridors claims for the 2015 BY, but that it had collected only $95.3 million in risk corridors payments and that all of these funds would be "used to pay a portion of [the government's] balance" from the 2014 program year. *See* CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, at 1 (Nov. 18, 2016).[12] Similarly, on November 13, 2017, HHS announced that issuers had made $3.98 billion in risk corridors claims for the 2016 BY, but that it had collected only $27 million in payments, all of which would be used "to make additional payments toward 2014 benefit year payment balances." *See* CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, at 1 (Nov. 15, 2017).[13]

Thus, when the risk corridors program ended in 2017, HHS had paid issuers only $482.3 million, or 17% of its $2.87 billion in risk corridors liability for the first year of the program. HHS paid nothing towards the $5.9 billion and $3.98 billion it owed issuers for 2015 and 2016, respectively. Over the course of three years, HHS paid issuers only 4% of the payments they are owed under the ACA's statutory

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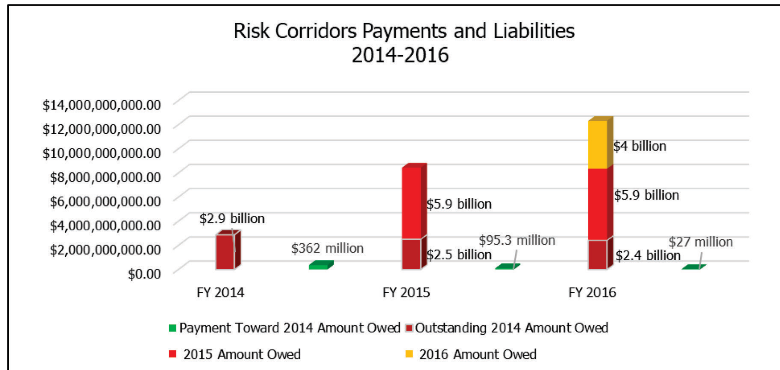
[11] https://tinyurl.com/y6jrpe8e

[12] https://tinyurl.com/gnucybu

[13] https://tinyurl.com/y2l4qqnb

formula. HHS currently owes nearly $12.3 billion to the issuers that partnered with it to launch the ACA Exchanges.



CMS, Risk Corridors Payment Proration Rates for 2014; CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year; CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year.

This loss has translated into concrete injuries to the healthcare industry and consumer premium rates. Eighteen issuers that participated in the Exchanges are no longer in business. *See* Nicholas Bagley, Trouble on the Exchanges—Does the United States Owe Billions to Health Insurers?, 375 New Eng. J. Med. 2017, 2018 (2016). And one study estimates that the risk corridors debacle caused 86% of the increase in health insurance premiums from 2016 to 2017. Daniel W. Sacks, et al., The Effect of Risk Corridors Program on Marketplace Premiums and Participation, Nat'l Bureau of Econ. Research, Working Paper No. 24129 at 4 (2017).

E. Blue Plans Were Disproportionately Harmed by the Government's Bait-and-Switch

Relying on the risk corridors program, Blue Plans invested heavily in the Exchanges. Indeed, in 2014, Blue Plans offered 74 different Exchange plans, covering nearly 6.4 million enrollees, or 59% of all Exchange participants. In 2015 and 2016, Blue Plans continued to cover a significant portion of Exchange enrollees, reaching 8.1 million members in 2016.

Due to their heavy involvement in the Exchanges, Blue Plans were hit particularly hard by the government's default. Blue Plans are owed $4.9 billion, or 40% of all outstanding risk corridors payments.

Despite these losses, Blue Plans have remained loyal to the Exchanges. Since several large insurers exited these markets, Blue Plans have been the only insurers to offer Exchange coverage in certain parts of the country. *See* Rachel Fehr et al., Kaiser Family Foundation, Insurer Participation on the ACA Marketplaces, 2014-2019 (Nov. 14, 2018). They have remained due to their commitment to serving their members.[14]

[14] As Blue Cross Blue Shield of Tennessee put it: "[W]e believe it is an extension of our mission to serve our fellow Tennesseans, especially those who do not have other options for coverage." *See* Jessie Hellmann, The Hill, BlueCross Set To Fill ObamaCare Coverage Gap in Tennessee (May 9, 2017).

