

No. 18-1028

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

BRIEF FOR PETITIONERS

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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statutory commitment was unambiguous, but relied on legislative history to hold that the appropriations riders had repealed the statutory guarantee.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 Partners, Inc., which in turn is owned by Moda Holdings Group, Inc., which is wholly 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.

TABLE OF CONTENTS

QUESTION PRESENTED.....	i
PARTIES TO THE PROCEEDING	ii
CORPORATE DISCLOSURE STATEMENT.....	iii
TABLE OF AUTHORITIES.....	vi
INTRODUCTION.....	1
OPINIONS BELOW	2
JURISDICTION	3
STATUTORY PROVISIONS INVOLVED.....	3
STATEMENT OF THE CASE	3
A. Factual and Statutory Background.....	3
B. Proceedings Below.....	19
SUMMARY OF ARGUMENT	24
ARGUMENT.....	27
I. Congress Did Not Eliminate The Government’s Clear Obligations Under §1342 Through Ambiguous Appropriations Riders And Legislative History	27
A. An Appropriations Rider Does Not Repeal a Substantive Obligation Unless that Intent Is Clearly Expressed in the Statutory Text	27
B. The Appropriations Riders Here Come Nowhere Near Satisfying that Clear- Statement Rule.....	30
C. This Court’s Appropriations Rider Cases Reinforce that Conclusion.....	39
D. Allowing the Appropriations Riders to Eliminate the Government’s Clear	

Obligations Under §1342 Would Raise Grave Constitutional Concerns	46
E. If the Appropriations Riders Really Did Impliedly Repeal §1342, then the Government Has Committed a Breach of Contract	50
II. Allowing The Government To Evade Its Obligations Under §1342 Would Have Dire Consequences.....	53
A. Holding the Government to the Clear-Statement Rule Preserves Accountability.....	54
B. The Government’s Position Threatens Future Government Partnerships with the Private Sector.....	56
C. The Government’s Refusal to Abide by §1342 Had Devastating Effects on the Health Insurance Market	58
CONCLUSION	61

TABLE OF AUTHORITIES

Cases

<i>Aldridge v. Williams</i> , 44 U.S. (3 How.) 9 (1845).....	33
<i>Bank Markazi v. Peterson</i> , 136 S. Ct. 1310 (2016).....	47
<i>Belknap v. United States</i> , 150 U.S. 588 (1893).....	30, 39
<i>Cook Cty. v. United States ex rel. Chandler</i> , 538 U.S. 119 (2003).....	28
<i>Dr. Foster’s Case</i> , (1614) 77 Eng. Rep. 1222; 11 Co. Rep. 56b	28
<i>E. Enters. v. Apfel</i> , 524 U.S. 498 (1998).....	47, 48
<i>Epic Sys. Corp. v. Lewis</i> , 138 S. Ct. 1612 (2018).....	28, 33, 54
<i>Exxon Mobil Corp. v. Allapattah Servs. Inc.</i> , 545 U.S. 546 (2005).....	34
<i>Ferris v. United States</i> , 27 Ct. Cl. 542 (1892)	30
<i>Fourth Estate Pub. Benefit Corp.</i> <i>v. Wall-Street.com, LLC</i> , 139 S. Ct. 881 (2019).....	37
<i>Free Enter. Fund v. Public Co. Accounting</i> <i>Oversight Bd.</i> , 561 U.S. 477 (2010).....	56
<i>Harford v. United States</i> , 12 U.S. (8 Cranch) 109 (1814)	28
<i>In re Aiken Cty.</i> , 725 F.3d 255 (D.C. Cir. 2013).....	30

<i>INS v. Chadha</i> , 462 U.S. 919 (1983).....	33, 54
<i>Land of Lincoln Mut. Health Ins. Co. v. United States</i> , 129 Fed. Cl. 81 (Fed. Cl. 2016).....	59
<i>Landgraf v. USI Film Prods.</i> , 511 U.S. 244 (1994).....	34, 47
<i>Lynch v. United States</i> , 292 U.S. 571 (1934).....	53
<i>Minis v. United States</i> , 40 U.S. (15 Pet.) 423 (1841).....	29, 30
<i>Mobil Oil Expl. & Prod. S.E., Inc. v. United States</i> , 530 U.S. 604 (2000).....	52, 53
<i>Morton v. Mancari</i> , 417 U.S. 535 (1974).....	28
<i>Murr v. Wisconsin</i> , 137 S. Ct. 1933 (2017).....	48
<i>Nat’l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co.</i> , 470 U.S. 451 (1985).....	51
<i>New York v. United States</i> , 505 U.S. 144 (1992).....	55
<i>Penn Cent. Transp. Co. v. City of N.Y.</i> , 438 U.S. 104 (1978).....	48
<i>Plaut v. Spendthrift Farm, Inc.</i> , 514 U.S. 211 (1995).....	49
<i>Posadas v. Nat’l City Bank</i> , 296 U.S. 497 (1936).....	22

<i>Printz v. United States</i> , 521 U.S. 898 (1997).....	49
<i>Salazar v. Ramah Navajo Chapter</i> , 567 U.S. 182 (2012).....	24, 30, 35, 57
<i>Schwegmann Bros.</i> <i>v. Calvert Distillers Corp.</i> , 341 U.S. 384 (1951).....	35
<i>Shannon v. United States</i> , 512 U.S. 573 (1994).....	36
<i>Tenn. Valley Auth. v. Hill</i> , 437 U.S. 153 (1978).....	<i>passim</i>
<i>U.S. Fidelity & Guar. Co.</i> <i>v. Struthers Wells Co.</i> , 209 U.S. 306 (1908).....	47
<i>United States v. Borden Co.</i> , 308 U.S. 188 (1939).....	28
<i>United States v. Bostwick</i> , 94 U.S. 53 (1876).....	53
<i>United States v. Dickerson</i> , 310 U.S. 554 (1940).....	<i>passim</i>
<i>United States v. Kwai Fun Wong</i> , 135 S. Ct. 1625 (2015).....	35
<i>United States v. Langston</i> , 118 U.S. 389 (1886).....	<i>passim</i>
<i>United States v. Mitchell</i> , 109 U.S. 146 (1883).....	<i>passim</i>
<i>United States v. R.L.C.</i> , 503 U.S. 291 (1992).....	35
<i>United States v. Vulte</i> , 233 U.S. 509 (1914).....	28, 29, 30, 31

<i>United States v. Will</i> , 449 U.S. 200 (1980).....	<i>passim</i>
<i>United States v. Winstar</i> , 518 U.S. 839 (1996).....	52, 53, 57, 58

Statutes

26 U.S.C. §36B.....	4
42 U.S.C. §1395w-115	8
42 U.S.C. §18031	3
42 U.S.C. §18062	5, 6, 8, 34
42 U.S.C. §300gg-94	11
Pub. L. No. 111-148, 124 Stat. 119 (2010).....	10
Pub. L. No. 113-235, 128 Stat. 2130 (2014).....	14, 30
Pub. L. No. 114-113, 129 Stat. 2242 (2015).....	14, 30
Pub. L. No. 115-141, 132 Stat. 348 (2018).....	15
Pub. L. No. 115-245, 132 Stat. 2981 (2018).....	15
Pub. L. No. 115-31, 131 Stat. 135 (2017).....	14, 30
Alaska Stat. §21.51.405.....	11
Alaska Stat. §21.55.430.....	18
N.C. Gen. Stat. §58-51-95.....	11
Or. Rev. Stat. §743.018(1)	11
Wash. Rev. Code §48.44.020	11

