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 Writs 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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Cape Cod Hosp. v. Sebelius,
630 F.3d 203 (D.C. Cir. 2011)............................ 24

Carcieri v. Salazar,
555 U.S. 379 (2009).. 20

Exxon Mobil Corp. v. Allapattah Servs., Inc.,
545 U.S. 546 (2005).. 27

Fernandez-Vargas v. Gonzales,
548 U.S. 30 (2006).. 22

Jaskolski v. Daniels,
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King v. Burwell,
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Landgraf v. USI Film Prods.,
511 U.S. 244 (1994)...................................4, 22, 23

Lexington Ins. Co. v. Precision Drilling Co., L.P.,
830 F.3d 1219 (10th Cir. 2016).......................... 27

Moda Health Plan, Inc. v. United States,
130 Fed. Cl. 436 (2017)...................................... 26

Moda Health Plan, Inc. v. United States,
892 F.3d 1311 (Fed. Cir. 2018)...........7, 24, 26, 27

Moda Health Plan, Inc. v. United States,
908 F.3d 738 (Fed. Cir. 2018)............................ 26

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Nat'l Ass'n of Home Builders v. Defenders of Wildlife,
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New York v. United States,
505 U.S. 144 (1992) 22

Salazar v. Ramah Navajo Chapter,
567 U.S. 182 (2012) 20, 21, 23

St. Martin Evangelical Lutheran Church v. S. Dakota,
451 U.S. 772 (1981) 26

TVA v. Hill,
437 U.S. 153 (1978) 21, 27

United States v. Langston,
118 U.S. 389 (1886) 4, 23, 25

United States v. Mitchell,
109 U.S. 146 (1883) 25

United States v. Will,
449 U.S. 200 (1980) 20

United States v. Winstar,
518 U.S. 839 (1996) 20

Va. Uranium, Inc. v. Warren,
139 S. Ct. 1894 (2019) 27

STATUTES

42 U.S.C. § 1395w-115 9

42 U.S.C. § 1396d 30

TABLE OF AUTHORITIES
(continued)

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42 U.S.C. § 18021 6

42 U.S.C. § 18062 .... 7, 9

42 U.S.C. § 300gg-1–5 6

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (Dec. 16, 2014)............ 12

Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, div. H, title II, 128 Stat. 5 (Jan. 17, 2014).. 25

Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242 (Dec. 18, 2015).. 12

Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135 (May 5, 2017).. 12

Iowa Code § 507C.17 6

RULES

House Rule XXI(2)(b) 21

Senate Rule XVI(4) 21

REGULATIONS

45 C.F.R. § 153.230(d).. 10

77 Fed. Reg. 73,118 (Dec. 7, 2012).......................... 10

78 Fed. Reg. 15,410 (Mar. 11, 2013)....................... 10

79 Fed. Reg. 13,744 (Mar. 11, 2014)....................... 10

TABLE OF AUTHORITIES
(continued)

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79 Fed. Reg. 30,240 (May 27, 2014) 9

80 Fed. Reg. 10,750 (Feb. 27, 2015)........................ 13

OTHER AUTHORITIES

2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds (Apr. 22, 2019)..29, 30

Am. Acad. of Actuaries, Fact Sheet: ACA Risk-Sharing Mechanisms – The 3Rs (Risk Adjustment, Risk Corridors, and Reinsurance) Explained (Dec. 2013)................... 8

Am. Acad. of Actuaries, Issue Brief: Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act (June 2011)... 6

Ctr. for Consumer Info. and Ins. Oversight, CMS, 2015 Letter to Issuers on Federally-Facilitated Marketplaces (Mar. 14, 2014) 11

Ctr. for Consumer Info. and Ins. Oversight, CMS, FINAL 2016 Letter to Issuers on Federally-Facilitated Marketplaces (Feb. 20, 2015).. 11

Ctr. for Consumer Info. and Ins. Oversight, CMS, Letter to Issuers on Federally-Facilitated and State Partnership Exchanges (Apr. 5, 2013).................................. 11

TABLE OF AUTHORITIES
(continued)

Page(s)

Ctr. for Consumer Info. and Ins. Oversight, CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) 13

Ctr. for Consumer Info. & Ins. Oversight, Premium Stabilization Programs 13

CMS Letter to State Insurance Commissioners (Nov. 14, 2013) 11

CMS, Nat'l Health Expenditure Data, Table 05-3 (last modified Dec. 11, 2018) 29

CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016) 17, 18

CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (Nov. 15, 2017) 17, 18

CMS, Risk Corridors Payment Proration Rates for 2014 (Oct. 1, 2015) 17, 18

CMS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) 13

Congressional Research Service, Medicare Primer, R40425 (Aug. 13, 2019) 29, 30

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 (2017) 19

TABLE OF AUTHORITIES
(continued)

