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

In the Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,
Petitioner,
v.
UNITED STATES,
Respondent.

MODA HEALTH PLAN, INC., ET AL.
Petitioners,
v.
UNITED STATES,
Respondent.

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NONPROFIT MUTUAL INSURANCE CORPORATION,
Petitioner,
v.
UNITED STATES,
Respondent.

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

BRIEF OF 24 STATES AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Is the federal government required to make the "risk corridors" payments to insurers that Congress mandated in the Affordable Care Act?

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Page(s)

CASES CITED

CONSTITUTIONAL AND STATUTORY PROVISIONS

TABLE OF AUTHORITIES
(continued)

Page(s)

OTHER AUTHORITIES

TABLE OF AUTHORITIES
(continued)

Page(s)

TABLE OF AUTHORITIES
(continued)

Page(s)

INTEREST OF THE AMICI STATES

This case implicates the interests that states have as the primary regulators of the health insurance industry. *See* 15 U.S.C. § 1012(a) ("[t]he business of insurance * * * shall be subject to the laws of the several States"); 15 U.S.C. § 1011 ("the continued regulation and taxation by the several States of the business of insurance is in the public interest").

In the Affordable Care Act ("ACA"), Congress mandated "risk corridors" payments to insurance companies to entice those companies into a marketplace that was untested in crucial respects, as well as to mitigate the need to account for that uncertainty when setting rates. Under section 1342 of the ACA, insurers that had to pay out benefits that were more than 3% higher than anticipated would receive reimbursement for a portion of the excess; conversely, insurers that had to pay out benefits that were more than 3% lower than anticipated would have to pay the government a portion of the windfall. *See* 42 U.S.C. § 18062(b). State regulators relied on those mandated payments when reviewing proposed rates to ensure that their citizens would receive access to affordable health insurance from financially stable companies.

The federal government's decision to renege on those promised payments has affected and will continue to affect the viability of insurance companies regulated by the amici states. It will also affect future cases in which Congress mandates risk-mitigating payments to attract participation in a state-regulated industry, or otherwise enacts statutes

that alter the financial incentives in a particular market.

The amici states submit this brief because of their strong interest in maintaining healthy and financially sound insurance markets that protect consumers.

SUMMARY OF ARGUMENT

In the ACA, Congress mandated that the federal government make the full risk-corridors payments it promised to insurers, regardless whether making those payments would cause the risk-corridors program to be a net liability rather than budget neutral. And Congress did not renege on that promise through appropriations riders restricting the source of funding for risk-corridors payments, riders that by their terms did not prevent the payments from being made out of the Judgment Fund. In addition to the other arguments advanced by petitioners, those conclusions follow from the nature of the state-regulated rate-setting process.

Many states subject health insurance rates to prior review and approval. But to conduct meaningful rate review, and to perform their regulatory duties adequately, states need to assess whether a proposed rate will jeopardize an insurer's financial health—which, in turns, requires state regulators to forecast insurers' receipts and expenses over a range of possible scenarios. Congress understood this when it enacted the ACA; the ACA itself requires the federal government to work with the states to review proposed rates.

Congress knew that the ACA—which was intended to ensure that millions of previously

uninsured citizens would receive coverage—introduced a host of unknowns into the health insurance marketplace. To mitigate those uncertainties, Congress created three risk-mitigation programs. One of those was the risk-corridors program, which mandated payments, under a statutory formula, to insurance companies under certain circumstances, in the event that insurers had set their rates too low. The purpose of that program was to keep insurance rates affordable by relieving insurers of the need to charge a "risk premium to account for perceived uncertainties in the 2014 through 2016 markets." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,413 (2013).

Congress anticipated and intended that insurers would rely on the mandatory nature of the risk-corridors payments when proposing rates, and that state regulators would rely on the payments' mandatory nature when reviewing those rates. That supports the inference that Congress intended the mandated payments to constitute an enforceable obligation to pay the full amount due under the statutory formula, an obligation that could be satisfied from the Judgment Fund in the event that Congress did not expressly identify some other source.