Rules and Regulations

45 C.F.R. §153, Subpart F.....	6, 7
45 C.F.R. §154.200-.230	11
48 C.F.R. §1.102.....	56
77 Fed. Reg. 17,220 (Mar. 23, 2012)	7
78 Fed. Reg. 15,410 (Mar. 11, 2013)	8, 37

79 Fed Reg. 13,786 (Mar. 11, 2014)	12, 13
79 Fed. Reg. 30,240 (May 27, 2014).....	14
79 Fed. Reg. 30,260 (May 27, 2014).....	14
80 Fed. Reg. 10,750 (Feb. 27, 2015)	16
H. Rule XXI.....	29
S. Rule XVI	29
Other Authorities	
160 Cong. Rec. H9838 (daily ed. Dec. 11, 2014).....	21, 37
Bernadette Fernandez, Cong. Research Serv., R44425, Health Insurance Premium Tax Credits and Cost-Sharing Subsidies (2018).....	5
CBO, The Budget and Economic Outlook: 2014 to 2024 (Feb. 2014), <i>available at</i> https://bit.ly/2Oeq3ps	8
CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016), https://go.cms.gov/2eZPxot	17
CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year (Nov. 15, 2017), https://go.cms.gov/2yNTxyk	17, 18
H.R. 2740, 116th Cong. (2019).....	15
H.R. 724, 114th Cong. (2015).....	16, 38
H.R. Subcomm. on Health, <i>The Affordable Care Act on Shaky Ground: Outlook and Oversight</i> , Preliminary Transcript (Sept. 14, 2016)	17

HHS 2015 Health Policy Standards Fact Sheet, https://go.cms.gov/2OdvZza (Mar. 5, 2014).....	11
HHS, Preliminary Regulatory Impact Analysis, CMS-9989-P2 (July 2011), available at https://go.cms.gov/2LEc3DC	7
HHS, Risk Corridors and Budget Neutrality (Apr. 11, 2014), available at https://go.cms.gov/2Y9pDk8	13
HHS, Risk Corridors Payments for 2015 (Sept. 9, 2016)	16
HHS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015)	16, 18
<i>How Do Insurance Firms Respond to Financial Risk Sharing Regulations?</i> , Nat'l Bureau of Econ. Research, Working Paper No. 24129 (rev. 2019), available at https://bit.ly/2FobV73	60
Jeff Manning, <i>Moda Sues U.S. Government Demanding Promised \$180 Million</i> , OregonLive, June 1, 2016, available at https://bit.ly/2R6Xff3	18
Letter from Gary Cohen, Centers for Medicare & Medicaid Services ("CMS"), to State Insurance Commissioners 1 (Nov. 14, 2013), https://go.cms.gov/32QFMP5	10, 11
Nicholas Bagley, <i>Trouble on the Exchanges: Does the United States Owe Billions to Health Insurers?</i> , 375 New Eng. J. Med. 2017 (2016).....	59, 60

Putting America's Health First, FY 2019
President's Budget for HHS (2018) 45
S. 123, 114th Cong. (2015) 15, 38
S. 1726, 113th Cong. (2013) 15, 38
S. 2214, 113th Cong. (2014) 15, 22, 37
S. 359, 114th Cong. (2015) 16, 38
The Federalist No. 70 (Clinton Rossiter ed.
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U.S. Gov't Accountability Off.,
GAO-16-464SP, Principles of Federal
Appropriations Law (4th ed. 2016) 30

INTRODUCTION

This case 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 or underinsured individuals could buy health insurance. Because no reliable historical data about the medical costs of these new consumers were available, insurers faced significant risks if they offered policies on the new exchanges—risks that 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 who suffered actual losses because their costs exceeded their premium revenues. 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. In December 2014, after petitioners had already provided coverage under insurance purchased through the exchanges for nearly

a year, and had already set premiums for 2015, Congress included an appropriations rider in the HHS appropriations bill for 2015 providing that “[n]one of the funds made available by this Act ... may be used” for payments under §1342. Although by its terms, that provision only limited the source of funds to satisfy the government’s obligations under §1342, HHS has relied on that appropriations rider and identical riders for subsequent fiscal years to refuse 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.

That bait-and-switch is legally indefensible and enormously consequential. The government’s view that it may promise boldly, renege obscurely, and avoid both financial and political accountability for retroactively depriving private parties of billions of dollars in reliance interests is truly remarkable. It finds no support in this Court’s cases, which strongly disfavor implied repeals, it raises grave constitutional concerns, and it would fatally undermine government accountability. The government’s attempt here to escape clear textual commitments through inferences from legislative history and GAO correspondence may serve its short-term interests, but only at the cost of sacrificing its long-term integrity and credibility as a reliable business partner. The Court should reverse the decision below and hold the government to the commitments that it unambiguously made.

OPINIONS BELOW

The Federal Circuit’s opinion in *Moda* is reported at 892 F.3d 1311 and reproduced at Pet.App.1-60. The

Court of Federal Claims' opinion in *Moda* is reported at 130 Fed. Cl. 436 and reproduced at Pet.App.85-152.

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

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

JURISDICTION

The Federal Circuit issued its divided opinion in *Moda* on June 14, 2018, and its *BCBSNC* disposition on July 9, 2018. The court denied rehearing in both cases on November 6, 2018. The petition for a writ of certiorari was filed on February 4, 2019, and granted on June 24, 2019. This Court has jurisdiction under 28 U.S.C. §1254 (1).

STATUTORY PROVISIONS INVOLVED

Relevant statutory provisions are reproduced in the appendix to the petition.

STATEMENT OF THE CASE

A. Factual and Statutory Background

1. The ACA aimed to extend health insurance coverage to millions of uninsured and underinsured Americans. To that end, the ACA established "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 previously uninsured or underinsured individuals with easy

access to the health insurance market, and to encourage competition among insurers for those new customers. Pet.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 individuals. But precisely because those new customers were not in the health insurance market at that time, insurers “lacked reliable data to estimate the cost of providing care for th[is] expanded pool of individuals,” and therefore faced “significant risk” if they chose to offer plans on the exchanges. Pet.App.2. That risk created strong incentives for insurers either to avoid the new exchanges altogether, or to charge higher premiums.

That risk and those corresponding incentives threatened not only to undermine the ACA’s goal of providing affordable health insurance options for consumers, but also to impose substantial costs on the government. To ensure access to affordable care, the ACA created a tax credit for low-income taxpayers to cover the difference between their cost of obtaining insurance through the exchanges and a specified percentage of their income. 26 U.S.C. §36B(a)-(b). As a result, lower premiums on the exchanges translate directly into lower outlays by the government for those tax credits. Conversely, higher premiums on the exchanges would make the promised tax subsidies far more expensive for the government, potentially adding billions to the ACA’s total price tag. See Bernadette Fernandez, Cong. Research Serv., R44425, Health Insurance Premium Tax Credits and Cost-

Sharing Subsidies 9-10 (2018) (reporting \$11.2 billion in ACA tax credits in 2014 and \$18.1 billion in 2016).