Page(s)

GAO, Health Insurance Exchanges: Claims Costs and Federal and State Policies Drove Issuer, Participation, Premiums, and Plan Design, GAO-19-215 (Jan. 2019) 14, 16

GAO, Patient Protection and Affordable Care Act: Despite Some Delays, CMS Has Made Progress Implementing Programs to Limit Health Insurer Risk, GAO-15-447 (Apr. 2015) 6

America's Affordable Health Choices Act of 2009, Report of the Committee on Energy and Commerce on H.R. 3200, H.R. Rep. No. 111-299 (2009) 5

HHS Notice of Benefit and Payment Parameters for 2014 – CMS-9964-P (Dec. 31, 2012) 10

HUD, Office of Policy Development and Research, The Evolution of HUD'S Public-Private Partnerships (Oct. 2015) 31

Jessie Hellmann, The Hill, BlueCross Set To Fill ObamaCare Coverage Gap in Tennessee (May 9, 2017) 19

Jim McLean, Kansas Insurance Commissioner Reduces Proposed Obamacare Rate Increases, KCUR (Aug. 26, 2015) 16

TABLE OF AUTHORITIES
(continued)

Page(s)

John Holahan et al., 2016 Premium Increases in the ACA Marketplaces: Not Nearly As Dramatic As You Think, Urban Institute (Nov. 2015) 16

Letter from Charles E. Metz, Geisinger Health Plan, to Marilyn Tavenner, CMS re: Patient Protection and Affordable Care Act 10

Letter from Kevin Counihan to State Insurance Commissioners (July 21, 2015)...14, 16

Moshe Schwartz et al., Congressional Research Services, Defense Acquisitions: How and Where DOD Spends Its Contracting Dollars, R44010 (July 2, 2018) 31

Nicholas Bagley, Trouble on the Exchanges—Does the United States Owe Billions to Health Insurers?, 375 New Eng. J. Med. 2017 (2016) 18

Obamacare Taxpayer Bailout Prevention Act, S. 147, 115th Cong. (2017) 13

Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) 12

Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014) 12

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) 1

TABLE OF AUTHORITIES
(continued)

Page(s)

Rachel Fehr et al., Kaiser Family Foundation, Insurer Participation on the ACA Marketplaces, 2014-2019 (Nov. 14, 2018)......... 20

Rachel Garfield et al., Medicaid Managed Care Plans and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans, Kaiser Family Foundation (Mar. 5, 2018)........ 31

Taxpayer Bailout Protection Act, H.R. 724, 114th Cong. (2015).. 13

Timothy Stoltzfus Jost, Stabilizing Forces, The Actuary (Oct./Nov. 2016).............................. 9

USDA, Programs & Services 31

Wolfe et al., HHS, 2017 Actuarial Report on the Financial Outlook for Medicaid 30

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 health insurance to nearly 106 million people—nearly one-third of all Americans—in every zip code in all fifty states, the District of Columbia, 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 in the ACA markets ("Exchanges"). By the end of 2018, Blue Plans insured over 4.1 million enrollees who obtained their health insurance through the Exchanges.

The question presented by this petition concerns the government's ability to abrogate its payment obligations under the ACA's risk corridors program. Congress intended the risk corridors program 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 peti-

[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. All parties have consented to the filing of this brief.

tion because the reasoning of the decision below would undermine numerous public-private partnerships in which Blue Plans participate. In addition to the ACA, Blue Plans partner with the government to offer health insurance to beneficiaries of various government programs, including Medicare and Medicaid.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

One of the ACA's central innovations was the creation of government-run health insurance markets, or "Exchanges," in which private health insurers can offer individual and small-group health plans to the public. The health plans offered on Exchanges must satisfy, among other things, generous minimum coverage requirements, and millions of low-income Americans are eligible for government-subsidies to offset their enrollment costs.

In order for this new public-private partnership to function, Congress needed health insurers to agree to sell health plans on the Exchanges. But the health plans that Congress required insurers to offer were unprecedented, and insurers lacked the historical data that they needed about potential enrollees to price the plans accurately. To mitigate these enormous risks of participation, Congress created a "risk corridors" program through which the government promised to shoulder some of the issuers' pricing risk for the first three years that the Exchanges operated. Through this temporary program, Congress committed to make payments to offset losses incurred by insurers whose costs exceeded their premiums by a specified percentage and obligated insurers to pay

the government a portion of their profits if their premiums exceeded their costs by a similar percentage. 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 government to make good on its commitment to health insurers, the government reneged, withholding the billions of dollars it owed.