By contrast, if the federal government were not required to make the payments at issue, petitioners and other insurance companies would be compromised in their ability to continue providing health insurance coverage, costs would be transferred to consumers, and states would bear additional

regulatory burdens. Ultimately, such a construction would undermine Congress's stated goal in adopting the ACA—providing affordable health insurance coverage for millions of Americans who previously were uninsured.

Moreover, having created an enforceable promise to pay insurance companies the full amount due under the statutory formula applicable to risk-corridors payments, Congress did not repeal the promised obligation implicitly through post-enactment appropriations riders. It would be unreasonable to infer such a repeal in the absence of an enactment that expressly reflects a change in course from Congress's earlier policy choice to mandate the payments as a way of promoting broad and affordable health insurance coverage. Requiring express legislation would ensure that *Congress*—and not the states or other branches of the federal government—is politically accountable for the consequences of reneging on its promise, especially when those consequences undermine the efforts of state regulators.

ARGUMENT

Congress recognized that mandatory and enforceable payments under the risk-corridors program were crucial to the success of the ACA. Given the significance of those payments, Congress must have intended them as enforceable statutory obligations of and promises by the federal government. And precisely because those payments are so significant to the success of the ACA, this Court should not conclude that Congress tacitly

repealed the federal government's obligation merely by limiting the available sources of payment.

A. Congress intended risk-corridors payments as an enforceable obligation of the federal government regardless of receipts into the program.

When it adopted the ACA, Congress expected and intended that state regulators and insurance companies—in making rate-setting decisions in the new health-insurance marketplace that the ACA created—would treat risk-corridors payments as mandated if an insurer experienced higher-than-expected losses, regardless whether other insurers experienced lower-than-expected losses. That expectation proved correct, as evidenced by the turmoil created when the government failed to make those payments in full. Congress's correct expectation supports the inference that Congress intended that payments would be made even if it did not separately appropriate funds to do so.

1. Congress expected and intended that state regulators and insurance companies would treat risk-corridors payments as unconditionally mandated by the ACA.

When enacting the risk-corridors program, Congress must have acted with knowledge that states have long regulated the actuarial soundness of insurance rates. Against that backdrop, Congress necessarily expected and intended for state regulators to rely on the promise of risk-corridors payments as offsetting some of the actuarial uncertainty created by other provisions of the ACA.

a. States have long regulated insurance rates to ensure that they are actuarially sound.

Even before the ACA was enacted, many states subjected health insurance rates to prior approval. *See generally* Angelo Borselli, *Insurance Rates Regulation in Comparison with Open Competition*, 18 Conn. Ins. L.J. 109, 113–27 (2012) (discussing history of state regulation of insurance rates, including prior-approval method of regulation). In Oregon, for example, state statutes required the state to review proposed rates to assess whether they were "[a]ctuarially sound," reasonable, and "[b]ased upon reasonable administrative expenses." Or. Rev. Stat. § 743.018(4) (2009); Or. Laws 2009, ch. 595, § 31. The state considered, among other things, the insurer's "financial position," its "projected loss ratio between the amounts spent on medical services and earned premiums," and whether the proposed rate was "necessary to maintain the insurer's solvency." Or. Rev. Stat. § 743.018(5)(a), (c), (g) (2009); Or. Laws 2009, ch. 595, § 31.

The ACA requires the federal government to act "in conjunction with" the states to conduct annual rate reviews. *See* 42 U.S.C. § 300gg-94(a)(1) (requiring federal government, "in conjunction with States," to "establish a process for the annual review, beginning with the 2010 plan year * * * , of unreasonable increases in premiums for health insurance coverage"); 42 U.S.C. § 300gg-94(b)(2)(A) (requiring government, beginning with 2014 plan years, to act "in conjunction with the States" to "monitor premium increases of health insurance

coverage"). Congress thus expected, and intended, the states to bear most of the regulatory load in reviewing rates, and it created a grant program to help states do so. *See* 42 U.S.C. § 300gg-94(c)(1) (requiring "a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including * * * reviewing and, if appropriate under State law, approving premium increases for health insurance coverage").