2. To address these problems, Congress enacted three programs—the reinsurance, risk adjustment, and risk corridors programs—“to mitigate that risk [of offering plans on the new exchanges] and discourage insurers from setting higher premiums to offset that risk.” Pet.App.2. This case concerns the risk corridors program. Under that program, the government committed to share part of the risk of providing insurance on the exchanges for the first three years of operations. To that end, §1342 of the ACA directed 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.*

Under §1342, plans whose costs of providing care exceeded the premiums they received by more than specified amounts would receive “payments out” from the government to protect them against extreme losses. For plans whose “allowable costs” (the costs of paying health benefits) were between 103% and 108% of their “target amount” (the premiums charged minus the plan’s administrative costs), §1342 provided that HHS “shall pay” half of the allowable costs above that 103% threshold. *Id.* §18062(b)(1)(A); *see id.* §18062(c)(1)(A) (defining “allowable costs” as “the total costs (other than administrative costs) of the plan in providing benefits covered by the plan”); *id.* §18062(c)(2) (defining “target amount” as “total premiums ... reduced by the administrative costs of

the plan”). For plans whose allowable costs were more than 108% of their target amount, §1342 provided that HHS “shall pay” 2.5% of the target amount (which corresponds to half of the allowable costs between the 103% and 108% thresholds), plus 80% of the allowable costs above the 108% threshold. *Id.* §18062(b)(1)(B).

Section 1342 also required mirror-image “payments in” from insurers whose actual costs of providing care fell below their premiums received by more than specified amounts. The statute provided that participating plans whose allowable costs were between 97% and 92% of their target amounts “shall pay” the government half the amount by which the allowable costs fell below that 97% threshold. *Id.* §18062(b)(2)(A). The statute further specified that any participating plans whose allowable costs were less than 92% of the target amount “shall pay” the government 2.5% of the target amount (which corresponds to half the difference between the target amount and the allowable costs between the 97% and 92% thresholds), plus 80% of the amount by which allowable costs fell below the 92% threshold. Unsurprisingly, HHS has always understood the “shall pay” language in §1342’s “payments in” provisions to be mandatory, requiring insurers whose premiums exceed costs by the specified amounts to make the specified payments in regardless of the amount of payments out. *See, e.g.*, 45 C.F.R. §153.510(d) (requiring insurers to make “payments in” within 30 days after receiving notification of the amounts owed).

In short, the risk corridors program committed the government to share the risk that previously

uninsured individuals with uncertain risk profiles would turn out to have higher healthcare costs than anticipated (while sharing the benefits if those costs were lower than anticipated). By doing so, the risk corridors program ensured that insurers would offer plans on the exchanges and saved the government billions in the form of reduced outlays for tax credits. Pet.App.2. As HHS understood, that program was designed to “play a critical role in ensuring the success of the [ACA] Exchanges.” HHS, Preliminary Regulatory Impact Analysis, CMS-9989-P2 (July 2011), *available at* <https://go.cms.gov/2LEc3DC>.

3. Roughly two years after the ACA’s passage, and nearly two years before the exchanges were scheduled to go live, HHS promulgated regulations to govern the risk corridor 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). In announcing those regulations, HHS specifically recognized that the risk corridors program was intended to “protect against uncertainty in rate setting by qualified health plans” by allowing them to “shar[e] risk in losses and gains with the Federal government.” *Id.* at 17,220. It likewise recognized the mandatory nature of the payment obligations created by the statute, stating that insurers “will receive payment from HHS” under the statutory formula for payment out and “must remit charges to HHS” under the statutory formula for payments in. 45 C.F.R. §153.510(b), (c).

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 specified that the government’s obligation to make payments to insurers with excess costs was not conditional on the amount of payments in by insurers with excess premiums. As HHS explained, “the risk corridors program is not statutorily required to be budget neutral,” and “[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342.” *Id.* at 15,473.¹

That understanding was critical to insurers, as they had no greater certainty about the relative volumes of payments in and out under §1342 than about the costs associated with previously uninsured individuals buying insurance on exchanges. That understanding also was consistent with the statutory command in §1342 that the risk corridors program should be “based on” the similar Medicare Part D risk corridors program, which likewise is not budget-neutral. 42 U.S.C. §18062(a); *see* 42 U.S.C. §1395w-115(e). This 2013 rulemaking by HHS constituted its “final word ... on the risk corridors program before the exchanges opened and the program began.” Pet.App.7.

¹ The Congressional Budget Office (“CBO”) agreed with that understanding, issuing a report in February 2014 explaining that risk corridor payments in “will not necessarily equal risk corridor payments [out], so that program can have net effects on the budget deficit.” Pet.App.98 (quoting CBO, *The Budget and Economic Outlook: 2014 to 2024*, at 59 (Feb. 2014), *available at* <https://bit.ly/2Oeq3ps>). In other words, CBO agreed that the program need not be budget neutral and in fact predicted that payments in would exceed payments out by \$8 billion. Pet.App.98-99.

Petitioners and numerous other insurers responded to the government's commitment exactly as Congress intended, relying on it to offer health plans on the new exchanges at relatively affordable rates that in turn reduced the government's outlays for tax credits. Pet.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* Fed.Cl.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* Fed.Cl.Dkt. 1.

Despite the inherent risk of offering insurance to a new population with no reliable healthcare-cost data, petitioners and other insurers agreed to offer plans on the new exchanges based on the government's repeated assurances that it would honor its statutory obligation to share the downside risk if premiums did not cover costs. And because the inflows and outflows under the new statutory scheme were as unpredictable as the risk profile of the new insureds, 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."

4. 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, under the statute, healthy individuals with cheaper non-ACA-compliant health plans were obligated to buy ACA-compliant policies by that date.

In November 2013, however, HHS unilaterally announced a “transitional policy” that allowed individuals to remain on their existing health plans even if those plans failed to comply with the ACA. *Pet.App.8*; *see* Letter from Gary Cohen, Centers for Medicare & Medicaid Services (“CMS”), to State Insurance Commissioners 1 (Nov. 14, 2013), <https://go.cms.gov/32QFMP5> (“Transitional Policy Letter”). HHS encouraged state agencies to adopt the same transitional policy. *Pet.App.8*; *see* Transitional Policy Letter 3. That unilateral policy change came after insurers had already agreed to participate in the exchanges and after their premiums for 2014 had already been set. Thus, as HHS acknowledged, “this transitional policy was not anticipated by health insurance issuers” in the rate-setting process. Transitional Policy Letter 3; *see* *Pet.App.9*.²

That unexpected policy change had marked and predictable effects. By allowing individuals with bare-bones health insurance to keep their existing plans, the transitional policy “dampened ... enrollment” on

² HHS initially announced that this “transitional” policy would apply only until October 1, 2014; however, it has since issued numerous extensions. *Pet.App.43, 97*. The policy is currently set to expire on October 1, 2020. CMS, Extended Non-Enforcement of Affordable Care Act-Compliance with Respect to Certain Policies (Mar. 25, 2019), <https://go.cms.gov/2JIg4qd>.

the exchanges, “especially by healthier individuals who elected to maintain their [existing] lower level of coverage.” Pet.App.8. And because the announcement came after premiums had been set, it “[e]ft insurers participating in the exchanges to bear greater risk than they accounted for in setting premiums.” Pet.App.8. Given the extensive federal and state regulatory process governing health insurance rates, moreover, insurers could not unilaterally adjust their premiums to reflect that late-breaking increased risk. *See* 42 U.S.C. §300gg-94(a) (requiring federal review of “unreasonable” premium increases); 45 C.F.R. §154.200-.230 (federal review process); *see also, e.g.*, Alaska Stat. §21.51.405; N.C. Gen. Stat. §58-51-95; Or. Rev. Stat. §743.018(1); Wash. Rev. Code §48.44.020 (state review processes).

HHS recognized that its unexpected policy shift could subject insurers on the exchanges to “unanticipated higher average claims costs.” Pet.App.96 n.2 (quoting HHS 2015 Health Policy Standards Fact Sheet, <https://go.cms.gov/2OdvZza> (Mar. 5, 2014)). But HHS reassured insurers that “the risk corridor program should help ameliorate unanticipated changes in premium revenue,” and that HHS would “explore ways to modify the risk corridor program final rules to provide additional assistance.” Transitional Policy Letter at 3; *see* Pet.App.9, 96.