To defend its decision to withhold $12.3 billion in risk corridors payments to insurers, the government attempted to rewrite history, arguing that, notwithstanding its many earlier contrary statements, the ACA *never* obligated the federal government to make them. In the alternative, the government asserted that even if the ACA required the government to make these payments, that commitment was implicitly abrogated by the legislative intent reflected in later-enacted appropriations riders, which prohibited the government from fulfilling its risk corridors obligations with one source of program funds.

The Federal Circuit rejected the government's argument that the ACA did not require risk corridors payments to insurers. But it held that the obligation created by the ACA was amended by legislative history associated with the later appropriations riders. That decision, however, cannot be squared with two well-established principles in this Court's precedent. First, this Court has long required that a later-in-time appropriation must contain "words that expressly, or by clear implication, modif[y] or repeal[] the previous law" before a court will recognize that the appropriation amends an existing statute. *Unit-*

ed States v. Langston, 118 U.S. 389, 394 (1886). Second, this Court requires an expression of "clear congressional intent" before legislation can "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 280 (1994).

The court below disregarded these presumptions, which are critical to the proper functioning of public-private partnerships. They allow the government's private sector partners to structure their business affairs in reliance on Congressional intent, as memorialized in statutes, unless and until Congress clearly repeals or amends those statutes. By contrast, under the rule that the government advances and that the Federal Circuit accepted, the government's private sector partners must vigilantly track and analyze otherwise irrelevant legislation and, even more absurdly, legislative history, to ensure that Congress has not made any statement that could possibly be construed to amend prior statutory commitments.

Blue Plans responded in good faith to the government's call for help to solve real problems with the nation's healthcare system. Many Blue Plans 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 opaque text in an appropriations bill, they may have acted differently, either by charging higher premiums or declining to participate in the Exchanges altogether. The message that the

Federal Circuit's decision sends to all of the government's prospective private sector partners is clear: Think twice before relying on the U.S. government. That is a dangerous message indeed. This Court should therefore reverse the Federal Circuit's erroneous decision and reaffirm that the federal government must stand behind the statutory payment commitments it makes to private-sector partners.

BACKGROUND

A. The Risk Corridors Program Is An Essential Feature Of A Public-Private Partnership Created By The ACA

The ACA contained a series of legislative reforms intended 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. The Exchanges are public-private partnerships—publicly operated markets offering publicly subsidized private insurance—to "facilitate access of individuals and employers to a variety of choices of affordable, quality health insurance coverage." America's Affordable Health Choices Act of 2009, Report of the Committee on Energy and Commerce on H.R. 3200, H.R. Rep. No. 111-299, at 402 (2009). For the Exchanges to succeed, however, Congress needed to convince private insurers to participate in them. This was no easy task.

Setting accurate premium rates is critical to the insurance business. This process is challenging even under stable market conditions. Too high, and

health insurers price potential enrollees out of the market and drive up healthcare costs. Too low, and health insurers cannot cover claims and can be forced into liquidation. *See, e.g.*, Iowa Code § 507C.17 (authorizing forced liquidation of health insurer).

Health insurers 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, health insurers that were considering offering new plans on the Exchanges did not have this data for prospective insureds. This uncertainty was compounded by additional requirements that the ACA imposed on Exchange plans, such as the "Guaranteed Issue" requirement, which prohibits insurers from denying coverage to high-risk individuals with difficult-to-predict losses. *See* 42 U.S.C. §§ 18021(a), 300gg-1–5; GAO-15-447, at 6-7. It was nearly impossible for health insurers to determine accurately how much it would cost to deliver an unprecedented package of benefits to an unknown population of insureds.

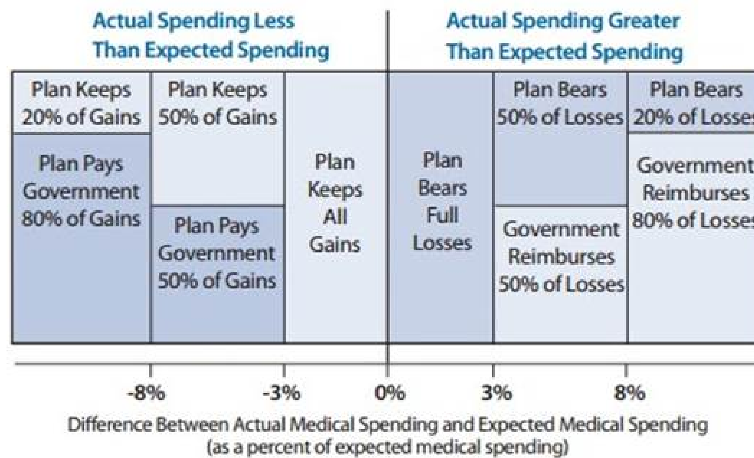
Health insurers could have responded to the uncertainty inherent to the new Exchanges by offering plans with high premiums or by refusing to participate altogether. *See* Am. Acad. of Actuaries, Issue Brief: Risk Adjustment and Other Risk-Sharing Provisions in the Affordable Care Act, at 3-4 (June