To conduct meaningful rate review, state regulators need to assess whether a proposed rate will jeopardize an insurer's financial health. Doing so enables them to fulfill their twin regulatory objectives: (1) assuring that affordable health insurance is available to their citizens while (2) ensuring that insurers are financially strong enough to be able to provide such insurance into the foreseeable future. *See generally* Banks McDowell, *Competition As A Regulatory Mechanism in Insurance*, 19 Conn. L. Rev. 287, 293 (1987) ("In most states, the statutorily prescribed purposes of rate regulation are: to ensure that premiums are not so inadequate that they endanger the solvency of the insurers and affect their ability to pay claims; to ensure that premiums are not so excessive as to be unreasonably high for the kind of insurance being purchased; and, to ensure that rates do not unfairly discriminate among the various classes of insureds.").

Assessing the financial viability of a proposed rate, in turn, requires projecting how much revenue an insurer will bring in through premiums and other receipts, as well as how much the insurer will pay out

in benefits. If the receipts are likely to exceed the benefits due and the insurer's reasonable administrative costs, the state may require the insurer to lower the proposed rate. Conversely, if there is a risk that the receipts will not cover the full amount of the benefits due, the state may require the insurer to raise the proposed rate to ensure the insurer's continued financial health.

b. The promise of risk-corridors payments offset some of the actuarial uncertainty created by other provisions of the ACA.

Making those assessments following the ACA's passage was no easy task. The ACA essentially created a new insurance marketplace, one full of unknowns. Congress's stated goal was to "add millions of new consumers to the health insurance market * * * and increase the number and share of Americans who are insured." 42 U.S.C. § 18091(2)(C). The ACA created a new federally regulated marketplace, in which federally shaped products would be offered to millions of citizens whose health histories or risks were largely undocumented, and whose purchasing behavior under the new marketplace rules was difficult to predict. Further, the ACA required policies to be "guaranteed issue"—i.e., issued without regard to the applicant's health. Before the ACA, nearly all states had permitted individualized medical underwriting. *Compare*, e.g., Or. Rev. Stat. § 743.766 (2009); Or. Laws 2003, ch. 748, § 7 (pre-ACA version of statute allowing "carriers who offer individual health benefit plans" to "evaluate the health status of individuals

for purposes of eligibility"), *with* Or. Rev. Stat. § 743.766 (2013); Or. Laws 2011, ch. 500, § 24 (post-ACA version allowing such health status evaluation only for "grandfathered health plans," i.e., health plans in existence prior to enactment of the ACA); *see also* 42 U.S.C. § 18011 (defining "grandfathered health plan" as one in which such individual was enrolled on March 23, 2010). Due to the new marketplace's many uncertainties, many health insurance companies were reluctant to enter it. The same uncertainties bedeviled many state regulators as they tried to assess the rates that insurers proposed for covering the previously uninsured.

Congress understood the problems of uncertainty when it mandated risk-corridors payments. As the government concedes, Congress sought "to mitigate the pricing risk and the incentives for adverse selection arising from" these new marketplaces, and it established the risk-corridors program as one way to achieve that goal. *Moda* BIO 4. More specifically, the risk-corridors program was intended to "protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (2013). The program achieved that goal in part by risk-sharing *among* insurers: "more evenly spread[ing] the financial risk borne by issuers" through the transfer of funds "from issuers with lower-risk enrollees to issuers with higher-risk enrollees." *Id.* But another key effect of that framework was risk-sharing *with the government*: requiring the federal government and insurers "to

share in profits or losses resulting from inaccurate rate setting from 2014 through 2016." *Id.* at 15,412.