5. 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, so 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 March 2014, despite recognizing that its late-breaking transitional policy could increase losses to insurers by producing “increased claims costs not accounted for when setting 2014 premiums,” HHS continued to optimistically project that the risk corridors program “will result in net payments that are budget neutral in 2014”—in other words, that payments in from some insurers would equal payments out to others. 79 Fed. Reg. at 13,786-87; *see* Pet.App.99 (“HHS ... expected that ‘payments in’ to the risk corridors program would equal or exceed ‘payments out’ of the program.”). Relying on that rosy scenario, HHS announced for the first time—well after the insurers had agreed to provide plans on the exchanges, and after having reassured insurers to the contrary—that it “intend[ed] to implement this [risk corridors] program in a budget neutral manner,” and would “make future adjustments ... to the extent

necessary to achieve this goal.” 79 Fed Reg. at 13,787; *see* Pet.App.97.

One month later, HHS explained its new budget-neutral approach to the program in a public guidance memorandum. HHS, Risk Corridors and Budget Neutrality (Apr. 11, 2014), <https://go.cms.gov/2Y9pDk8> (“2014 Risk Corridors Mem.”); *see* Pet.App.9-10, 99-101. The agency reaffirmed that it “anticipate[d] that risk corridors collections [from payments in] will be sufficient to pay for all risk corridors payments [out].” 2014 Risk Corridors Mem.1. But “if risk corridors collections are insufficient to make risk corridors payments for a year,” HHS declared that “all risk corridors payments for that year will be reduced pro rata.” 2014 Risk Corridors Mem.1; *see* Pet.App.10, 99. HHS did not assert that in that event its statutory obligation to make full payments out pursuant to the statutory formula would somehow disappear; instead, it indicated that payments in from later years would be used to make up for insufficient payments out in earlier years. 2014 Risk Corridors Mem.1; *see* Pet.App.10, 99-100. Should the payments in for the entire program prove insufficient, HHS stated, it would “establish in future guidance” how it would cover its statutory obligation to make payments out. 2014 Risk Corridors Mem.2; *see* Pet.App.10, 100.

HHS repeated its new position in a May 2014 rulemaking, reiterating that it “intend[ed] to administer [the] risk corridors [program] in a budget neutral way,” and that it “anticipate[d] that risk corridors collections will be sufficient to pay for all risk corridors payments.” Exchange and Insurance

Market Standards for 2015 and Beyond, 79 Fed. Reg. 30,240, 30,260 (May 27, 2014). At the same time, the agency recognized that the ACA “requires [HHS] to make full payments to issuers,” and that if necessary it would “use other sources of funding for the risk corridors payments, subject to the availability of appropriations.” *Id.*; see Pet.App.101-02.

6. In December 2014—after petitioners and other insurers not only had provided insurance on the exchanges for 2014, but had already set premiums and committed to provide coverage for 2015—Congress inserted a rider into the annual appropriations bill for fiscal year 2015 limiting the ability of HHS to use certain funds appropriated in that bill for risk corridors payments. In particular, the rider provided that “[n]one 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 [the risk corridors program].” Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227, 128 Stat. 2130, 2491 (2014). Congress subsequently enacted identical riders for the following two fiscal years that the risk corridors program remained in effect. 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 (2017).³

³ Continuing resolutions in advance of the 2017 appropriations included the same restrictions. Pet.App.13 n.1. Congress has

As might be expected from a provision in an appropriations act, these riders did not purport to repeal the government's substantive obligation to make the risk corridors payments promised by §1342. Instead, each rider simply restricted the use of particular funds that Congress intended to appropriate for other purposes. Each rider was expressly limited to the "funds made available by this Act," without addressing the underlying obligation to pay or whether funds from other sources could be used to cover that obligation. Pet.App.209-10; *see* Pet.App.129 n.13 (noting availability of other funds). By contrast, bills that *did* propose to repeal the government's obligations under the risk corridors program altogether, or to limit those obligations to the amount of payments in, were repeatedly rejected by Congress both before and after the first appropriations rider was enacted. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (proposing to repeal §1342); Obamacare Taxpayer Bailout Prevention Act, S. 123, 114th Cong. (2015) (same); Obamacare Taxpayer Bailout Protection Act, S. 2214, §2, 113th Cong. (2014) (proposing to limit payments

continued to enact the same rider in subsequent appropriations acts even though the risk corridors program has expired. Consolidated Appropriations Act, 2018, Pub. L. No. 115-141, §222, 132 Stat. 348, 740 (2018); Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, Pub. L. No. 115-245, §221 132. Stat. 2981, 3093 (2018); *see also* Labor, Health and Human Services, Education, Defense, State, Foreign Operations, and Energy and Water Development Appropriations Act, 2020, H.R. 2740, 116th Cong. §221 (2019) (proposed appropriations bill for fiscal year 2020).

out to payments in); Taxpayer Bailout Protection Act, S. 359, 114th Cong. (2015) (same); Taxpayer Bailout Protection Act, H.R. 724, 114th Cong. (2015) (same).

For years after the first appropriations rider was enacted, and despite its hopeful statements about budget-neutral implementation, HHS continued to openly acknowledge its statutory obligation under §1342 to make full risk corridors payments. Pet.App.106-07, 167-68. In a February 2015 final rule, for example, HHS acknowledged that the ACA “requires [HHS] to make full payments to issuers.” HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015). In an October 2015 letter to Moda, HHS “reiterate[d]” that the ACA “requires [HHS] to make full payments to issuers” as “obligations of the United States Government for which full payment is required.” Pet.App.106; *see also* Pet.App.168-69 (similar letter to BCBSNC). HHS repeated that assurance in a public bulletin the following month. HHS, Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015); *see Moda C.A.App.245*. And it repeated it again the following year, in another public bulletin issued in September 2016. HHS, Risk Corridors Payments for 2015 (Sept. 9, 2016); *see* Pet.App.106-07 & n.7, 167-68. HHS then reaffirmed the point in testimony to Congress, where the Acting Administrator of the Center for Medicare & Medicaid Services testified that “insurance plans are entitled to be made whole on risk corridor payments” as an “obligation of the federal government.” H.R. Subcomm. on Health, *The Affordable Care Act on Shaky Ground: Outlook and Oversight*, Preliminary Transcript at 84-85 (Sept. 14,

2016) (testimony of Acting Administrator Andy Slavitt).

7. The government's projection that the payments it owed under the risk corridors program would be fully covered by the payments it received turned out to be wildly optimistic. For the 2014 year, HHS owed insurers some \$2.87 billion in payments out, while its payments in totaled only about \$362 million—a shortfall of more than \$2.5 billion. Pet.App.13. The discrepancy only increased over the following two years, with HHS owing payments out of \$5.9 billion while collecting payments in of only \$95.3 million for 2015, and owing payments out of \$3.98 billion while collecting payments in of only \$25 million in 2016. See CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, at 1 (Nov. 18, 2016), <https://go.cms.gov/2eZPxot>; CMS, Risk Corridors Payment and Charge Amounts for the 2016 Benefit Year, at 1 (Nov. 15, 2017), <https://go.cms.gov/2yNTxyk> (“2016 Risk Corridors Amounts Mem.”). By the end of the three-year program, the total payments in added up to only about 4% of the total payments out, and HHS owed insurers more than \$12 billion. Pet.App.14.