2011).[2] Both of these responses, however, would have frustrated Congress's goal of improving access to quality and affordable health insurance.

To incentivize health insurers to participate in the Exchanges and give them time to learn how to price their plans competitively in this new market, § 1342 of the ACA established "a program of risk corridors" for the initial three years of the Exchanges. 42 U.S.C. § 18062(a); *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1314 (Fed. Cir. 2018) (recognizing that the risk corridors program was created "to mitigate th[e] risk [of absent historical data] and discourage insurers from setting higher premiums to offset that risk."); *Moda Health Plan, Inc. v. United States*, No. 18-1028, Br. for United States in Opp. to Cert. at 4 (similar). Under this program, Congress promised to "adjust[]" issuer payments for the first three years the Exchanges operated "based on the ratio of allowable [plan] costs … to the plan's aggregate premiums." 42 U.S.C. § 18062(a). More specifically, the ACA provided that the government "shall pay" participating health 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), (b)(1). Conversely, the ACA required participating health plans whose claim-related costs were *less* than 97% of received premiums to pay the government a statutorily prescribed portion of their excess profits. *Id.* § 18062(b)(2). The American

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

Academy of Actuaries ("AAA") has previously explained the program through 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 program was a risk-sharing agreement between the government and health insurers that formed a core part of a new public-private partnership. Through this program, the government encouraged insurers to offer affordable health plans on the Exchanges.

B. Congress, HHS, And Health Insurers Understood That The Risk Corridors Program Was Not Budget Neutral

From its inception, Congress, HHS, and insurers understood that the risk corridors program was not budget neutral. Put another way, all parties recog-

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

nized that the government's obligation to reimburse health insurers 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 public-private partnership through which the federal government partners with private health plans to offer prescription drug benefits to qualifying Medicare beneficiaries. *See* 42 U.S.C. §§ 1395w-115(e) (establishing Medicare Part D risk corridors program); 18062(a) ("Such program shall be based on" the Part D risk corridors program). The government concedes that the Part D risk corridors program is not budget neutral. *See* Exchange and Insurance Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014). Like the health plans offered on the ACA Exchanges, Medicare Part D prescription drug plans did not exist before Congress established the Part D program. Insurers therefore lacked sufficient information about what it would cost to provide the prescription drug coverage 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 government anticipated. *See* Timothy Stoltzfus Jost, Stabilizing Forces, The Actuary (Oct./Nov. 2016).[4]

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

HHS also repeatedly recognized that the ACA risk corridors program required the federal government to compensate health insurers for qualifying losses. For instance, in its rulemaking describing how the first year of the Exchanges would operate, a health 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). The final rule confirmed that the risk corridors program was a risk-sharing agreement between health plans and the government, explaining that 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).[5]

Finally, in November 2013, long after premium rates for 2014 benefit year ("BY") Exchange plans were finalized, HHS announced that it would permit issuers to renew policies that existed prior to 2014

[5] By contrast, 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).

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 and 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 Exchange enrollee population. HHS responded to complaints from insurers that this significant policy change undermined their BY 2014 premium calculations by assuring them that any losses suffered due to this untimely shift in policy would be "ameliorate[d]," in part, by the risk corridors program. *See id.* at 3.[6]

C. The Government Reneged On Its Promise To Health Insurers

1. Like other parts of the ACA, the risk corridors program was politically contentious. Before the program even started, several Members of Congress introduced bills to make it a budget-neutral risk shar-

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[6] Health insurers submitted to state insurance regulators their proposed rates for the 2014 BY in the spring of 2013. See Ctr. for Consumer Info. and Ins. 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, insurers executed formal agreements with the federal government to offer Exchange plans in September 2013. *Id.* 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).

ing program between insurers or to 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, Congress passed a continuing resolution to fund the government. *See generally* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130 (Dec. 16, 2014) ("FY 2015 CR"). Buried deep in this 701-page appropriations bill, opponents of the risk corridors program included a provision that blocked HHS from using funds from specifically enumerated sources to satisfy the government's risk corridors obligations. *Id.* § 227, 128 Stat. 2491. Specifically, the FY 2015 CR provided that "[n]one of the funds made available by this Act from" several specific sources, including CMS's general program fund, "may be used for payments under section 1342(b)(1) of Public Law 111–148 (relating to risk corridor)." *Id.*[7] Nothing in the legislation purported to repeal § 1342 or to amend the ACA to limit risk corridors

[7] Identical language appears in the appropriations riders for the subsequent two fiscal 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").

payments to the government's collections from health insurers.

