No. _____

In the
# Supreme Court of the United States

MODA HEALTH PLAN, INC.,
*Petitioner*,
v.
UNITED STATES,
*Respondent*.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
*Petitioner*,
v.
UNITED STATES,
*Respondent*.

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

## PETITION FOR WRIT OF CERTIORARI


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## QUESTION PRESENTED

To encourage health insurers to offer insurance on newly created health benefit exchanges, and to keep premiums low, the federal government made an unambiguous statutory commitment: If the costs of claims under these new health insurance policies exceeded the premiums charged in the first three years, the government would reimburse insurers a specified percentage of the difference. Numerous health insurers, including petitioners, relied on that promise, joined the exchanges, set their premiums, and incurred significant losses in providing health coverage. Congress later enacted a series of appropriations riders restricting the sources of funds available to the Department of Health and Human Services ("HHS") to pay insurers what was owed, but never amended the underlying statute. A divided Federal Circuit panel agreed that the government's initial statutory commitment was unambiguous, but relied on legislative history to hold the appropriations riders had repealed the statutory guarantee. The net effect was a bait-and-switch of staggering dimensions in which the government has paid insurers $12 billion less than what was promised.

The question presented is:

Whether Congress can evade its unambiguous statutory promise to pay health insurers for losses already incurred simply by enacting appropriations riders restricting the sources of funds available to satisfy the government's obligation.

## PARTIES TO THE PROCEEDING

*Moda Health Plan, Inc. v. United States*: Petitioner Moda Health Plan, Inc. was plaintiff in the Court of Federal Claims and appellee in the Federal Circuit. Respondent United States was defendant in the Court of Federal Claims and appellant in the Federal Circuit.

*Blue Cross and Blue Shield of North Carolina v. United States*: Petitioner Blue Cross and Blue Shield of North Carolina was plaintiff in the Court of Federal Claims and appellant in the Federal Circuit. Respondent United States was defendant in the Court of Federal Claims and appellee in the Federal Circuit.

## CORPORATE DISCLOSURE STATEMENT

Petitioner Moda Health Plan, Inc. is owned by Moda, Inc., which in turn is owned by Oregon Dental Service.

Petitioner Blue Cross and Blue Shield of North Carolina has no parent corporation, and no publicly held company owns 10% or more of its stock.

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## PETITION FOR WRIT OF CERTIORARI

This petition arises out of a massive government bait-and-switch. The Patient Protection and Affordable Care Act ("ACA") created new "health benefit exchanges" on which previously uninsured individuals could buy health insurance. Because no reliable historical data about the medical costs typically incurred by these new consumers were available, insurers faced significant risk if they offered policies on the newly created exchanges, which ordinarily would have translated into high premiums to account for uncertain costs. To encourage insurers both to participate and to offer relatively affordable policies despite those risks, §1342 of the ACA established a program for the first three years of the exchanges' operation in which the government committed to partially reimburse participating insurers whose costs exceeded their premiums. Like numerous other insurers, petitioners responded exactly as Congress intended, participating in the exchanges and charging lower premiums than they would have absent the government's commitment to share some of the risk.

Shortly before the exchanges opened and after premiums for the first year (2014) were already set, the Department of Health and Human Services ("HHS") unilaterally altered its policies in ways that caused far fewer relatively healthy individuals to purchase insurance on the exchanges. As a direct and predictable result, participating insurers suffered far greater losses than anticipated. Rather than honoring its now-more-substantial commitment, Congress limited the source of funds available to HHS to fulfill

the government's promise. In December 2014, after petitioners had already provided insurance through the exchanges for nearly a year, and had already set premiums for the following year, Congress included an appropriations rider in HHS' annual appropriations bill providing that "[n]one of the funds made available by this Act … may be used" for payments under §1342. Based on that appropriations rider and identical riders enacted for the following two fiscal years, HHS has refused to pay insurers (including petitioners) more than $12 billion in payments that were promised under §1342 to offset a portion of the losses these insurers actually incurred in providing coverage to consumers.

While the Court of Federal Claims recognized this impermissible bait-and-switch for what it was and ordered the federal government to honor its commitment to Moda, a divided panel of the Federal Circuit reversed. The majority recognized that §1342 "unambiguously" obligated the government to make the full payments owed. But it nevertheless held that the later-enacted appropriations riders expressed a "clear intent" to override that unambiguous obligation—an intent that the majority divined not from the text of the riders (which simply restricted one source of funds to honor the commitment), but from two snippets of purported legislative history. That holding disregards literally centuries of precedent holding that a later statute cannot be construed to repeal or suspend an earlier one unless that construction is "necessary and unavoidable." *Harford v. United States*, 12 U.S. (8 Cranch) 109, 109-110 (1814) (Story, J.); *see Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018). That principle is supposed to

apply with especial force when, as here, the latter statute is an appropriations measure and the former is a substantive commitment. To state the obvious, legislative history cannot satisfy that demanding test, and the decision below cannot be reconciled with this Court's precedents.

That $12 billion error alone cries out for this Court's review. But the consequences of the divided decision extend much further. By giving judicial approval to the government's egregious disregard for its unambiguous statutory and contractual commitments, the decision provides a roadmap for the government to promise boldly, renege obscurely, and avoid both financial and political accountability for depriving private parties of billions in reliance interests. That the decision emanates from the court with exclusive jurisdiction over financial claims against the government only underscores the need for this Court's review. There is no prospect of further percolation; there is only the certainty of further damage. The Court should grant certiorari.

## OPINIONS BELOW

The Federal Circuit's opinion in *Moda* is reported at 892 F.3d 1311 and reproduced at App.1-60. The Court of Federal Claims' opinion in *Moda* is reported at 130 Fed. Cl. 436 and reproduced at App.85-152.

The Federal Circuit's opinion in *BCBSNC* is reported at 729 F. App'x 939 and reproduced at App.61-62. The Court of Federal Claims' opinion in *BCBSNC* is reported at 131 Fed. Cl. 457 and reproduced at App.153-206.

The Federal Circuit's order denying rehearing in both cases is reported at 908 F.3d 738 and reproduced at App.63-84.[1]

## JURISDICTION

The Federal Circuit issued its divided opinion in *Moda* on June 14, 2018, and its *BCBSNC* disposition on July 9, 2018. The Federal Circuit denied rehearing in both cases on November 6, 2018. This Court has jurisdiction under 28 U.S.C. §1254(1).

## STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the appendix.

## STATEMENT OF THE CASE

### A. Factual and Statutory Background

1. The ACA aimed to extend health insurance coverage to millions of previously uninsured and underinsured Americans. To that end, the ACA established new "health benefit exchanges" on which individuals and small groups could purchase health insurance from participating insurers. 42 U.S.C. §18031(b)(1). These exchanges were intended to provide uninsured or underinsured individuals with easy access to the health insurance market, and to encourage competition among insurers for those new customers. App.2-3.

That plan, however, faced a substantial hurdle. To succeed, the exchanges needed to attract insurers willing to offer affordable plans to large numbers of previously uninsured or underinsured buyers. But

[1] Pursuant to Rule 12.4, this petition seeks review of two Federal Circuit decisions that raise identical issues.

precisely because those new customers were not already participating in the health insurance market, insurers "lacked reliable data to estimate the cost of providing care for th[is] expanded pool of individuals," and so faced "significant risk" if they chose to offer plans on the exchanges. App.2. That risk created a strong incentive for insurers to avoid the new exchanges altogether. Alternatively, insurers could charge high premiums to compensate for that risk, but that would undermine the ACA's goal of providing a more affordable option and make promised tax subsidies for individuals buying insurance on the exchanges far more expensive for the government.

2. To address this problem, Congress enacted, *inter alia*, the "risk corridors" program at issue here. Under that program, the government committed to share part of the risk of providing insurance on the exchanges for the first three years after they began operating. Specifically, §1342 of the ACA instructed HHS to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016." 42 U.S.C. §18062(a). The program was designed around a "payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." *Id.* For any participating plan whose costs for exchange-based policies exceeded 103% of its premiums received, §1342 provided that HHS "shall pay" the plan based on a prescribed formula that would compensate the plans for a subset of their actual losses. *Id.* §18062(b)(1).[2] Conversely, for any

[2] To be precise, for plans whose "allowable costs" were more than 103% but not more than 108% of their "target amount," §1342 committed the government to pay the plan half of the

participating plan whose costs of providing coverage were less than 97% of its premiums received, §1342 provided that the plan "shall pay" the government a portion of those excess profits. *Id.* §18062(b)(2). By committing the government to share the risk that individuals buying insurance on the exchanges might have higher healthcare costs than anticipated, §1342 encouraged insurers to offer plans on the new exchanges and "discourage[d] insurers from setting higher premiums to offset that risk." App.2.

In 2012, HHS promulgated regulations to govern the program. Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220 (Mar. 23, 2012) (codified at 45 C.F.R. Pt. 153, Subpart F). HHS followed up in 2013 with another more detailed rulemaking. HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410 (Mar. 11, 2013). The 2013 rulemaking plainly provided that the government's obligation to make payments to insurers with excess costs was not conditional on the extent of payments in by insurers with excess premiums. As HHS explained, the "program is not statutorily required to be budget

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allowable costs above that 103% threshold. 42 U.S.C. §18062(b)(1)(A). For plans whose "allowable costs" were more than 108% of their "target amount," §1342 committed the government to pay 2.5% of the "target amount" (which corresponds to half the allowable costs between 103% and 108%), plus 80% of allowable costs above the 108% threshold. *Id.* §18062(b)(1)(B). "Allowable costs" are "the total costs (other than administrative costs) of the plan in providing benefits covered by the plan," while the "target amount" is the "total premiums … reduced by the administrative costs of the plan." *Id.* §18062(c)(1)-(2).

neutral," and "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342," *id.* at 15,473.

Petitioners and numerous other insurers responded to that government commitment exactly as Congress intended, relying on it to offer qualified health plans on the new exchanges at relatively affordable rates that in turn reduced the government's fiscal outlays on tax subsidies to finance the premiums. *See* App.95. Petitioner Moda Health Plan, Inc. ("Moda") became a leading insurer on the exchanges, designing and selling plans in Alaska, Oregon, and Washington that covered some 121,000 individuals in 2014 alone, and enrolling more individuals through the Oregon exchange than any other insurer in 2014 and 2015. Compl. ¶6, *Moda* Cl.Ct.Dkt.1. Petitioner Blue Cross and Blue Shield of North Carolina ("BCBSNC") likewise took a leading role on the exchanges as the largest plan participating in the North Carolina ACA market in 2014 and the only one to offer ACA plans in all 100 counties in North Carolina. Compl. ¶27, *BCBSNC* Cl.Ct.Dkt. 1.

Despite the inherent risk of offering insurance to a new population with no reliable healthcare-cost data, petitioners and other insurers stepped up based on the repeated assurances that the government would honor its statutory obligation to share the downside risk if the premiums collected were inadequate to cover the costs incurred. And because the extent of inflows and outflows under the new statutory scheme were as unpredictable as the risk profile of the newly created market, insurers relied not just on the government's unambiguous promise to pay,

but also on its assurance that payments out to insurers were not dependent on the extent of payments in, or whether the program was "budget-neutral."

3. By its terms, the ACA required health plans to comply with its new requirements by January 1, 2014. *See* Pub. L. No. 111-148, 124 Stat. 119 §1255 (2010). Accordingly, healthy individuals with cheaper and more minimal health plans that were not ACA-compliant should have been obligated to buy ACA-compliant policies on the exchanges as of that date. But in November 2013—after insurers had already agreed to participate in the exchanges and their premiums had been set for the next year—HHS unilaterally announced a "transitional policy" allowing individuals to remain on their existing health plans even if those plans were not ACA-compliant. App.8.

That unexpected policy change had a marked and predictable effect on the ACA exchanges. By allowing individuals with bare-bones health insurance to keep their existing plans, the transitional policy "dampened … enrollment" on the exchanges, "especially by healthier individuals who elected to maintain their [existing] lower level of coverage." App.8. And because the announcement came after premiums had been set, it "le[ft] insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums." App.8. HHS recognized its sudden policy shift "was not anticipated by health insurance issuers when setting rates for 2014," but reassured insurers that "the risk

corridor program should help ameliorate unanticipated changes in premium revenue." App.9.