Despite regularly acknowledging its statutory obligation to make payments out in full regardless of the amount of payments in, *see supra* pp.7-8, 11-12, HHS has never satisfied that obligation. Instead, HHS has made payments out only from the relatively modest payments in, meaning that HHS has paid out

only a tiny pro rata share—about 4%—of its total statutory obligations. Pet.App.13-14.⁴

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 Washington and Alaska. That eliminated any competition on Alaska's exchange, sent premiums there skyrocketing, and forced the state to create an emergency reinsurance fund. H.B. 374, 29th Leg., 4th Spec. Sess. (Alaska 2016) (codified at Alaska Stat. §21.55.430); *see also, e.g.*, Brief of 18 States and the District of Columbia as Amici Curiae in Support of Petitioners ("State Amici Br.") 7-9. In Oregon, Moda was placed under supervision by the 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 Fed.Cl.Dkt.1.*; Jeff Manning, *Moda Sues U.S. Government Demanding Promised \$180 Million*, OregonLive, June 1, 2016, available at <https://bit.ly/2R6Xff3>. BCBSNC likewise suffered heavily from the government's decision, losing \$130 million for 2014 and more than

⁴ Based on its policy that payments in from later years would be used first for payments out owed from previous years, HHS has paid out about 17% of its statutory obligations under §1342 for 2014, and has made *no payments whatsoever* toward its billions of dollars in obligations under §1342 for 2015 and 2016. *See* 2016 Risk Corridors Amounts Mem.1; 2014 Risk Corridors Mem.1.

\$215 million for 2015. Pet.App.188; *BCBSNC* C.A.App.1023.

B. Proceedings Below

1. When it became clear that the government would not honor its obligations under §1342, petitioners (and dozens of other insurers) filed suits in the Court of Federal Claims to recover the payments the government owed them 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 and then purport to escape that commitment through a series of appropriations riders that by their terms limited only the use of specific funds. Pet.App.152. Shortly thereafter, a different judge ruled for the government in the suit brought by *BCBSNC*. Pet.App.188-204. Appeals followed in both cases.

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 mandatory payment obligation, 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." Pet.App.16. As the majority explained, the fact that Congress had not simultaneously appropriated funds to make risk corridor payments did not affect the mandatory nature of the obligation §1342 imposed, as "it has long been the law that the government may incur a debt independent of an appropriation to satisfy that debt."

Pet.App.18-20. Indeed, the government cited “no authority for its contention that a statutory obligation cannot exist absent budget authority.” Pet.App.20. Given §1342’s “plain language,” the statute created a clear and mandatory “obligation of the government to pay participants in the [ACA] exchanges the full amount indicated by the statutory formula.” Pet.App.20.

Notwithstanding that clear mandate, however, the majority concluded that the later appropriations riders “repealed or suspended” that obligation. Pet.App.21. The majority acknowledged the bedrock rule that “[r]epeals by implication are generally disfavored,” Pet.App.21, which carries “‘especial force’ when the alleged repeal occurred in an appropriations bill,” Pet.App.25 (quoting *United States v. Will*, 449 U.S. 200, 221-22 (1980)). It likewise recognized the long-established rule that whether a later law repeals an earlier one depends on “the intention of [C]ongress as expressed in the statutes.” Pet.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 legislative history to conclude that Congress had “clearly indicated its intent” to “suspend” the obligation imposed by §1342. Pet.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 GAO responded by identifying two sources: HHS’ annual lump-sum appropriation and payments

in from profitable insurers. Pet.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 incoming payments. Pet.App.26-27.

Second, the majority relied on two sentences from a nearly 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. Pet.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. Pet.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 repeal the government’s payment obligation under §1342. Pet.App.39.

The majority acknowledged that this 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. Pet.App.34. But the majority dismissed that as a mere “policy choice” by Congress. Pet.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.” Pet.App.38. Instead, the majority concluded that “[t]he statute, its regulations, and HHS’s conduct all simply worked towards crafting an incentive program.” Pet.App.38.

3. Judge Newman dissented. She agreed that the government’s commitment to make payments to unprofitable insurers was unambiguous, but unlike the majority, she would have “held the government to its statutory and contractual obligations.” Pet.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.” Pet.App.50. Given the “cardinal rule ... that repeals by implication are not favored,” Pet.App.47 (quoting *Posadas v. Nat’l City Bank*, 296 U.S. 497, 503 (1936)), particularly “when ... the subsequent legislation is an *appropriations* measure,” Pet.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 repeal §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 rejected that proposal. Pet.App.49-50 & n.3 (citing S. 2214, 113th Cong.). That “highly probative” 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 it had rejected. Pet.App.50-51. Judge Newman further noted that nothing in the legislative history indicated that the appropriations riders were specifically enacted in response to the correspondence months earlier between two Members of Congress and the GAO. Pet.App.48.

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 insurer and [HHS].” Pet.App.57. In her view, that 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.” Pet.App.57-58. By concluding otherwise, she explained, the majority’s decision “undermines the reliability of dealings with the government.” Pet.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. Pet.App.59.

4. After issuing its divided opinion in *Moda*, the panel summarily affirmed in *BCBSNC*. Pet.App.61-62. *Moda* and *BCBSNC* each sought rehearing en banc, which the court denied, over dissents from Judge Newman and Judge Wallach (each of whom joined the other’s dissent). Judge Newman emphasized that the majority’s view threatened “significant harm to insurers who participated in the [ACA] program,” Pet.App.68, and would undermine government contracting more broadly. As she explained, government contracting “depends on trust in the government as a fair partner.” Pet.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.” Pet.App.68-69 (quoting *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012)). By “mak[ing] it a risky business to rely upon the government’s assurances,” Pet.App.68, the majority’s decision would inevitably raise the cost of future contracting.

Judge Wallach agreed. He stressed that repeals by appropriation are disfavored, and that the appropriations riders here “do not clearly establish that Congress intended to repeal the Government’s obligation” for the simple reason that the “riders do not address *whether the obligation remains payable*.” Pet.App.76. He also emphasized that these cases “cast[] doubt on the Government’s continued reliability as a business partner in all sectors.” Pet.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.” Pet.App.83.

SUMMARY OF ARGUMENT

The government cannot be allowed to promise boldly, inducing massive reliance by private parties that directly benefits the government, and then renege obscurely via implications drawn from legislative history and GAO correspondence. Yet the decision below endorsed that stratagem and upheld a \$12 billion bait-and-switch. That remarkable position finds no support in this Court’s precedent, raises grave constitutional concerns, and would fatally undermine

both political accountability and the government's integrity as a contracting partner.

Few principles have deeper roots than that implied repeals are disfavored. A statute will be construed to repeal an earlier-enacted law only when Congress makes that intent unambiguously clear, and that rule applies with especial force when, as here, the later-in-time statute is an appropriations rider. After all, the basic purpose of appropriations measures is to fund government obligations, not eviscerate them. Yet here, while Congress' promise to *make* risk corridor payments was unambiguous, its purported attempt to *rescind* that promise was anything but.

Indeed, neither the government nor the court below has suggested that the text of the appropriations riders, which by their terms simply foreclose the use of one source of government funding, clearly repeals the government's obligations under §1342. Rather, the government and the panel below resorted to legislative history and inferences from GAO correspondence as the basis for an implied repeal. To state the obvious, legislative history and intragovernmental correspondence not even included in the legislative record cannot provide the clear statement that statutory text lacks. And it certainly cannot do so here, where the most probative legislative history is Congress' repeated failures to directly and textually modify the government's payment obligations under §1342. To allow the government to vitiate clear obligations through obscure legislative history when politically accountable efforts to do the same thing directly failed would eviscerate the centuries-old presumption against implied repeals.