Tellingly, even those Members of Congress who opposed the risk corridors program did not construe the FY 2015 CR to eliminate the federal government's obligation to make risk corridors payments. After passage of the FY 2015 CR, these legislators continued to introduce bills to repeal the program or to amend it to be budget neutral for subsequent years. *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 health insurers 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]; CCIIO, CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) (same).[9] Indeed, in the summer of 2015, HHS went so far as to inform state insurance commissioners who were reviewing issuers' proposed 2016 BY rates that they should assume that issuers would receive full risk corridors

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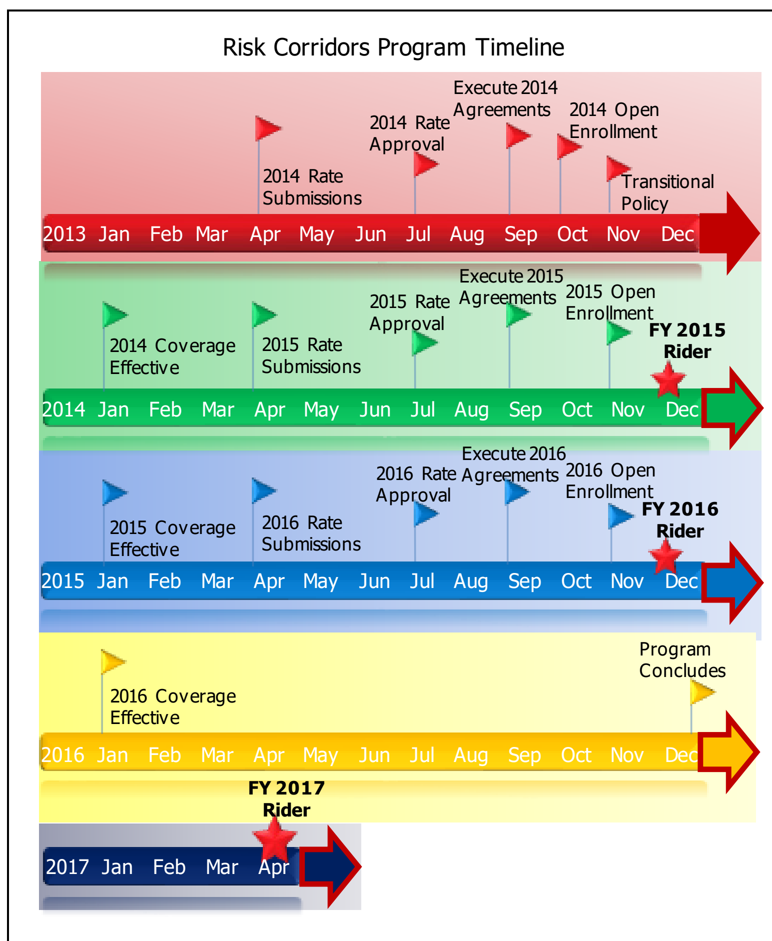
[8] https://tinyurl.com/y4cyclp6

[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 Oversight, Premium Stabilization Programs, https://tinyurl.com/y52ta7n5 (last visited Sept. 5, 2019).

payments. *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. Over the three years in which the risk corridors program was intended to operate, Exchange plans incurred massive losses. This was hardly surprising.

As illustrated by the chart below, when health insurers developed 2014 BY rates in the spring of 2013, they lacked data about the individuals who would enroll in Exchange plans. They also did not know that *after* rates were set, CMS would adopt the "Transition Policy," described *supra* at 10-11, which caused healthier individuals with health insurance that did not satisfy the ACA's requirements to refrain from switching to Exchange plans. These factors combined to produce unexpectedly-high liabilities. A recent GAO literature survey concluded that, in the first year of the Exchanges, claims costs were 6 to 10 percent higher than insurers expected, and in one state, some insurers received 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, Premiums, and Plan Design, GAO-19-215, at 10 (Jan. 2019).