4. To date, that reassurance has proved empty. In light of HHS' unanticipated "transitional policy," it quickly became clear that most insurers would suffer far greater losses from participating in the exchanges than expected—and that the government would correspondingly owe far greater risk corridor payments. The transitional policy and the corresponding change in the risk profile of those buying insurance on the exchanges also meant that fewer insurers would collect premiums in excess of costs—*i.e.*, there would be fewer "payments in" to the government than anticipated. The government's unilateral policy change thus made its statutory obligation to pay insurers for excess losses both more onerous in absolute terms and less "budget-neutral." But instead of honoring the government's commitment to cover that higher-than-expected cost reflected in actual losses by insurers (and actual savings to the government via reduced tax subsidies), Congress and the Executive attempted to shift blame for the shortfall.

In December 2014—after petitioners and other insurers not only had provided insurance on the exchanges for 2014, but had already set rates for 2015—Congress inserted a rider into the annual appropriations bill for fiscal year 2015 providing that "[n]one of the funds made available by this Act … may be used" to make payments under §1342. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227, 128 Stat. 2130, 2491 (2014). Congress then enacted identical riders

for the following two fiscal years. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, §225, 129 Stat. 2242, 2624 (2015); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, §223, 131 Stat. 135, 543 (2016).

As might be expected from a rider in an appropriations act, each of these riders was expressly limited to the "funds made available by this Act," without expressly addressing the underlying obligation to pay or whether funds from other sources could be used to cover that obligation. Nonetheless, based on those riders, HHS refused to pay insurers the full amounts due under §1342 for their annual losses in providing insurance through the exchanges in 2014, 2015, and 2016. Instead, HHS tapped only the relatively modest funds paid in by excess-premium insurers, and paid out only a small pro rata share of the government's total obligation to the excess-cost insurers. HHS thus continued to recognize the broader universe of payment obligations (which formed the denominator of its pro rata payments), but based on the appropriations riders actually only paid out a small pro rata share reflecting the extent of payments in by excess-premium insurers. App.13-14. *See*, *e.g.*, App.106 (quoting HHS communication expressly recognizing that §1342 "requires the Secretary to make full payments to issuers, and that HHS is recording those amounts that remain unpaid following our 12.6% payment"). Over the three-year life of the program, HHS refused to pay insurers more than *$12 billion*. App.14, 167-68.

The government's refusal to pay had a dramatic impact on petitioners and other insurers, as well as

their customers. Moda, for instance, was owed more than $210 million under §1342 for 2014 and 2015; when the government reneged on those payments, Moda was forced to withdraw from providing ACA plans in Alaska (eliminating any competition on Alaska's exchange), and was placed under supervision by the Oregon Department of Consumer and Business Services. It escaped receivership, and remained able to provide insurance in Oregon, only by raising $165 million in additional private capital. Compl. ¶¶64-67, *Moda* Cl.Ct.Dkt.1.; Jeff Manning, *Moda Sues U.S. Government Demanding Promised $180 Million*, OregonLive, June 1, 2016, https://bit.ly/2R6Xff3. BCBSNC likewise suffered heavily from the government's decision, losing $130 million for 2014 and over $215 million for 2015. App.188; *BCBSNC* C.A.App.1023.

### B. Proceedings Below

1. Petitioners (and dozens of other insurers) filed suits against the United States in the Court of Federal Claims to recover the payments they were owed under the unambiguous language of §1342. The court ruled for Moda, holding that as a matter of both statute and contract, the government could not induce Moda into participating in the exchanges by making a clear commitment to share risk only to subsequently repudiate that commitment through a series of ambiguous appropriations riders. App.152. Shortly thereafter, a different judge ruled for the government

in the suit brought by BCBSNC. App.188-204. Appeals followed in both cases.[3]

2. In *Moda*, a divided panel of the Federal Circuit reversed. The majority rejected the government's dubious claim that §1342 does not impose any obligation, instead agreeing with the Court of Federal Claims that §1342 is "unambiguously mandatory" and "obligated the government to pay the full amount of risk corridors payments according to the formula it set forth." App.16. Notwithstanding that clear mandate, however, the majority concluded that the later appropriations riders had unilaterally "repealed or suspended" that obligation. App.21.

The majority acknowledged the bedrock rule that "[r]epeals by implication are generally disfavored," App.21, which carries "'especial force' when the alleged repeal occurred in an appropriations bill," App.25 (quoting *United States v. Will*, 449 U.S. 200, 221-22 (1980)). It likewise recognized the century-old rule that whether a later law repeals an earlier one depends on "the intention of [C]ongress as expressed in the statutes." App.21 (alteration in original) (quoting *United States v. Mitchell*, 109 U.S. 146, 150 (1883)). But instead of focusing on the text of the riders, the majority relied on two pieces of purported

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[3] Other decisions reached disparate outcomes. *See Me. Cmty. Health Options v. United States*, 133 Fed. Cl. 1 (2017) (holding appropriations riders "nullif[ied]" the "otherwise … binding commitments" of §1342); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 106 (2016) (finding §1342 ambiguous and applying *Chevron* deference to dismiss insurer's claims). Those decisions were appealed and disposed of based on the Federal Circuit's decision in *Moda*.

legislative history to conclude that Congress had "clearly indicated its intent" to "suspen[d]" the obligation imposed by §1342. App.26, 27 n.6.

First, the majority noted that in February 2014, two members (or more likely their staffers) asked the Government Accountability Office ("GAO") to identify the funds available to HHS to make payments under §1342, and the GAO had identified two sources: HHS' annual lump-sum appropriation and incoming payments from excess-premium insurers. App.11-12, 26. According to the majority, that inquiry and response indicated that when Congress decided several months later to restrict HHS from using its annual lump-sum appropriation to make the payments, it must have meant to limit the underlying substantive obligation to the amount of the incoming payments. App.26-27.

Second, the majority relied on two sentences from an immense 700-page "explanatory statement" submitted by Representative Harold Rogers, then-chair of the House Appropriations Committee, addressing all manner of provisions included in the fiscal year 2015 appropriations bill. App.12-13, 25-26. Those two sentences noted that HHS had predicted that the risk corridor program would be "budget neutral" and stated that the appropriations rider would prevent the annual lump-sum appropriation to HHS from being used to make risk corridor payments. App.12-13, 26 (citing 160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014)). That legislative history sufficed, in the majority's view, to show Congress' "clear intent" to supersede the plain text of §1342. App.39.