The government's implied-repeal claim is all the more incompatible with this Court's cases given its retroactive nature. The government is not merely trying to alter salaries or eliminate bonuses prospectively. It is claiming the extreme power to rescind government obligations already incurred simply by refusing to pay for them. This Court has never sanctioned an effort to use an appropriations rider to *retroactively* repeal an obligation *after* Congress has already secured private party performance—and for good reason, as that result would raise constitutional concerns of the first order.

Indeed, it is far from clear that the Due Process and Takings Clauses would 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, at the very least, it must be politically accountable for wielding it. Yet by the government's telling, it may vitiate a clear textual commitment to pay with ambiguous legislative history about how it will pay. In other words, in the government's view, it may promise boldly and clearly, renege quietly and ambiguously, and escape all political and financial accountability for doing so.

That view has nothing to recommend it, either legally or practically. While evading its obligations here may help the government's finances in the short term, it will inevitably harm them in the long term, by discouraging private entities from partnering with the government and driving up the prices of those who remain willing. The government's effort to evade its

risk corridor obligations has already done enough damage, both to the nation's health insurance markets and to the government's credibility as a contracting partner. This Court should reject the government's untenable bait-and-switch and hold the government to the unambiguous promise it made.

ARGUMENT

I. Congress Did Not Eliminate The Government's Clear Obligations Under §1342 Through Ambiguous Appropriations Riders And Legislative History.

A long line of this Court's cases confirms the well-settled principle that a statute should not be read as repealing an earlier statute unless that construction is unavoidable. That principle applies with especial force when, as here, the second-in-time statute is an appropriations measure, for such measures ordinarily address sources of funding, rather than the underlying substantive obligations. Applying those settled principles, it is abundantly clear that Congress did not repeal the government's substantive obligation to make risk corridor payments by enacting a series of equivocal appropriation riders that by their terms did no more than limit potential sources of funds to satisfy that obligation.

A. An Appropriations Rider Does Not Repeal a Substantive Obligation Unless that Intent Is Clearly Expressed in the Statutory Text.

As this Court has recognized for more than two centuries, a "repeal by implication ought not to be presumed" unless the statutory language makes it "necessary and unavoidable." *Harford v. United*

States, 12 U.S. (8 Cranch) 109, 109-10 (1814) (Story, J.); see, e.g., *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018); *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). In fact, that principle was already recognized two centuries before this Court first invoked it. See *Dr. Foster's Case*, (1614) 77 Eng. Rep. 1222, 1232; 11 Co. Rep. 56b (statutes “ought not by any constrained construction out of the general and ambiguous words of a subsequent Act, to be abrogated”). Under that long-established rule, “[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.

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.” *Id.* As such, 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.*; see *United States v. Vulte*, 233 U.S. 509, 514-15 (1914) (presumption that appropriations bills do not amend substantive law “follows naturally from the nature of appropriation bills”). For that reason, “the rules of both Houses limit the ability to change substantive law through appropriations measures.” *Will*, 449 U.S.

at 222; see H. Rule XXI.2 (b) (“A provision changing existing law may not be reported in a general appropriation bill[.]”); S. Rule XVI(2), (4) (prohibiting appropriations amendments “proposing new or general legislation”).

Without that limiting principle, authorizing committees and appropriations committees would be in constant battle. “[E]very appropriations measure would be pregnant with prospects of altering substantive legislation ... requiring Members to review exhaustively the background of every authorization before voting on an appropriation.” *Hill*, 437 U.S. at 190. Worse still, allowing Congress to effectuate an implied repeal through an equivocal appropriations rider would 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.” Pet.App.47 (quoting Pet.App.132).

To avoid those untoward outcomes, this Court has long held that if Congress wishes to alter 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); see, e.g., *Vulte*, 233 U.S. at 514-15; *Minis v. United States*, 40 U.S. (15 Pet.) 423, 445 (1841) (Story, J.). Unless an appropriations rider includes “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,” it cannot be read to alter the substantive law created by an earlier enactment. *Langston*, 118 U.S. at 394; see, e.g., *Hill*,

437 U.S. at 190; *Vulte*, 233 U.S. at 515; *Minis*, 40 U.S. at 445 (appropriations act should not be interpreted to amend substantive law “unless it is expressed in the most clear and positive terms, and where the language admits of no other reasonable interpretation”).

Absent such express words of repeal, an appropriations 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)). Simply put, the “mere failure to appropriate” is “not, in and of itself alone, sufficient to repeal the prior act.” *Belknap v. United States*, 150 U.S. 588, 594 (1893); *see also In re Aiken Cty.*, 725 F.3d 255, 260 (D.C. Cir. 2013) (Kavanaugh, J.) (“[C]ourts generally should not infer that Congress has implicitly repealed or suspended statutory mandates based simply on the amount of money Congress has appropriated.”); U.S. Gov’t Accountability Off., GAO-16-464SP, Principles of Federal Appropriations Law 2-63 (4th ed. 2016) (“mere failure to appropriate is not enough” to repeal an extant obligation).

B. The Appropriations Riders Here Come Nowhere Near Satisfying that Clear-Statement Rule.

1. The appropriations riders at issue here do not come close to satisfying the demanding test that this Court’s precedents establish. Those riders provide only that “[n]one of the funds made available *by this Act*” should be used for payments under §1342. Pet.App.12 (emphasis added) (quoting 128 Stat. at 2491); *see* 129 Stat. at 2624; 131 Stat. at 543. The

riders neither expressly repeal §1342 nor expressly limit the government's obligations to make "payments out" to the extent of "payments in." Thus, as one would expect from an appropriations measure, the riders, by their express terms, simply put a limit on the funds appropriated by that particular annual appropriations bill. They say nothing whatsoever about repealing, revising, or suspending the underlying substantive obligation that §1342 creates. As Judge Wallach put it below, 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*." Pet.App.76; see *Vulte*, 233 U.S. at 514 (appropriations measures do not amend substantive law where "no words were used to indicate any other purpose than the disbursement of a sum of money for the particular fiscal years").

That conclusion is powerfully reinforced by considerations of timing and chronology. Section 1342 was enacted in 2010 and obligated the government to make payments out (and some insurers to make payments in) covering the first three years of the exchanges' operation (starting in 2014). Because the exchanges would not even begin operating until 2014, the ACA naturally did not appropriate funds for §1342 back in 2010, as it did for other ACA programs that required immediate outlays. The premiums charged by insurers for policies on the exchanges, on the other hand, needed to be calculated and approved before 2014. In all 50 states, insurance regulators normally approve premium rates in the year before an insurance policy will go into effect, and insurers then offer their policies in "open enrollment" periods in the late fall of the year before the policy's coverage year.

See, e.g., Pet.App.95. As such, insurers sold policies at fixed and approved premium rates in 2013 for the 2014 year, and incurred the costs of providing benefits under those policies throughout 2014.

The first of the appropriations riders was not enacted until *December 2014*, in the appropriations bill covering fiscal year 2015. At that point, not only were the premiums for both 2014 and 2015 already fixed, but insurers had already incurred the costs of providing benefits for practically the entirety of 2014—and the government likewise had already incurred its corresponding obligation under §1342 to reimburse a portion of the losses that insurers had suffered in that year.

While a December 2014 appropriations provision addressing fiscal year 2015 can be readily understood to address how an obligation incurred in 2014 could be *satisfied* in 2015, it cannot, absent the clearest language, be understood as trying to make that already-incurred obligation simply *disappear*. Indeed, even if the December 2014 appropriations rider addressing 2015 outlays had expressly repealed §1342, it is not clear that it would have *ipso facto* wiped out the government's obligations to make payments for losses already incurred. After all, it is not at all clear that the government *could* retroactively disavow an obligation to cover losses already incurred without violating the Due Process Clause, the Takings Clause, or both. *See infra* Part I.B.3. Courts should not lightly conclude that Congress intended such a constitutionally suspect result. Instead, the logical inference is that a bill providing funding for 2015 is directed at how

obligations fully incurred in 2014 will be paid; it is not an effort to revisit those substantive obligations and to retroactively eviscerate them.