As the chart shows, health insurers confronted similar challenges when setting rates for the 2015 BY 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. And while issuers pro-

posing premiums for the 2016 BY in the spring of 2015 had access to financial results from the 2014 BY, 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 enrollee population or other Exchange anomalies, like the Transition Policy. *Id*. But even without those unexpected shocks, the risk corridors program was designed to last for three years for good reason: It is exceedingly difficult to price health plan premiums based on just one year of data.

Some health insurers tried to account for 2014 losses by increasing 2016 BY premium rates, only to be frustrated by state regulators. For instance, in August 2015, the Kansas Insurance Commissioner reported that his office's review process had decreased 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 regulatory constraints guaranteed that insurers could not limit their losses through full premium increases. *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).

4. Despite advising state insurance regulators in July 2015 that the federal government was committed "to mak[ing] full [risk corridors] payments to is-

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

suers," Letter from Kevin Counihan to State Insurance Commissioners, at 2 (July 21, 2015), when the bill came due in the fall of 2015, HHS made only pro rata payments. On October 1, 2015, HHS announced that for BY 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 that 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

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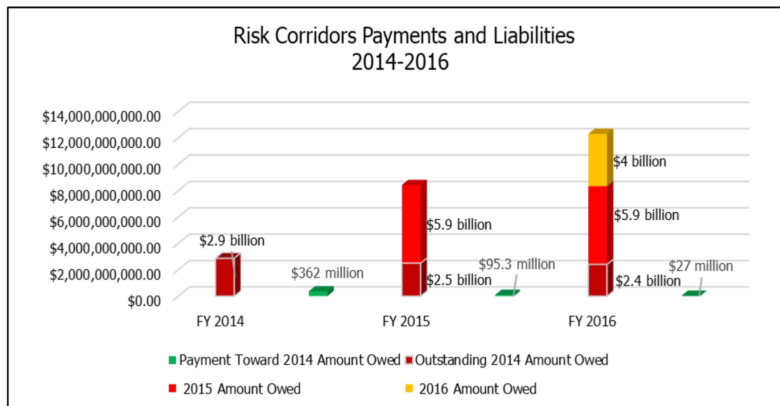
[11] https://tinyurl.com/y6jrpe8e

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

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

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 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 es-

timates 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).

D. Health Insurers That Invested Most In The Exchanges—Like 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 because of their commitment to serving their members.[14] Since several large insurers exited these markets, Blue Plans have been the only insurers to offer Exchange coverage in cer-

[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).

tain parts of the country. *See* Rachel Fehr et al., Kaiser Family Foundation, Insurer Participation on the ACA Marketplaces, 2014-2019 (Nov. 14, 2018).

ARGUMENT

I. This Court's Precedent Protects The Private Sector's Ability To Rely On The Government As A Business Partner

Like many business relationships, public-private partnerships require sustained collaboration based on long-term commitments. Private-sector partners 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.

1. This Court's long-standing precedent concerning when a later act of Congress amends prior legislation facilitates "the Government's own long-run interest" in being "a reliable contracting partner." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191 (2012) (quoting *United States v. Winstar*, 518 U.S. 839, 883 (1996) (plurality)). The 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 the appropria-

tions bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980); *see also Nat'l Ass'n of Home Builders v. Defenders of Wildlife*, 551 U.S. 644, 662 (2007) (noting that a "later-enacted statute . . . can sometimes . . . amend . . . an earlier statutory provision," it is "not favored" (internal citation and quotation omitted)).

By requiring Congress to speak clearly to amend prior statutes, the Court's jurisprudence ensures that the private sector has notice of the applicable law and protects its interest in participating in the legislative process. And because appropriations measures generally "have the limited and specific purpose of providing funds for authorized programs" rather than changing the nature of the programs themselves, this Court has noted that it would be "absurd" to expect even Members of Congress to "review exhaustively the background of every … appropriation." *TVA v. Hill*, 437 U.S. 153, 190 (1978); *see also* House Rule XXI(2)(b) (prohibiting changing existing substantive law through appropriation); Senate Rule XVI(4) (prohibiting amendments to appropriations bill that propose general legislation).

The contrary rule that the Federal Circuit applied in the decision below would allow ambiguous language in appropriations bills to upend the settled expectations of multi-billion dollar industries and wreak havoc on public-private partnerships that are critical to the proper functioning of government programs. *Cf. Ramah Navajo*, 567 U.S. at 191-92 (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 surrounding the Appropriations Riders at issue here.

While opponents of the risk corridors program were unable to muster the votes to repeal or amend § 1342, their efforts to add ambiguous language to must-pass appropriations triggered little scrutiny from their colleagues, the healthcare industry or the public precisely *because the implications of the rider were unclear*. *See Landgraf*, 511 U.S. at 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."); *cf. New York v. United States*, 505 U.S. 144, 168 (1992) (holding that the Constitution requires each branch of government to make decisions "in full view of the public, and … suffer the consequences if the decision turns out to be detrimental or unpopular").