The majority acknowledged that its result was arguably "inconsistent with the purpose of the risk corridors program," as it jettisoned the firm government commitment that had induced insurers to participate in the exchanges. App.34. But the majority dismissed that as a mere "policy choice" by Congress. App.35.

Finally, the majority rejected Moda's alternative argument that the government committed a breach of contract by reneging on its obligation. According to the majority, "no statement by the government evinced an intention to form a contract." App.38. Instead, the majority concluded that "[t]he statute, its regulations, and HHS's conduct all simply worked towards crafting an incentive program." App.38.

3. Judge Newman dissented. She agreed that the government's commitment to make payments to excess-cost insurers was unambiguous, but unlike the majority, she would have "held the government to its statutory and contractual obligations." App.41, 46. As she explained, the majority identified "no statement of abrogation or amendment of [§1342]" and "no disclaimer by the government of its statutory and contractual commitments." App.50. Given the "cardinal rule … that repeals by implication are disfavored," App.47 (quoting *Posadas v. Nat'l City Bank*, 296 U.S. 497, 503 (1936)), particularly "when … the subsequent legislation is an *appropriations* measure," App.47 (ellipsis in original) (quoting *Tenn. Valley Auth. v. Hill*, 437 U.S. 153, 190 (1978)), Judge Newman concluded that neither the language nor the legislative history of the

appropriations riders could be read to supersede §1342.

In fact, Judge Newman noted, the broader legislative history supported the opposite result. When faced in 2014 with a bill that would have expressly limited outgoing payments under §1342 to the amount of incoming payments, Congress specifically rejected that proposal. App.49-50 & n.3. That history cast considerable doubt on the majority's conclusion that Congress *sub silentio* meant for its later appropriations riders to have the same effect as the bill Congress had rejected. App.50.

Judge Newman concluded that the nature of the program weighed heavily against reading the riders to "den[y] the legislative commitment of the government and the contractual understanding between the insurers and [HHS]." App.57. In her view, that history sufficed to "negate any after-the-fact implication" that the riders were intended to "have retroactive effect on obligations already incurred and performance already achieved." App.57-58. By concluding otherwise, she explained, the majority's decision "undermines the reliability of dealings with the government." App.60. Finally, Judge Newman agreed with the Court of Federal Claims that "the risk corridors statute is binding contractually," thus supporting Moda's breach of contract claim. App.59.

5. After issuing its divided opinion in *Moda*, the panel summarily affirmed in *BCBSNC*. App.61-62. Moda and BCBSNC each sought rehearing. In November 2018, the Federal Circuit denied rehearing en banc, over dissents from Judge Newman and Judge Wallach (each of whom joined the other's dissent).

Judge Newman emphasized the "national impact" of the majority's decision, App.66, not only in terms of the "significant harm to insurers who participated in the [ACA] program," App.68, but from its broader effects on government contracting. As she explained, government contracting "depends on trust in the government as a fair partner." App.67. Absent that trust, "would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." App.68-69 (quoting *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012)). By allowing the government to "renege on its legislated and contractual commitments," the majority endorsed conduct that is "hardly worthy of our great government." App.68 (quoting App.152).

Judge Wallach agreed. After detailing the flaws in the panel majority's reasoning, he emphasized that these cases raise an "exceptionally important issue regarding the government's reliability as an honest broker." App.82. "To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government's credibility as a reliable business partner." App.83. Given the "important consequences" of the government's "refusal to honor its obligations," Judge Wallach concluded, the majority's rulings warranted further review. App.83.

## REASONS FOR GRANTING THE PETITION

The divided decision below gives judicial imprimatur to a $12 billion bait-and-switch. The bait was unambiguous: As the majority recognized, §1342 plainly and textually committed the government to

make the promised payments to insurers that ventured onto the new exchanges. The switch, by contrast, was a muddle: Nowhere did Congress clearly proclaim and become accountable for reneging on its substantive commitment. Instead, the majority was forced to rely on purported legislative history relating to the supposed import of appropriations riders that by their terms merely limited the source of funds to honor the commitment.

The decision below conflicts with this Court's precedents and makes a mockery of the presumption against implied repeals. The Court has emphasized time and again that implied repeals are generally disfavored, and that implied repeals via appropriations riders are particularly so. By finding an implied repeal of a substantive commitment based on the legislative history of appropriations riders that on their face did no more than limit funding sources, the majority failed to heed that precedent. Worse still, the decision leaves the government wholly unaccountable—financially or politically. It is far from clear that the Due Process and Takings Clauses allow the government to lure private parties into expensive undertakings with clear promises, only to renege after private parties have relied to their detriment and incurred actual losses. But if the government does possess that inequitable power, it must be politically accountable for wielding it. By allowing the government to vitiate a clear textual commitment to pay with ambiguous legislative history about how it will pay, the decision below creates the worst of both worlds: The government can destroy billions of dollars in reliance interests without even being squarely accountable for the destruction of those

interests, or the resulting ramifications on the marketplace.

As both Judge Newman and Judge Wallach recognized, the importance of the issues presented exceed even their $12 billion price tag. The government's decision to renege on its commitments under §1342 has had a dramatic effect on the national health insurance market, driving numerous insurers out of business (with an attendant reduction in competition), forcing others to substantially increase their premiums, and leaving millions of individuals scrambling to find new insurance. By upholding the government's bait-and-switch, the Federal Circuit has not only perpetuated that uncertainty in the healthcare market, but cast serious doubt on the government's reliability as a business partner. And because the Federal Circuit has exclusive jurisdiction over claims against the United States for money damages, *see* 28 U.S.C. §1491(a)(1), these issues cannot benefit from continued percolation; they can be resolved only by this Court. The Court should grant certiorari.

## I. The Federal Circuit's Decision, Which Will Govern All Cases Involving Government Payment Obligations, Cannot Be Reconciled With This Court's Precedents.

As the en banc dissenters and the Court of Federal Claims recognized, the decision below cannot be reconciled with this Court's precedents. The majority began on the right track, recognizing that §1342 created an "unambiguously mandatory" obligation—namely, that the government would make the promised payments to the excess-cost insurers.