2. The panel below never asserted that the actual text of the appropriations riders does anything more than limit one source of funds to satisfy the government's obligations under §1342. Instead, rather than focus on the text that actually satisfied bicameralism and presentment, *see INS v. Chadha*, 462 U.S. 919, 951 (1983); U.S. Const. art. I, § 7, the panel focused myopically on legislative history and GAO correspondence that never surfaced in the Congressional Record. Pet.App.25-27. But as this Court's cases make clear, it is the statute itself that must use "words that expressly, or by clear implication, modif[y] or repeal[] the previous law." *Langston*, 118 U.S. at 394. To state the obvious, legislative history—let alone GAO correspondence—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). After all, "legislative history is not the law." *Epic*, 138 S. Ct. at 1631; *see Hill*, 437 U.S. at 191 ("Expressions of committees ... cannot be equated with statutes enacted by Congress[.]"). "The law as it 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." *Aldridge v. Williams*, 44 U.S. (3 How.) 9, 24 (1845).

Allowing legislative history to do the work that the text does not would be particularly pernicious in the implied-repeal 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 there is a risk that a prior Act of Congress that fully complied with the constitutional prerequisites of bicameralism and presentment could be repealed via materials that complied with neither.

Allowing the government to repudiate its prior commitments through legislative history also raises serious notice problems. “Elementary considerations of fairness dictate that individuals should have an opportunity to know what the law is and to conform their conduct accordingly[.]” *Landgraf v. USI Film Prods.*, 511 U.S. 244, 265 (1994). Anyone reading §1342 could see from the plain text of the statute that the government had unambiguously committed to make full risk corridors payments. *See* 42 U.S.C. §18062(b). An exceptionally dedicated reader could conceivably also review Congress’ annual appropriations for HHS, and learn that Congress had limited the use of certain funds to satisfy the government’s obligation to make those payments. But the idea that private citizens should be charged with reviewing the whole legislative record of those appropriations riders, and GAO correspondence not even included in the legislative record, to ascertain what the legislators may have hoped to accomplish through language that merely limits one funding source “descends to needless farce.” *United States v.*

R.L.C., 503 U.S. 291, 309 (1992) (Scalia, J., concurring in part and concurring in the judgment).

The average citizen cannot afford “the cost of repeatedly examining the whole congressional history” to determine the state of the law. *Schwegmann Bros. v. Calvert Distillers Corp.*, 341 U.S. 384, 396 (1951) (Jackson, J., concurring). As a result, “[t]o accept legislative debates to modify statutory provisions is to make the law inaccessible to a large part of the country.” *Id.* at 396-97. Unpublished GAO correspondence is even less accessible. If the government can rely on legislative history and inferences from GAO correspondence to abrogate its prior statutory obligations, it will be utterly impossible for the public to know which commitments the government purports to honor. That uncertainty not only contravenes the clear-statement rule and fair notice principles, but inevitably will drive up the government’s future contracting costs once its counterparties begin pricing in the risks of “a future court’s uncertain interpretation of legislative history.” *Ramah Navajo*, 567 U.S. at 200.

3. In all events, “even assuming legislative history alone could provide a clear statement (which we doubt), none does so here.” *United States v. Kwai Fun Wong*, 135 S. Ct. 1625, 1633 (2015). In concluding otherwise, the majority below 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 letter 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 is nowhere to be found in the legislative record. Nor is there any “statement in the legislative history suggesting that the rider was enacted in response to the GAO’s report.” Pet.App.48. Indeed, there is nothing in the legislative history suggesting that Congress as a whole was even *aware* of the GAO letter. Attempting to cobble together clear congressional intent from inferences drawn from a GAO communication to two Members of Congress is a wildly misdirected inquiry.

While the majority’s second source, a comment by 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” that addresses all aspects of the fiscal year 2015 appropriations act and that fills almost 700 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, much less 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.”).

Even if relevant, moreover, those comments are fully consistent with an intent to limit the funding sources for risk corridor payments, which, not incidentally, is all that the statutory text provides. Indeed, nothing in those comments shows that Representative Rogers, let alone Congress, intended to repeal the substantive obligation to make risk

corridor payments. Instead, Representative Rogers simply noted that *HHS* had predicted that the risk corridor program would be budget neutral, and stated that the first appropriations rider would “prevent *the CMS Program Management appropriation account* from being used to support risk corridor payments”—not that it would limit the use of other government funds for those payments, or rescind the underlying obligation altogether. 160 Cong. Rec. H9838; see Pet.App.79-80.

Finally, even if legislative history were relevant in this clear-statement context (and it is not), the most telling aspects of that history reinforce the conclusion that Congress did *not* intend to repeal or suspend the substantive payment obligation created by §1342. See, e.g., *Fourth Estate Pub. Benefit Corp. v. Wall-Street.com, LLC*, 139 S. Ct. 881, 891-92 (2019) (upholding need for copyright registration and noting that Congress “rejected proposals that would have eliminated registration”). In April 2014—several months *before* the first appropriations rider—the Senate considered a bill 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. See S. 2214, 113th Cong. That bill never passed. Pet.App.49-50, 80. 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 those bills likewise failed to pass. Pet.App.80-81; see *supra* pp.15-16.

The failed bills provide a model of the kind of text that would clearly and accountably accomplish the legislative goal hypothesized by the panel majority.⁵ And that language looks nothing like the actual text of the appropriations riders here. Each of the proposals either expressly repeals or expressly amends §1342. *See, e.g.*, S. 1726, §2 (“The [ACA] is amended by striking section 1342[.]”); S. 123, §2 (same); S. 359, §2 (“The Secretary shall ensure that the amount of payments [out] to plans ... does not exceed the amount of payments [in] to the Secretary” by “proportionately decreas[ing] the amount of payments to plans”); H.R. 724 (same). Equating the actual text of the appropriations riders plus a few snippets of “legislative history” with this kind of clear and unambiguous text is a recipe for disaster. 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 letter and two sentences from a nearly 700-page explanatory statement.

In sum, the text of the appropriation riders contains no “words that expressly, or by clear implication, modif[y] or repeal[]” §1342. *Langston*, 118 U.S. at 394. That ought to be the end of the inquiry. But even if this Court were inclined to look behind the text, the history of the appropriations riders only underscores that they do not eliminate the government’s substantive obligations under §1342.

⁵ Tellingly, Congress used similarly explicit language when it wanted to repeal preexisting substantive provisions elsewhere in the same appropriations legislation at issue here. *See* Highmark Amicus Br.14 n.2 & 15 n.3 (collecting examples).

C. This Court’s Appropriations Rider Cases Reinforce that Conclusion.

This Court’s cases dealing with implied-repeal arguments in the context of appropriations riders reinforce the conclusion that the text and history of the riders compel. Indeed, the careful statutory analysis employed in those cases forecloses the government’s attempt to eliminate its statutory payment obligations through appropriations riders and equivocal legislative history.