2. The presumption against construing statutes to have retroactive effect also protects the government's ability to rely upon public-private partnerships to address the Nation's problems. This Court has repeatedly held that Congress must speak clearly before legislation will be construed to "impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Landgraf*, 511 U.S. at 280; *see also Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006) (holding that Congressional intent to apply a statute retroac-

tively must be communicated through "explicit language or by necessary implication" (quotation omitted)).

It is obvious why this rule is critical to public-private partnerships: The government's private sector partners rely on statutes to arrange their affairs. For instance, the government required health insurers interested in participating in the Exchanges to seek approval of their plans well before they were available to the public. If Congress can easily upset its private partners' settled expectations after it is too late for them to change course, any private enterprise that does business with the government will charge prices that reflect the additional risk of doing business with such an unreliable partner. *See Ramah Navajo*, 567 U.S. at 191-92 ("If the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment.").

* * *

In sum, under this Court's longstanding precedent, for a later-in-time appropriations rider to amend § 1342, its text must include "words that expressly, or by clear implication, modif[y] or repeal[] the previous law." *Langston*, 118 U.S. at 394; *see also Landgraf*, 511 U.S. at 264 (holding that because "retroactivity is not favored in the law … congressional enactments and administrative rules will not be construed to have retroactive effect unless their language requires this result" (quotation omitted)). Nothing in the Appropriations Riders that the feder-

al government now claims supersede the ACA satisfies this exacting standard.

II. The Federal Circuit's Atextual Decision Misapplied This Court's Well-Established Precedent And Impedes The Government's Ability To Partner With The Private Sector

After health insurers had fulfilled their end of the bargain, the Federal Circuit held that the *legislative history* of the Appropriations Riders evidenced Congressional intent to amend the ACA's clear and unambiguous payment mandate. *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1321-22 (Fed. Cir. 2018). That holding flouts the presumptions against implied repeal and retroactivity, and it calls into question the government's continued ability to partner effectively with the private sector to achieve important public objectives.

1. The court below correctly held that the risk corridors payment formula in the ACA established a mandate to pay that is not budget neutral. *Id.* The plain text of the Appropriations Riders does not change a single word of § 1342 or any other part of the ACA. Nor do the Riders add language similar to the 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 legislative text); *Adirondack*

Med. Ctr. v. Burwell, 782 F.3d 707, 710 (D.C. Cir. 2015) (*per curiam*) (same).[15]

Instead, the Appropriations Riders simply prohibit HHS from using one source of program funds to make 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 id.* (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 funds than required to pay statutory rate does not impliedly suspend payment obligation); *United States v. Mitchell*, 109 U.S. 146, 150 (1883) (holding that the effect of appropriations riders "depends on the intention of congress *as expressed in the statutes*" (emphasis added)). Indeed, given that three of the judges who considered whether the Appropriations Riders modified the ACA concluded that they did not, it strains credulity

[15] The sponsors of the Appropriations Riders tried and failed to add terms requiring budget neutrality to the ACA's risk corridors provision. *See supra* at 11-12.

to believe that the text *clearly* establishes such a change.[16]

In light of the well-established presumptions against implied amendment and retroactivity, if Congress had intended to modify the risk corridors program after health insurers had relied on it, Congress was required to make its intent clear to insurers and courts alike. Its failure to do so is dispositive of the claims in this petition.

2. The Federal Circuit ignored the Appropriations Riders' plain text and erroneously focused its analysis primarily on two wholly irrelevant forms of legislative history: communications between an agency and Members of Congress, and an explanatory statement of another Member. *Moda*, 892 F.3d at 1321-22; *but see St. Martin Evangelical Lutheran Church v. S. Dakota*, 451 U.S. 772, 788 (1981) (holding equivocal legislative history is an "indefinite congressional expression[] [that] cannot negate plain statutory language [or] work a repeal or amendment by implication"). If adopted by this Court, that reasoning would undermine the integrity of the democratic process by creating a system in which individual Members of Congress could effectively legislate by slipping innocuous and ambiguous language into must-pass legislation and simultaneously adding

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[16] *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).