Congress thus intended the statutory risk-corridors program to help stabilize an essentially new and unknown market place, and to diminish the risks of entering that market place. Congress would have known that, unless insurance companies and states believed that the mandated payments would be made, insurers would be less willing to enter that market, and states would find it difficult to perform their regulatory duties—assessing the health and solvency of insurance companies when deciding whether to approve rates proposed by those companies. Worse yet, without guaranteed risk-corridors payments, state regulators might require insurers to raise their rates to account for the risk that the federal government would not make those payments. The resulting increase in insurance rates would not just defeat the purpose of the risk-corridors program; it would undermine the ACA's fundamental goal of making affordable insurance more widely available. Higher premiums would drive some healthy people to pay a penalty rather than purchase insurance, resulting in precisely the sort of adverse-selection problem that might undermine the ACA as a whole. *See generally King v. Burwell*, 135 S. Ct. 2480, 2485–86 (2015) (describing adverse selection and how it can lead to a "death spiral" in insurance markets); *see also* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (2013) ("Premium stabilization programs—risk adjustment, reinsurance, and risk corridors—are expected to protect against the effects of adverse selection.").

Thus, for the risk-corridors program to have the effect intended by Congress (in part, facilitating insurance for millions of previously uninsured citizens at a rate that encourages healthy individuals to purchase insurance), the payment mandate needed to create an enforceable obligation that would be guaranteed regardless how much money the program brought in from insurers that experienced lower-than-expected losses. Otherwise, insurance companies would be deterred by the risks they faced from entering that new market, and state regulators would be deterred from allowing carriers to shoulder those risks. At a minimum, without the risk-corridors program insurers and state regulators would have to set higher rates to account for the risks.

2. As Congress expected, failing to honor the promise of risk-corridors payments has significantly and adversely affected the insurance markets in many states.

As Congress expected and intended, insurers and insurance regulators relied on the risk-corridors payments as an enforceable promise. By upsetting that reliance expectation, the government's failure to make the promised payments has had a significant adverse impact on the insurance market in multiple states.

Before the federal government announced in October 2015 that it would not be making the majority of the mandated 2014 risk-corridors payments, states had—following guidance published by the National Association of Insurance

Commissioners (NAIC)—allowed insurers to list anticipated risk-corridors payments as assets for statutory accounting purposes. *See* National Association of Insurance Commissioners, *Accounting for the Risk-Sharing Provisions of the Affordable Care Act* 10 (2014) ("Risk corridor receivables due to the reporting entity meet the definition of an asset and are admissible to the extent that they meet all of the criteria in this issue paper."), *available at* https://www.naic.org/sap_app_updates/documents/150_a.pdf. Only after the federal government's announcement did states (following further NAIC guidance) begin treating the risk-corridors payments as "not reasonably collectible," and begin disallowing them as assets for statutory accounting purposes. Across the country, similar developments have thrown insurance markets into turmoil.

In Oregon, for example, the federal government's unfulfilled promises caused the failure and subsequent state supervision of Health Republic Insurance Company (HRIC), which insured more than 10,000 members and was owed roughly $20 million in promised risk-corridors payments for 2014–15. Nick Budnick, *Oregon Insurer Health Republic to Shut Down in 2016, Cites $20 Million Federal Hit*, The Oregonian, Oct. 16, 2015, *available at* https://www.oregonlive.com/health/2015/10/oregon_insurer_health_republic.html (last visited July 26, 2019). HRIC, which is the lead plaintiff in a class action contesting the governmental nonpayments, was a co-op formed with federal start-up loans totaling more than $50 million. *Id.; see also Health Republic Ins. Co. v. United States*, No. 16-259C (Fed.

Cl.). In licensing such companies, Oregon had relied on pro forma financial statements that included substantial risk-corridors payments.