App.16. By instructing HHS that it "shall pay" insurers the amounts described, "the plain language of section 1342 created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula." App.20. As the majority recognized, that obligation was specifically designed to induce insurers to participate in the exchanges and to offer affordable plans "without a risk premium to account for the unreliability of data relating to participation [on] the exchanges." App.37. And there can be no serious dispute that insurers were induced by and did rely on that obligation and incurred actual losses. App.81.

At that point, however, the majority went astray. Despite the unambiguous language of §1342, and its recognition that implied repeals are disfavored, the majority allowed ambiguous legislative history to override a clear textual commitment. App.26-27. That holding cannot be squared with this Court's precedents.

### A. Congress Did Not Eliminate the Government's Obligations Under §1342 With the Clarity Demanded by This Court's Precedents.

1. As this Court has recognized from the earliest days of the Republic, a "repeal by implication ought not to be presumed" unless the statutory language makes it "necessary and unavoidable." *Harford*, 12 U.S. (8 Cranch) at 109-110 (Story, J.); *see, e.g.*, *Epic*, 138 S. Ct. at 1624; *Cook Cty. v. United States ex rel. Chandler*, 538 U.S. 119, 132 (2003); *Hill*, 437 U.S. at 189-90; *Morton v. Mancari*, 417 U.S. 535, 549 (1974);

*United States v. Borden Co.*, 308 U.S. 188, 198 (1939).[4] Accordingly, "[a] party seeking to suggest that two statutes cannot be harmonized, and that one displaces the other, bears the heavy burden of showing 'a clearly expressed congressional intention' that such a result should follow." *Epic*, 138 S. Ct. at 1624 (quoting *Vimar Seguros y Reaseguros, S.A. v. M/V Sky Reefer*, 515 U.S. 528, 533 (1995)).

That rule "applies with even *greater* force when the claimed repeal rests solely on an Appropriations Act." *Hill*, 437 U.S. at 190. Unlike substantive provisions in authorizing legislation, appropriations measures "have the limited and specific purpose of providing funds for authorized programs," and lawmakers voting on them are "entitled to operate under the assumption" that they will be interpreted as addressing *how* to pay for authorized programs, rather than reopening or revisiting the underlying authorization itself. *Id.* For that reason, "the rules of both Houses limit the ability to change substantive law through appropriations measures." *Will*, 449 U.S. at 484; *see* H. Rule XXI.2(b) ("A provision changing existing law may not be reported in a general appropriation bill[.]"); *accord* S. Rule XVI. Without that limiting principle, authorizing committees and appropriations committees would be in constant battle, as "every appropriations measure would be pregnant with prospects of altering substantive legislation … requiring Members to review exhaustively the background of every authorization

[4] In fact, the principle is almost 200 years older than this Court. *See Dr. Foster's Case*, 77 Eng. Rep. 1222, 1228-29, 1232-33 (K.B. 1614) (Coke, L.J.).

before voting on an appropriation." *Hill*, 437 U.S. at 190. Worse still, allowing Congress to effectuate an implied repeal through an ambiguous appropriations rider would only encourage "clever legislators" to attempt "an end-run around the substantive debates that a repeal might precipitate" by "burying [the] repeal in a standard appropriations bill." App.47 (quoting App.132).

To avoid those untoward outcomes, this Court has long held that if Congress wishes to repeal a substantive law through an appropriations measure, it must do so clearly and textually, using "words that expressly, or by clear implication, modif[y] or repeal[] the previous law." *United States v. Langston*, 118 U.S. 389, 394 (1886). Absent such "express words of repeal, or … such provisions as would compel the courts to say that harmony between the old and the new statute was impossible," a later appropriations rider cannot be read to alter the substantive obligations created by an earlier enactment. *Id.*; *see, e.g.*, *Hill*, 437 U.S. at 190 ("[I]n the absence of some affirmative showing of an intention to repeal, the only permissible justification for a repeal by implication is when the earlier and later statutes are irreconcilable." (quoting *Mancari*, 417 U.S. at 550)). Instead, such a rider "merely imposes limitations upon the Government's own agents," but does not "pay the Government's debts, nor cancel its obligations." *Ramah Navajo*, 567 U.S. at 197 (quoting *Ferris v. United States*, 27 Ct. Cl. 542, 546 (1892)); *see Belknap v. United States*, 150 U.S. 588, 594 (1893) ("mere failure to appropriate" is "not, in and of itself alone, sufficient to repeal the prior act").

2. Although the majority below paid lip service to the presumption against implied repeals, *see* App.21, its conclusion that the presumption was overcome by the appropriations riders here is fundamentally incompatible with this Court's precedents. The majority allowed ambiguous legislative history to do work that, under this Court's precedents, only clear legislative text can accomplish.

The majority never claimed to have discovered any language in the text of the appropriations riders that "expressly, or by clear implication," repealed or suspended §1342. *Langston*, 118 U.S. at 394. Nor could it, as those riders provided only that "[n]one of the funds made available *by this Act*" should be used for payments under §1342. App.12 (emphasis added) (quoting 128 Stat. at 2491); *see* 129 Stat. at 2624; 131 Stat. at 543. Thus, as one would expect from an appropriations measure, the riders simply put a limit on the funds appropriated by that particular annual appropriations bill. They said nothing whatsoever about repealing, revising, or suspending the underlying substantive obligation created by §1342. As Judge Wallach put it, the riders "do not address *whether the obligation remains payable*," but "at most, only address *from whence the funds to pay the obligation may come*." App.76.

That conclusion is powerfully reinforced by considerations of timing and chronology. Section 1342 was enacted in 2010 and obligated the government to make payments for the first three years of the exchanges' operation—2014, 2015, and 2016. The first of the appropriations riders was not enacted until December 2014, and it addressed appropriations for

fiscal year 2015. At that point, the government's obligation for 2014 was already incurred. While a rider on an act appropriating funds for FY2015 could be readily understood to address how an obligation incurred in 2014 could be satisfied, it would not, absent the clearest of language, be understood to try to make an already-incurred obligation simply disappear. Indeed, it is not at all clear that the government could retroactively disavow an obligation already incurred that had occasioned significant reliance interests without violating the Due Process Clause, the Takings Clause, or both. Accordingly, reading the appropriations riders as repealing the substantive payment obligation implicates not just the presumption against implied repeals, but the presumption against retroactivity and the canon of constitutional avoidance as well. And this issue is not limited to the 2015 appropriations rider and the 2014 obligation, as the text of each of the three appropriations ridesrs address only the expenditure of funds appropriated for the next fiscal year. None textually suggested that it revisited, repealed, or suspended obligations already incurred.