statements into the legislative history that support a controversial construction of that 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—ignoring the plain text of the statute to instead ask "What else could Congress have intended?"—its reasoning is equally flawed. *Moda*, 892 F.3d at 1325. Several circuit courts have held that the absurdity doctrine is no longer good law—and for good reason. *See Lexington Ins. Co. v. Precision Drilling Co., L.P.*, 830 F.3d 1219, 1222 (10th Cir. 2016) (Gorsuch, J.); *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). As then-Judge Gorsuch explained, "[t]o label a statute's consequences 'absurd,' a court usually must … engage in the doubtful business of guessing at hidden legislative intentions." *Lexington Ins. Co.*, 830 F.3d at 1222; *see also Va. Uranium, Inc. v. Warren*, 139 S. Ct. 1894, 1908 (2019) (lead opinion) ("[I]n piling inference upon inference about hidden legislative wishes we risk displacing the legislative compromises actually reflected in the statutory text—compromises that sometimes may seem irrational to an outsider com-

ing to the statute cold, but whose genius lies in having won the broad support our Constitution demands of any new law.").

In any event, the Federal Circuit's absurdity argument fails on its own terms. It is possible—indeed, likely—that the sponsors of the Appropriation Riders, having failed to substantively amend the law, introduced the Riders as a fallback position to do no more than what the Riders' plain text commands: temporarily restrict a key source of risk corridors funding while they sought sufficient political support to make the program budget neutral or repeal it entirely. *See supra* at 11-12. This interpretation is also supported by subsequent legislative history. The sponsors of the Riders continued to introduce further legislation to make the program budget neutral even after passing the Appropriation Riders. *See supra* at 13. If the Riders already 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 (with or without their legislative history) fall short of providing the "clear implication" that this Court's precedent requires.

III. The Public-Private Partnerships Threatened By The Federal Circuit's Decision Are A Useful Tool For Cost-Efficient And Effective Governance

The public-private partnerships threatened by the novel rule that the Federal Circuit applied in the instant case are essential to the effective and efficient delivery of basic government benefits. This is

especially true for healthcare. 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).[17]

These partnerships extend far beyond the ACA provisions at issue in this litigation. Over 35% of all Medicare beneficiaries—or around 21 million Americans—receive their benefits from a private insurer, a number the government predicts will reach 40% in the next decade. *See* 2019 Annual Report of the Boards of Trustees of the Federal Hospital Insurance and Federal Supplementary Medical Insurance Trust Funds, at 20, 148, 173 (Apr. 22, 2019) ("Medicare Trustee Report"). Most of these Americans are enrolled in Medicare Part C, also called "Medicare Advantage" ("MA"), on which the federal government spent an estimated $232.7 billion in 2018. *Id.* at 10, 153. In MA, private insurers receive capitated payments to deliver at least the same benefits offered in Medicare Parts A and B, also known as the "traditional Medicare" program. *See* Congressional Research Service, Medicare Primer, R40425, at 20-21 (Aug. 13, 2019). Insurers, in turn, compete for enrollees by offering benefits that exceed the minimum program requirements, including vision, dental and wellness programs, and/or offering lower deductibles or co-payments. *See id.*

A similar framework governs prescription drug benefits in Medicare Part D. As in MA, private in-

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

surers bid for contracts wherein the government pays participating insurers risk-adjusted capitated payments for meeting certain statutory benefit requirements. *See* Congressional Research Service, Medicare Primer at 22-23. In 2018, the government paid an estimated $94.7 billion in benefits for nearly 46 million participants. *See* Medicare Trustee Report at 10, 173.

The private sector also works closely with the federal government to administer the traditional Medicare program in which beneficiaries receive services from healthcare providers who are reimbursed by the federal government on a fee-for-service basis. In 2018, the government spent $403.4 billion providing health care to roughly 59 million beneficiaries. *See* Medicare Trustee Report at 11, 173. 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.[18] 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.[19]

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[18] https://tinyurl.com/yd8sooh9 (last visited Sept. 5, 2019).

[19] 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

Public-private partnerships are equally important outside the healthcare context. 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.[20] 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 Its Contracting Dollars, R44010, at 2 (July 2, 2018). The Department of Defense alone spent $320 billion on private sector contractors that year. *Ibid.*

In sum, while the Federal Circuit's decision would save the government some money today, the fundamental rules that it violated are critical to the

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and Access to Care: Results from the Kaiser Family Foundation 2017 Survey of Medicaid Managed Care Plans, Kaiser Family Foundation (Mar. 5, 2018), https://tinyurl.com/y35d7z7s.

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

proper function of the United States government in the long-run. To preserve the government's ability to partner effectively with the private sector, this Court should reaffirm that Congress must speak clearly to amend prior legislation, especially when private parties have relied on the earlier statute.

CONCLUSION

The decision of the Federal Circuit should be reversed.

Respectfully submitted,

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