Petitioner Land of Lincoln suffered a similar fate when the federal government failed to make nearly $70 million in promised risk-corridor payments to the nonprofit health insurer. *See Hammer v. U.S. Dep't of Health & Human Servs.*, 905 F.3d 517, 523 (7th Cir. 2018) When Land of Lincoln was liquidated, nearly 50,000 Illinois residents lost their health insurance in the middle of the 2016 plan year. *See* Lisa Schencker, *State Invites Land of Lincoln Insurance Members To File Claims*, Chicago Tribune, Apr. 6, 2017, *available at* https://www.chicagotribune.com/business/ct-land-of-lincoln-claims-0407-biz-20170406-story.html (last visited Aug. 27, 2019). That mid-year collapse was particularly disruptive because it required members to choose between accepting the risk of a lapse in coverage or purchasing new insurance for the remainder of the year, without credit for having paid out towards the deductibles and out-of-pocket maximums applicable under their original plans. *See id.*

Another Oregon insurer also suffered catastrophic consequences when the federal government failed to make its promised payments. Petitioner Moda Health Plan, Inc. had, as of 2015, enrolled roughly 244,000 Oregonians for insurance. Oregon Department of Consumer and Business Services, News release, *State places Oregon health insurer under supervision* (Jan. 28, 2016) ("DCBS news release"), *available at*

http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=947 (last visited July 26, 2019). For 2014 and 2015, the government owed and failed to pay Moda more than $210 million in risk-corridors payments. Pet. 11. Those non-payments resulted in Moda descending into hazardous operating conditions, which in turn prompted the State of Oregon to assume supervision of Moda, meaning that it maintained a representative on site and controlled all financial decisions. DCBS news release, *supra*. The State of Oregon subsequently lifted the supervision order, based on Moda's commitment to raise $179 million in new capital—nearly the amount that Moda had failed to collect from the federal government under the risk-corridors program. *In the Matter of Moda Health Plan, Inc.*, No. INS 16-13-002, Consent Order (Or. Dep't of Consumer & Bus. Servs. Feb. 6, 2016).

Other states also were adversely affected by the federal government's broken promise. On the same day that Oregon announced its supervision order, the State of Alaska issued an order requiring Moda, due to inadequate capital, to withdraw from Alaska's individual market. Tegan Hanlon, *Alaska Kicks Moda Health out of Individual Insurance Market*, Anchorage Daily News, Jan. 28, 2016, *available at* https://www.adn.com/health/article/alaska-kicks-moda-health-out-individual-insurance-market-leaving-only-premera/2016/01/28/ (last visited July 26, 2019). To stabilize its Oregon operation, Moda also pulled out of the Washington market, thus weakening the health insurance market in that state. Washington State Health Care Authority, News

release, *Moda Health Pullout from Washington Health Insurance Market Doesn't Affect Its Participation with PEBB Program in 2016* (Nov. 2, 2015), *available at* https://www.hca.wa.gov/about-hca/moda-health-pullout-washington-health-insurance-market-doesn-t-affect-its-participation (last visited July 26, 2019) (noting that "Moda Health has notified the Office of the Insurance Commissioner that it will not participate in the Washington Health Benefit Exchange * * * for 2016 coverage").

The failure to make full risk-corridors payments similarly undermined the ACA's goal of promoting stability in Pennsylvania's insurance market. After the federal government announced that it would not be making full payments for 2015, several insurance carriers there sought to raise their rates by more than 40%. *See* Brief of Pennsylvania Insurance Department as Amicus Curiae Supporting Plaintiffs 13–14, *First Priority Life Ins. Co., et al. v. United States*, No. 16-587C (Ct. Fed. Cl. Oct. 14, 2016).

When the federal government reneged on its promise of risk-corridors payments, regulators and insurers had to address the permanent loss of the promised risk-corridors payments on which they had relied. In some instances, the federal government's unpaid risk-corridors obligations were passed on to ratepayers, thus shifting costs of the federal default to the consumers themselves. In other instances, unpaid risk-corridors obligations, by increasing the costs and risks of doing business in the individual health insurance markets, reduced the number of carriers willing to cover those markets, particularly in rural areas.