ARGUMENT

I. Private-Partnerships Are Critical to the Administration of Healthcare in the United States and Review By this Court is Necessary to Protect Legal Principles that are Essential to their Continued Success

1. Public-private partnerships like the ACA risk corridors program are essential to the effective and efficient delivery of basic government benefits, especially healthcare benefits. In 2017, 78% of the roughly $982 billion that the federal government spent on healthcare services was delivered through partnerships with the private sector. See CMS, Nat'l Health Expenditure Data, Table 05-3 & n.2 (last modified Dec. 11, 2018).[15]

Independent from the Exchanges at the center of this litigation, roughly a third of all Medicare beneficiaries—or around 20 million Americans—receive their Medicare benefits from a private insurer through Medicare Part C, more commonly referred to as "Medicare Advantage" ("MA"). *See* 2018 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, at 181 (June 5, 2018) ("Medicare Trustee Report"). Insurers that participate in MA receive capitated payments to deliver at least the same benefits and services offered in Medicare Parts A and B, also known as the "traditional Medicare" program. *See* Congressional Research Service, Medicare Primer, R40425, at 20-21 (July 5, 2018). Insurers, however, compete for enrol-

[15] https://tinyurl.com/cm5jfk4

lees by offering benefits that exceed the minimum program requirements, including vision, dental and wellness programs. *See id.* The federal government spent an estimated $209.6 billion on MA in 2017. Medicare Trustee Report at 11, 155.

The private sector also works closely with the federal government to administer the traditional Medicare program in which beneficiaries receive services from private providers who are reimbursed by the federal government on a fee-for-service basis. In 2017, the government spent $392.3 billion providing health care on a fee-for-service basis for roughly 58 million beneficiaries. *See* Medicare Trustee Report at 11, 181. Similarly, in the Medicaid program, the federal government partners with states to provide medical services to an estimated 72.2 million low-income or otherwise vulnerable people. *See* Wolfe et al., HHS, 2017 Actuarial Report on the Financial Outlook for Medicaid, at 24-25.[16] A statutory formula prescribes the rate at which the federal government pays healthcare providers who treat Medicaid beneficiaries. *See* 42 U.S.C. § 1396d(b). In fiscal year 2017, the federal government spent an estimated $378 billion on Medicaid, or 9.3% of federal spending and 3.1% of the GDP. *See* Wolfe et al. at 26-28.[17]

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[16] https://tinyurl.com/yd8sooh9 (last visited Mar. 8, 2019).

[17] Most Medicaid beneficiaries receive benefits through a program in which states make capitated payments to private insurers to deliver services; it is the analogue of MA for Medicaid. *See* Rachel Garfield et al., Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation

Blue Plans are active participants in these programs. In 2018, for instance, Blue Plans provided coverage to roughly 7.1 million Medicaid beneficiaries and nearly 3 million MA beneficiaries. They also provided Medicare Part D insurance to roughly 440,000 members.

Of course, outside the healthcare context, there are just as many examples of important public-private partnerships. For instance, according to the Department of Housing and Urban Development ("HUD"), "*most* HUD programs are structurally public-private partnerships," including housing choice vouchers that support more than 2 million low-income families. *See* HUD, Office of Policy Development and Research, The Evolution of HUD'S Public-Private Partnerships (Oct. 2015) (emphasis added). Similarly, the Department of Agriculture promotes rural development through, among other things, several loan guarantee programs that rely on the participation of various financial institutions to extend needed credit directly to program beneficiaries.[18] These examples are not unique: The Congressional Research Service estimates that the federal government spent $507 billion or 13% of the 2017 budget on contracts with the private sector for goods, services, and research and development. *See* Moshe Schwartz et al., Congressional Research Services, Defense Acquisitions: How and Where DOD Spends

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2017 Survey of Medicaid Managed Care Plans, Kaiser Family Foundation (Mar. 5, 2018), https://tinyurl.com/y35d7z7s.

[18] USDA, Programs & Services, https://www.rd.usda.gov/programs-services (last visited Mar. 7, 2019).

Its Contracting Dollars, R44010, at 2 (July 2, 2018). The Department of Defense alone spent $320 billion on private sector contractors that year. *Ibid.*

2. Like all long-term business relationships, public-private partnerships require sustained collaboration in which reliance on commitments is possible. Businesses will not make the investments required to achieve public objectives if they cannot rely on the government's commitment to follow through on its end of the bargain, particularly when those promises are chiseled in statute.