It should come as little surprise, then, that the majority paid practically no attention to the text of the appropriations riders, and instead focused on legislative history. App.25-27. That alone puts the decision below in irreconcilable conflict with the Court's precedents. To state the obvious, legislative history cannot provide the clear "intention of Congress *as expressed in the statutes*" that is necessary to demonstrate an implied repeal. *Will*, 449 U.S. at 222 (emphasis added); *cf. Aldridge v. Williams*, 44 U.S. (3 How.) 9, 24 (1845) ("The law as it is passed is the will

of the majority of both houses, and the only mode in which that will is spoken is in the act itself."). The majority's contrary conclusion is reason enough for this Court's review. Indeed, the use of legislative history is especially pernicious in this context. One of the principal concerns with reliance on legislative history is that it risks enabling "unrepresentative committee members—or, worse yet, unelected staffers and lobbyists—[with] both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text." *Exxon Mobil Corp. v. Allapattah Servs. Inc.*, 545 U.S. 546, 568 (2005). Those concerns are at their zenith when the result secured is the repeal of a prior act of Congress that did comply with the constitutional requirements of bicameralism and presentment.

But even if the legislative history of an appropriations measure could suffice to repeal a substantive obligation, the paltry legislative history invoked below is not remotely up to the task. *Cf. United States v. Kwai Fun Wong*, 135 S. Ct. 1625, 1633 (2015) ("[E]ven assuming legislative history alone could provide a clear statement (which we doubt), none does so here.").

The majority first invoked a novelty even in the soft science of legislative history: a back-and-forth between two members (or more likely their staffers) and the GAO culminating in a GAO report concerning the likely funding sources for satisfying the obligations incurred under §1342. But that back-and-forth occurred months before the first appropriations rider was enacted, and, as Judge Newman observed in

dissent, there is "no statement in the legislative history suggesting that the rider was enacted in response to the GAO's report," App.48. Attempting to piece together a clear congressional intent from the implications of a GAO Report requested by two offices is a wildly misdirected inquiry.

While the majority's second source, a comment of Representative Rogers, at least qualifies as legislative history, it is no more probative. It is a two-sentence excerpt drawn from an extensive "explanatory statement" addressing all aspects of an appropriations act that fills hundreds of pages in the Congressional Record. Those brief remarks buried in a mountain of unrelated commentary are hardly a definitive guide to the intent of the full Congress in passing the first appropriations rider, let alone in passing the second and third riders years later. *Cf. Shannon v. United States*, 512 U.S. 573, 583 (1994) ("We are not aware of any case … in which we have given authoritative weight to a single passage of legislative history that is in no way anchored in the text of the statute."). And even if relevant, the comments are fully consistent with an intent to limit the funding sources for risk corridor payments—not to eviscerate the government's underlying commitment to make those payments. *See* App.138-39.

Even if legislative history were relevant in this clear statement context (and it is not), the most telling indicators suggest Congress did *not* intend to repeal or suspend the substantive payment obligation created by §1342. As Judge Newman and Judge Wallach recounted, a bill was introduced in the Senate in April 2014 that would have specifically, expressly, and

accountably amended §1342 to cap the government's obligation to make outgoing risk corridor payments at the amount of incoming risk corridor payments from profitable insurers. App.49-50, 80 (citing S. 2214, 113th Cong. (2014)). That bill never passed. App.49-50, 80. And two similar bills were introduced a few months *after* the first appropriations rider (and *after* HHS provided reassurances that full payment would be forthcoming, 78 Fed. Reg. at 15,473) and likewise failed to pass. App.80-81.

Those failed bills provide a clear illustration of the kind of explicit language that is necessary to repeal a prior substantive commitment, and that unquestionably is missing from the appropriations riders. While inferring legislative intent from failed legislation is generally a dubious enterprise, it is rock-hard science compared to inferring a clear statement from a GAO report and two sentences from a nearly-seven-hundred-page explanatory statement. In all events, finding a clear statement in such ambiguous materials fundamentally conflicts with this Court's precedents.

### B. The Federal Circuit's Confusion Over This Court's Precedents Only Underscores The Need For Review.

The majority attempted to draw support from decisions of this Court addressing appropriations riders. *See* App.21-27. But those same cases were reviewed by the Court of Federal Claims, App.132-37, by Judge Newman, App.46-47, 51-57, and by Judge Wallach, App.75-78, with strikingly different results. Correctly understood, the decisions undermine the majority's holding. At a minimum, the disagreement

among the judges below on the meaning of this Court's implied-repeal/appropriations cases only further reinforces the need for this Court's review.

1. The majority began with *United States v. Langston*, 118 U.S. 389 (1886), which involved a statute entitling an American diplomat in Haiti to an annual salary of $7,500. *Id.* at 389; *see* App.18-19. Despite that statute, Congress later appropriated only $5,000 to pay that salary. This Court concluded that no repeal had occurred, explaining that the appropriations bill contained no "words that expressly, or by clear implication, modified or repealed the" obligation to pay the full $7,500 salary. *Langston*, 118 U.S. at 394; *see Belknap*, 150 U.S. at 594 (explaining that the "mere failure to appropriate the full salary" in *Langston* "was not, in and of itself alone, sufficient to repeal the prior act").

That result contrasted with the Court's earlier decision in *United States v. Mitchell*, 109 U.S. 146 (1883), in which Congress had set a fixed $400 annual salary for certain interpreters. *Id.* at 148. Later, however, Congress enacted an appropriations measure appropriating $300 per year for those same interpreters, along with an additional lump-sum appropriation of $6,000 for "additional pay" to be "distributed in the discretion of the secretary." *Id.* at 149. Because that part-fixed, part-discretionary scheme was fundamentally "irreconcilable" with the earlier non-discretionary, fixed-compensation scheme, this Court concluded that the appropriations measure could only be understood as repealing the earlier statute. *Id.* at 149-50.