None of this is surprising. Indeed, as set forth above, Congress was well aware that, in the absence of an enforceable promise of payments under the risk-corridors program, these effects were entirely predictable.

3. Congress's correct expectations support the inference that Congress intended that payments would be made even if it did not separately appropriate funds to do so.

As the court of appeals recognized, section 1342 of the ACA "is unambiguously mandatory" in its requirement that the government "'*shall* pay'" the risk-corridors obligations at issue, and it contains no indication "that the payment methodology is somehow limited by payments in." *Moda* Pet. App. 17 (emphasis in original; quoting 42 U.S.C. § 18062).

The mandatory phrasing of section 1342 reflects Congress's understanding that insurers and insurance regulators would rely on risk-corridors payments as enforceable promises. That supports inferring that Congress intended state regulators and insurance companies to be able to rely on the expectation that the mandated payments would be made, even if Congress did not separately appropriate funds for that purpose. Put slightly differently, Congress *intended* the statutorily mandated payments to create a fully enforceable obligation and promise.

As a fully enforceable obligation and promise, those payments are not limited, as the government has consistently argued, by a requirement of budget neutrality—that is, a requirement that payments to

insurers be limited to funds received under the portion of the risk-corridors program requiring payments in from other insurers who collected premiums in excess of benefits paid. (*See* Cert. Opp. 5, 30). Even if Congress anticipated that the program would end up being budget neutral, see *Moda* Pet. App. 6, Congress did not intend budget neutrality to be a condition of payment. As set forth above, Congress conceived of the risk-corridors program as one in which the federal government shared risk with insurers, and risk-sharing means taking on an obligation to pay money beyond funds collected. Those payments amounted to subsidies by which Congress intended to shoulder some of the risk that would otherwise translate into risk premiums and higher insurance rates.

No contrary inference can be drawn from Congress's failure to appropriate specific additional funds to cover the risk-corridors payments if the program turned out not to be budget-neutral. Under *United States v. Langston*, 118 U.S. 389 (1886), a statutorily owed obligation can be owed independently of any budget authority and independently of a sufficient appropriation to meet the obligation, as the court of appeals correctly explained. *Moda* Pet. App. 19–20. Because Congress mandated risk-corridors payments to entice insurance companies into an untested marketplace without setting unreasonable high rates, the mandate creates an enforceable obligation even if Congress did not separately appropriate funds for the mandated payments. And in the absence of any other source of funding for those mandated payments, the Judgment

Fund was available. *See* 31 U.S.C § 1304(a) ("Necessary amounts are appropriated to pay final judgments, awards, compromise settlements, and interest and costs specified in the judgments or otherwise authorized by law" when "payment is not otherwise provided for" and other conditions are satisfied.).

B. Congress did not implicitly repeal the federal government's obligation to make risk-corridors payments.

Having made an enforceable promise with the understanding that it was fundamental to the success of the ACA and its state insurance marketplaces, Congress did not renege on that promise by burying an implicit new requirement—that the risk-corridors program be budget neutral—in appropriations riders.

The appropriations riders at issue did not purport to change the payment methodology or impose a new requirement of budget neutrality. To the contrary, their text did nothing more than prevent *certain* appropriations or funds from being diverted to pay for the risk-corridors program:

> None of the funds made available by this Act from the Federal Hospital Insurance Trust Fund or the Federal Supplemental Medical Insurance Trust Fund, or transferred from other accounts funded by this Act to the "Centers for Medicare and Medicaid Services—Program Management" account, may be used for payments under Section 1342(b)(1) of Public Law 111–148 (relating to risk corridors).

Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, § 227, 128 Stat. 2130, 2491. Those riders establish only that Congress did not want to fund risk-corridors payments by diverting money from certain important programs. But that intent is very different from an intent to renege on promised risk-corridors payments altogether if they could not be fully funded by incoming payments under that program. Nothing in the appropriations riders suggests that Congress wanted to eliminate the obligation to make risk-corridors payments from other sources, including if necessary, the Judgment Fund.