This Court's long-standing precedent concerning when a later act of Congress amends prior legislation facilitates public-private partnerships by protecting the private sector's reliance interest in past Congressional action. This Court has "repeatedly stated that absent a clearly expressed congressional intention, an implied repeal will only be found where provisions in two statutes are in irreconcilable conflict, or where the latter Act covers the whole subject of the earlier one and is clearly intended as a substitute." *Carcieri v. Salazar*, 555 U.S. 379, 395 (2009) (internal quotations, citations, and alterations omitted). This presumption applies "with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980).

By requiring Congress to speak clearly when modifying prior legislative action, this Court's jurisprudence not only ensures that the private sector has notice of the applicable law but also protects its interest in participating in the legislative process. *See TVA v. Hill*, 437 U.S. 153, 190 (1978) (holding

that it is "absurd" to require even Members of Congress to "review exhaustively the background of every . . . appropriation"). Moreover, this clear statement rule guarantees that the government's private sector partners need not await a court decision to understand their legal rights and obligations.

The rule applied in the decision below, by contrast, would allow ambiguous language in appropriations riders to upend the settled expectations of multi-billion dollar industries and wreak havoc on public-private partnerships that are critical to the proper function of government programs. *Cf. Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012) (rejecting notion that private parties with government contracts are responsible for "track[ing] … agencies' shifting priorities and competing obligations; rather, they may trust that the Government will honor its … promises" even when appropriations run short). To understand why this is so, the Court need look no further than the legislative history at issue here.

While opponents of the risk corridors program were unable to muster the votes to amend the program, their efforts to add ambiguous language to must-pass Appropriations Riders triggered little scrutiny from their colleagues, the healthcare industry or the public precisely *because the implications of the rider were unclear*. *See Landgraf v. USI Film Prods.*, 511 U.S. 244, 272–73 (1994) ("Requiring clear intent assures that Congress itself has affirmatively considered the potential unfairness" of its actions "and determined that it is an acceptable price to pay for the countervailing benefits."). Indeed, giv-

en that three of the judges who considered whether the Appropriations Riders modified the ACA concluded that they did not, it strains credulity to believe that all or a majority of Congress understood the Riders to amend an important ACA program.[19]

In sum, under this Court's longstanding precedent, for a later-in-time appropriations rider to repeal the ACA, its text would need to include "words that expressly, or by clear implication, modif[y] or repeal[] the previous law." *Langston*, 118 U.S. at 394. Nothing in the Appropriations Riders that the federal government now claims supersede the ACA satisfies this exacting standard.

II. The Federal Circuit's Atextual Decision Misapplied this Court's Well-Established Precedent

The Court below correctly held that the ACA does not contemplate a budget-neutral risk corridors program. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1321-22 (Fed. Cir. 2018). But it held that the federal government's obligation to compensate issuers for risk corridor losses was repealed by the Appropriation Riders' *legislative history*. *Id.* at 1325. That finding was plainly wrong.

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[19] *Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 457-62 (2017) (Wheeler, J.) ("Congress has not modified the risk corridors program to make it budget-neutral."); *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1338 (Fed. Cir. 2018) (Newman, J., dissenting) (same); *Moda Health Plan, Inc. v. United States*, 908 F.3d 738, 742 (Fed. Cir. 2018) (Wallach, J., dissenting from denial of rehearing *en banc*) (same).

1. The plain text of the Appropriation Riders does not purport to alter a single word of the ACA or change the payment formula in § 1342(b). Nor do the Riders supplement the relevant ACA provisions with language that courts have held compel budget neutrality. *Cf. Cape Cod Hosp. v. Sebelius*, 630 F.3d 203, 206 (D.C. Cir. 2011) (holding that statute was budget neutral based on text); *Adirondack Med. Ctr. v. Burwell*, 782 F.3d 707, 710 (D.C. Cir. 2015) (*per curiam*) (same).[20]

Instead, the Appropriation Riders merely prohibit the use of one source of funds for risk corridors payments without addressing others. *Compare* Consolidated Appropriations Act, 2014, Pub. L. No. 113–76, div. H, title II, 128 Stat. 5, 374 (Jan. 17, 2014) (restricting use of program funds for risk corridors payments) *with ibid* (appropriating, in addition to program funds, "user fees" as well as "all funds collected in accordance with section 353 of the PHS Act and section 1857(e)(2) of the Social Security Act, funds retained by the Secretary pursuant to section 302 of the Tax Relief and Health Care Act of 2006"). At most, then, the Riders demonstrate that Congress may have appropriated insufficient funds to make complete risk corridors payments. That legislative action, however, provides no basis from which to conclude that Congress amended a substantive provision of the ACA. *See Langston*, 118 U.S. at 394 (appropriating less than required to pay statutory rate does not impliedly suspend payment obligation).