This case is indistinguishable from *Langston* and nothing like *Mitchell*. The appropriations riders here included no "words that expressly, or by clear implication, modified or repealed the previous law," *Langston*, 118 U.S. at 394—let alone set forth a superseding statutory scheme, as in *Mitchell*.

2. The majority also attempted to derive support from *United States v. Dickerson*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980). But those cases only expose the errors in its analysis.

In *Dickerson*, Congress had passed a statute in 1922 authorizing a reenlistment bonus for honorably discharged servicemembers. 310 U.S. at 554-55. From 1934 to 1937, however, Congress enacted appropriations riders that explicitly stated that the reenlistment bonus "is hereby suspended." *Id.* at 556. In 1937, Congress passed an appropriations rider with slightly different language, providing that "no part of any appropriation contained in this or any other Act for the fiscal year ending June 30, 1938, shall be available" to pay the bonus "notwithstanding the applicable provisions" of the 1922 law. *Id.* at 556-57. It then passed an identical rider for the following fiscal year. *Id.* at 555. Although these last two riders used slightly different language, this Court found them sufficiently explicit. That conclusion was supported not only by the explicit cross-reference to the bonus-authorizing law, but by the unambiguous elimination of all funding "in this *or any other Act*." *Id.* at 557 (emphasis added). And the legislative history reinforced the text's plain meaning. *Id.* at 557-61 & nn.2-4.

In *Will*, this Court considered whether four appropriations riders suspended a law providing for a cost-of-living increase to the salaries of federal judges. For one of the riders, the inquiry was simple: Its "plain words" "expressly stated that the [cost-of-living] increase … 'shall not take effect.'" *Will*, 449 U.S. at 222. The other riders used somewhat different language, but with equally clear meaning: Two tracked the rider in *Dickinson* by barring the use of "the funds appropriated in this Act *or any other Act*" for the cost-of-living increase, while the final rider broadly barred the use of any "funds available for payment to [government] employees" for that increase. *Id.* at 205-08 (emphasis added). Once again, extensive legislative history reinforced plain text. *Id.* at 223-24.

The appropriations measures in *Dickerson* and *Will* thus differed meaningfully from those at issue here. Both cases involved measures that by their plain text prohibited the government from using *any* funds to pay the specified obligations. *Dickerson*, 310 U.S. at 556-57 ("any appropriation contained in this or any other Act"); *Will*, 449 U.S. at 205 (same). Here, by contrast, Congress limited the use of funds only from one specific source. *See* App.12 ("funds made available by this Act").

The appropriations riders here feature neither the kind of superseding regime in *Mitchell* nor the kind of emphatic "this-or-any-other-act" restriction at issue in *Dickerson* and *Will*. The decision below thus opens up an unprecedented "third way" for an appropriations rider to vitiate a prior substantive commitment. This new third way not only lacks support from this Court's

precedents, but contradicts them by allowing an implied repeal to be effectuated via ambiguity. Indeed, the majority's own language underscores the lack of clarity by repeatedly describing the riders as "suspending," rather than "repealing" the government's obligations. *See, e.g.*, App.21-22, 31-32, 38-39. But the net effect of three successive "suspensions" of an unambiguous obligation to pay was that the federal government owed petitioners nothing despite petitioners' actual losses induced by the government's unambiguous promise.

In part because it talked of "suspension" rather than repeal, the majority never confronted the serious constitutional takings and retroactivity issues that its interpretation of the riders implicates. It is one thing to deny a bonus or cost-of-living adjustment while continuing to pay the base salary, and quite another to vitiate retroactively an existing government obligation backed by the reliance interests of private parties who suffered enormous real-world losses. It is not clear that Congress has the power to wipe out such obligations even when it is explicit, but such an extraordinary result should not be lightly inferred from ambiguous appropriation riders, let alone obscure legislative history. Certainly, nothing in *Dickerson*, *Will*, or any other precedent of this Court supports that anomalous result.

3. The majority was equally wrong to summarily reject petitioners' breach-of-contract claims. If Congress really did unilaterally disclaim its mandatory payment obligation under §1342, then the government committed a clear breach of contract. As the Court of Federal Claims and Judge Newman

explained, "the insurers and the Medicare administrator entered into mutual commitments with respect to the conditions of performance of the Affordable Care Act." App.59. Indeed, insurers participated in the exchanges despite the acknowledged risks precisely because the government induced them to participate by promising to make payments if costs exceeded premiums. And the government not only induced reliance, but directly benefited from lower premiums that translated into reduced tax subsidies with attendant savings for the federal fisc. Thus, for all the same reasons that §1342 imposes an "unambiguously mandatory" obligation, App.16, it likewise evinces the requisite "clear indication that the legislature intend[ed] to bind itself contractually." *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.*, 470 U.S. 451, 465-66 (1985). Accordingly, even if Congress repealed its statutory obligation, it would still remain contractually obligated to fulfill it.

By refusing to enforce the government's obligation here, the decision below paradoxically makes congressional promises the easiest commitments to break. That is untenable. There is no question that a clear and binding promise from a contracting officer is binding. *See, e.g.*, *Mobil Oil Expl. & Prod. S.E., Inc. v. United States*, 530 U.S. 604, 607 (2000); *United States v. Winstar Corp.*, 518 U.S. 839 (1996). In light of those precedents, it would be nothing short of bizarre if Congress itself were not bound when it makes a clear and binding promise, induces beneficial reliance and reciprocal performance based on that promise, and then breaks that promise with impunity. Indeed, any

other rule would create an intolerable double standard.

This is a case in point. If the relatively few insurers who turned a profit on the exchanges suddenly announced that they were not going to make risk corridor payments *to* the government, it is hard to imagine the government would take the same nonchalant approach to the insurers' obligations under §1342. And it would amount to a double, double standard as even after the government indicated it would dishonor its own commitments, petitioners remained bound to provide the health coverage to their insured, *i.e.*, the very coverage the federal government induced petitioners to provide.

In sum, this Court's precedents confirm that much more is needed to allow the government to "renege on its legislated and contractual commitments" and then leave private parties bound by their own contractual obligations to bear the consequences. App.68. But to the extent there is any room for doubt, that only underscores the need for review. The decision below allows the government to evade billions of dollars in liability, and in the process "casts doubt on the Government's continued reliability as a business partner in all sectors." App.82; *see also* App.67. Whether that extraordinary result can be reconciled with this Court's precedents is a question this Court should answer.