Notwithstanding the appropriations riders' failure to require budget neutrality, the federal government would infer such a requirement from those enactments as an implicit repeal of the ACA's enforceable promise to make risk-corridors payments in amounts mandated by statutory formula. But the government's inferred repeal violates the "cardinal rule that repeals by implication are not favored" and that "the intention of the legislature to repeal must be clear and manifest," particularly "when the claimed repeal rests solely on an Appropriations Act." *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 189 (1978) (quotations omitted; discussing similar prudential concerns about the legislative process).

That cardinal rule disfavoring implicit repeals applies with particular force in this case for at least three related reasons.

First, this case involves a putative repeal by means of an implicit statutory amendment—that is, one requiring budget neutrality—that Congress

rejected as substantive legislation. Congress expressly considered and rejected stand-alone legislation to implement precisely the budget-neutral framework that the government has advanced. In 2014, a bill was introduced that proposed amending section 1342 by adding the following provision:

> In implementing this section, the Secretary shall ensure that payments out and payments in under paragraphs (1) and (2) of subsection (b) are provided for in amounts that the Secretary determines are necessary to reduce to zero the cost . . . to the Federal Government of carrying out the program under this section.

Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong., § 2(d) (2014); *see also Moda* Pet. App. 49–50 & n.3 (Newman, J., dissenting) (discussing same). When faced with an opportunity to expressly impose a requirement of budget neutrality on the risk-corridors program, Congress balked—the proposed bill was not enacted. *Moda* Pet. App. 49–50 (Newman, J., dissenting).

Second, the implicit repeal urged here would have the effect of not just amending but significantly impairing the ACA—which cannot reasonably be described as anything less than a "highly significant law." *See Sinclair Refining Co. v. Atkinson*, 370 U.S. 195, 210 (1962), *overruled on other grounds by Boys Mkts., Inc. v. Retail Clerks Union, Loc.* 770, 398 U.S. 235 (1970) ("When the repeal of a highly significant law is urged upon that body and that repeal is rejected after careful consideration and discussion, the normal expectation is that courts will be faithful to their trust and abide by that decision."). Just as

Congress knew that the ACA's success required risk-corridors payments and therefore intended to create an enforceable obligation to make those payments—as argued above—it also knew that repealing that obligation would undermine the ACA's success by destabilizing settled expectations in insurance markets. Having invited insurers and regulators to rely on the promise of risk-corridors payments, Congress is unlikely to have reneged on that promise or to have intended to amend the ACA in such a far-reaching and self-defeating way. For that reason, this Court should not infer such an amendment in the absence of legislation expressly repealing the obligation to make risk-corridors payments.

Third, the government's reliance on an implicit repeal undermines the goals of transparency and political accountability. This Court should not presume that Congress intended to use an ambiguous appropriations rider to obscure from voters whom they should "credit or blame" for the "benefits and burdens" of such a significant change to the law. *See Murphy v. NCAA*, 138 S. Ct. 1461, 1477 (2018). If this Court were to conclude that Congress eliminated risk-corridors payments through that rider rather than through express and clear legislation, it would allow Congress to shift the political consequences of those amendments onto the judicial branch or state regulators. The public would be left with the impression not that Congress eliminated a core element of the ACA, but rather that judges did. They also would be left with the impression not that Congress reneged on a promise it invited regulators to rely upon, but rather that state regulators failed to

ensure fiscally responsible rate-setting in the insurance market and therefore were to blame for resulting insurance bankruptcies and rising insurance rates. Such concerns about transparency and accountability in the legislative process are precisely what animates *Tennessee Valley*'s "cardinal rule" against repeals by implication. This Court should adhere to that rule here.

CONCLUSION

The Court should reverse the court of appeals' decisions.

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