[20] The sponsors of the Appropriation Riders tried and failed to have these terms added to the ACA's risk corridors. *See supra* at 10.

2. Rather than grappling with the text of the Appropriation Riders, the Federal Circuit primarily focused on its supposed legislative history; in particular, communications between an agency and two members of Congress, and the explanatory statement of another member. *See Moda Health Plan, Inc. v. United States*, No. 18-1028, Pet. for Cert., at 23-26 (Feb. 4, 2019). By doing so, the Federal Circuit's opinion suggests that individual members of Congress can make significant policy decisions (and do an end run around the legislative process) by slipping ambiguous, facially uncontroversial language into must-pass legislation and simultaneously adding statements into the legislative history that support their preferred interpretations of the text. *See Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005) (relying on legislative history may vest "committee members—or, worse yet, unelected staffers and lobbyists—[with] both the power and the incentive to … manipulat[e] … legislative history to secure results they were unable to achieve through the statutory text"). That is precisely the risk this Court sought to mitigate by adopting the presumption against implied repeals through appropriations laws. *TVA*, 437 U.S. at 191.

To the extent the decision below relies on the absurdity doctrine—asking "What else could Congress have intended?"—its reasoning is equally flawed. *Moda*, 892 F.3d at 1325. Other Circuits have held that the absurdity doctrine is no longer good law, and the Federal Circuit's embrace of the doctrine suggests an independent reason for this Court's review. *Compare ibid. with Lexington Ins. Co. v. Precision Drilling Co., L.P.*, 830 F.3d 1219,

1222 (10th Cir. 2016) (Gorsuch, J.) ("To label a statute's consequences 'absurd,' a court usually must … engage in the doubtful business of guessing at hidden legislative intentions.") *and Jaskolski v. Daniels*, 427 F.3d 456, 462 (7th Cir. 2005) (holding that the absurdity doctrine "has no modern traction" as a tool for statutory interpretation).

In any event, the argument fails on its own terms. It is possible—indeed, likely—that the sponsors of the Appropriation Riders, after failing to substantively amend the law, introduced the Riders as a fallback position to stem risk corridors payments temporarily while they sought to repeal the program entirely. *See supra* at 10-11. Indeed, that the sponsors of the Riders continued to introduce further legislation to make the program budget neutral even after passing the Appropriation Riders lends credence to this theory and rebuts the absurdity argument suggested by the Federal Circuit. *See supra* at 11. If the Riders rendered the risk corridors payments neither payable nor due, such amendments would be entirely unnecessary. At the very least, the lower court's invocation of the absurdity doctrine is further evidence that the Appropriations Riders fall short of providing the "clear implication" that this Court's precedent requires.

III. No Further Percolation is Necessary: This Court's Intervention is Necessary to Correct the Federal Circuit's Error

The Federal Circuit has exclusive jurisdiction over lawsuits under the Tucker Act and the Contract Disputes Act, meaning that it decides all, or nearly all, suits for damages brought by the private sector

against the federal government. *See* 28 U.S.C. § 1295(a)(3), (10) (exclusive jurisdiction in Contract Disputes Act claims); *United States v. Hohri*, 482 U.S. 64, 73 (1987) (noting "the creation of exclusive Federal Circuit jurisdiction over *every appeal* from a Tucker Act or nontax Little Tucker Act claim"). Moreover, the full court refused to correct the panel's error by denying the issuers' petition for *en banc* review. *See Moda Health Plan, Inc. v. United States*, 908 F.3d 738 (Fed. Cir. 2018) (mem.). Accordingly, absent this Court's intervention, the Federal Circuit's poorly conceived new rule of statutory construction will effectively become the law of the land. And this precedent will be cited again and again by the government to justify future decisions to renege on statutory commitments any time funding for those commitments is in doubt. In these circumstances, no further percolation is warranted and immediate action by this Court is required.

CONCLUSION

The petitions should be granted.

Respectfully submitted,

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