## II. The Question Presented Is Exceptionally Important.

As both dissenting judges recognized, this case is "exceptionally important" and has broad-ranging "national impact." App.66, 82. That assessment

reflects not only the undeniable reality that the decision allows the government to shirk a $12 billion commitment, but also the broader implications of that decision for the government's "credibility as a reliable business partner." App.83. Unless reversed, the decision provides a dangerous roadmap for the government to promise boldly and clearly, renege quietly and ambiguously, and escape all political and financial accountability for doing so. And because the Federal Circuit has exclusive jurisdiction over statutory claims against the United States for money damages, *see* 28 U.S.C. §1491(a)(1), the decision below will have a profound—and profoundly negative—impact on all manner of dealings with the government.

1. As the $12 billion price tag itself indicates, the immediate impact of the decision below on insurers and the healthcare market has been enormous. The government enacted §1342 "to persuade the nation's health insurance industry to provide insurance to previously insured or uninsurable persons" by committing the government to share the "insurance risks of unknown dimension" created by the exchanges. App.66. Relying on that commitment, insurers "entered the health care exchanges and set premiums with the belief that they would receive risk corridors payments." App.83. The government increased the need for and amount of those payments by unilaterally adopting a "transitional policy" that dramatically altered the risk profile of exchange participants. Having unilaterally caused the amount of its obligation to balloon, the government then reneged on its promise to pay. The effect on those who took the government at its word and responded to its

incentives precisely as the government intended has been devastating.

Two years after HHS began denying payment on its risk corridor obligations, "eighteen of twenty-four health cooperatives that were participating in the exchanges were no longer in business," leaving a million Americans without health insurance. App.84; Nicholas Bagley, *Trouble on the Exchanges: Does the United States Owe Billions to Health Insurers?*, 375 New Eng. J. Med. 2017, 2018 (2016). "Several health insurance companies 'withdrew from the ACA exchanges entirely,' and others still offering plans 'had to compensate for this uncertainty in payment by offering health plans at higher prices than before.'" App.84 (emphasis omitted); *see Land of Lincoln*, 129 Fed. Cl. at 89, 94 (describing imminent cancellation of insurance to 50,000 customers on account of government's failure to make $74 million in risk corridor payments). In fact, one study estimates that the government's refusal to honor its commitments caused 86% of the rise in health insurance premiums from 2016 to 2017. Daniel W. Sacks, et al., *The Effect of the Risk Corridors Program on Marketplace Premiums and Participation*, Nat'l Bureau of Econ. Research, Working Paper No. 24129 at 4 (2017), https://bit.ly/2FobV73.

In short, the government's refusal to honor its obligation to make the required payments has "impact[ed] the cost of health care insurance for virtually all Americans." App.84. Given the billions of dollars at stake, and the "national impact of these health insurance cases," App.66, the question presented plainly warrants this Court's review.

2. That question has ramifications far beyond the healthcare context. At the most basic level, it is "a question of the integrity of government." App.67. If the Federal Circuit's decision stands, it will not only perpetuate the existing uncertainty in the health insurance markets, but extend that uncertainty to all areas in which the government seeks to partner with private entities.

In practically every area in which it operates, the government "deals with non-governmental entities that carry out legislated programs." App.66. That "ability to benefit from participation of private enterprise depends on the government's reputation as a fair partner." App.59-60. "By holding that the government can avoid its obligations after they have been incurred, by declining to appropriate funds to pay the bill and by dismissing the availability of judicial recourse," the Federal Circuit fundamentally "undermine[d] the reliability of dealings with the government." App.60; *see* App.82-84. If the government can renege on its commitments at will, even after inducing private parties to rely on them, it will quickly find that its potential partners "bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." App.68-69 (quoting *Ramah Navaho*, 567 U.S. at 191-92).

Moreover, by allowing the government to shed its commitments via ambiguous appropriations riders and obscure legislative history, the decision below creates truly awful incentives. If the government really has the authority to make its solemn commitments disappear after the fact, it should have to make it pellucidly clear that it is invoking that

extraordinary power. Put differently, if the only constraint on the government's ability to induce massive reliance and then renege on its commitments is a political one, then it is imperative that Congress be forced to act clearly and with accountability—it should not be allowed to have its cake and eat it too by making statutory promises disappear via mere implications in the legislative history of appropriations bills. Yet the decision below permits the government to make its reliance-inducing promises openly and clearly, and then issue its reliance-destroying reversals quietly and through indirection. That is a recipe for disaster that no decision of this Court does or should countenance.

The rule that Congress must act clearly is crucial not only as a matter of statutory interpretation, but as a matter of democratic principle. If Congress intends to make drastic changes in an existing law—especially one that has induced billions of dollars of reliance—our democratic system requires it to do so through a "step-by-step, deliberate and deliberative process," *INS v. Chadha*, 462 U.S. 919, 959 (1983), ensuring that the public can understand those changes and that Congress can be held politically accountable for its decisions. The strong presumption against implied repeals effectuates that principle by preventing Congress from repealing legislation that satisfied bicameralism and presentment through mere implications or, worse yet, obscure legislative history. It also avoids the separation of powers confusion that occurs when Congress makes a clear promise to pay, only to ambiguously hamstring the ability of the Executive to cut a check, and force private parties to seek redress in the courts. *Cf. Epic*, 138 S. Ct. at 1624

(implied-repeal canon recognizes it is "the job of Congress by legislation, not [courts] by supposition, both to write laws and to repeal them"). If Congress intends to adopt a dramatic about-face of the kind that the Federal Circuit purported to find here, it must do so in clear and express terms where it takes responsibility for its actions, not by "burying a repeal in a standard appropriations bill" to make "an end-run around the substantive debates that [the] repeal might precipitate." App.47 (quoting App.132).

The majority's failure to respect that principle is profoundly wrong. It has already had devastating effects on the healthcare market and will inflict future harm on all government contractors. This Court should grant review.

## CONCLUSION

For the foregoing reasons, this Court should grant the petition.

Respectfully submitted,

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