1. The correct result in this case follows directly from this Court’s decision in *Langston*. *Langston* involved a statute entitling an American diplomat in Haiti to an annual salary of \$7,500. 118 U.S. at 389. Despite that statute, Congress later appropriated only \$5,000 to pay that salary. *Id.* at 391. This Court concluded that the later inadequate appropriation did not repeal the government’s obligation to pay the diplomat the full \$7,500 salary set by the prior statute. As the Court explained in reaching that conclusion, Congress could not be presumed to have eliminated its previously enacted statutory obligations through an appropriations bill without “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.” *Id.* at 394. Because the later appropriations bill contained no “words that expressly, or by clear implication, modified or repealed the previous law,” it could not be interpreted as rescinding the government’s existing statutory obligation. *Id.*; 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”).

Here too, the appropriations riders contain no “words that expressly, or by clear implication, modified or repealed the previous law.” *Langston*, 118 U.S. at 394. Indeed, the government has never even attempted to identify any language *in the statute* that purports to repeal its obligations under §1342. That is because, as one might expect from appropriations riders, the riders here simply limited the use of certain specific funds that Congress intended for other purposes. The result is no different from an appropriations bill that specified that appropriated funds should be used for a number of limited purposes with no funding for §1342 provided. The failure to appropriate sufficient funds does not extinguish the underlying obligation. Here, as in *Langston*, the fact that Congress “merely appropriated a less amount” to make risk corridor payments than its existing statutory obligations required does not cause those statutory obligations to vanish. *Id.*

2. While this Court had previously concluded that an appropriations rider modified a prior substantive provision in *Mitchell*, it did so because it confronted very different statutory text. In *Mitchell*, Congress had set a fixed \$400 annual salary for interpreters for Indian tribes in Nebraska, and provided that this salary should be “in full of all emoluments and allowances whatsoever.” 109 U.S. at 149; *see id.* at 147 (quoting relevant statutes). Later, however, Congress enacted an appropriations measure that set forth a different and incompatible compensation scheme: It provided \$300 per year in fixed salary 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 scheme of fixed annual compensation “in full of all emoluments and allowances whatsoever,” the Court concluded that the appropriations measure could only be understood as repealing the earlier statute. *Id.* at 149-50. The *Langston* Court thus had little difficulty distinguishing *Mitchell*, because the appropriations measure there contained what the measure in *Langston* lacked: “words that expressly, or by clear implication, modified or repealed the previous law.” *Langston*, 118 U.S. at 394. That conclusion, moreover, caused the plaintiff interpreter in *Mitchell* no unfair detriment, because the subsequent appropriations measure was “in force before and during ... his term of service,” so he had clear notice that his compensation would be based on that part-fixed, part-discretionary scheme. *Mitchell*, 109 U.S. at 150.

Unlike *Mitchell*, the appropriations riders here do not set forth any superseding statutory scheme that would be “irreconcilable” with the existing risk corridors program, or demonstrate that Congress intended to abrogate its commitments under that program. *Id.* And unlike *Mitchell*, the riders here were not “in force before” petitioners joined the risk corridors program, *id.*; the first rider was not enacted until more than a year after petitioners began offering coverage on the exchanges, and after petitioners had

already suffered substantial losses from offering that coverage (and the government had already incurred corresponding payment obligations). Both the statutory text and the palpable lack of fair notice that would result from a contrary conclusion readily distinguish this case from *Mitchell*.

3. This Court's decisions in *United States v. Dickerson*, 310 U.S. 554 (1940), and *United States v. Will*, 449 U.S. 200 (1980), likewise reinforce the conclusion that the riders here cannot be read to eliminate the government's statutory commitments.

In *Dickerson*, Congress had passed a statute in 1922 authorizing a reenlistment bonus for honorably discharged service members. 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, which were expressly cross-referenced. *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 that language, particularly in context, sufficiently clear and explicit to continue the ongoing suspension of the reenlistment bonus. That conclusion was supported not only by the command to withhold funding "notwithstanding" the expressly cross-referenced bonus-authorizing law, but

also by the unambiguous elimination of all funding “in this *or any other Act*” for that purpose. *Id.* at 555 (emphasis added). The legislative history unmistakably reinforced the text’s plain meaning, with repeated statements throughout the legislative record indicating that the later riders were intended to continue the existing suspension. *Id.* at 557-61 & nn.2-4. And as in *Mitchell*, the appropriations measure in *Dickerson* was enacted before the plaintiff reenlisted, providing fair notice in advance rather than purporting to retroactively eliminate the government’s obligations to pay Dickerson for his prior years of service. *Id.* at 555.

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” demonstrated that Congress intended to repeal its previous law, as the rider “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 *Dickerson* 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—including committee reports from both the House and the Senate, a conference report, and numerous statements in the floor debates—reinforced the plain text. *Id.* at 222-24 & nn.24-28.

Just as in *Mitchell*, then, the appropriations measures in *Dickerson* and *Will* 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 555-57 (“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. Pet.App.12 (“funds made available by this Act”). The riders here thus 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*. Equally significant, neither *Dickerson* nor *Will* involved appropriations measures passed long after the government had already incurred its obligations and had already induced literally billions of dollars in reliance by private parties.⁶

Moreover, even assuming legislative history can be relevant in this clear-statement context, *Dickerson* and *Will* each involved extensive and consistent legislative history *reaffirming* the plain meaning of the statutory text, and confirming that Congress did indeed intend to rescind its prior commitments.

⁶ The appropriations measures in *Mitchell* and *Dickerson*, and two of the four appropriations measures in *Will*, were passed before the government began incurring the obligations those measures suspended. *Mitchell*, 109 U.S. at 150; *Dickerson*, 310 U.S. at 555; *Will*, 449 U.S. 206-08. One of the other appropriations measures at issue in *Will* was enacted on the day that the government began incurring its obligations, and one was enacted 11 days after the government began incurring its obligations. *Will*, 449 U.S. at 205-06, 208.

Dickerson, 310 U.S. at 557-61 & nn.2-4; *Will*, 449 U.S. at 222-24 & nn.24-28. Here, by contrast, the record reflects only the kind of “contradictory[] or ambiguous” legislative history that *Dickerson* itself recognized “will not be permitted to control the customary meaning” of the statutory text. 310 U.S. at 562. Indeed, the decision below underscores the lack of clarity in what even the panel thought Congress accomplished, repeatedly describing the riders as “suspending” rather than “repealing” the government’s obligations. *See, e.g.*, Pet.App.21-22, 31-32, 38-39.⁷ But the net effect of three successive “suspensions” of an unambiguous obligation to pay, according to the government, is that it owes petitioners nothing, despite the actual losses they experienced in reliance on the government’s

⁷ That ambiguity is underscored by the formula CMS has used to make payments. CMS has not viewed the appropriation riders as limiting its 2014 payments-out obligation to the amount of 2014 payments in, with its 2015 payments-out obligation similarly restricted to 2015 payments in (which would appear more consistent with the panel majority’s view). Instead, CMS has applied 2015 and 2016 payments in to the government’s obligations for 2014, with no payments having been made for the government’s 2015 and 2016 payments-out obligations. *See supra* n.4. Moreover, appropriations riders enacted in 2018 and 2019 restrict the use of particular funds to make §1342 payments, *see supra* n.3, and HHS itself in its February 2018 proposed budget included an item to fully fund the unpaid risk corridor payments for fiscal years 2014-2016, *Putting America’s Health First, FY 2019 President’s Budget for HHS* 51 nn. 5, 7, 54, 93 (2018). Those actions are hardly consistent with view that those obligations were definitely eliminated by the appropriations riders enacted in 2015-2017. Given all that ambiguity, it strains credulity to claim that Congress unambiguously modified the government’s obligations under §1342.

unambiguous promise. That result finds no support whatsoever in the text of the riders, and it “cannot be squared with Supreme Court precedent.” Pet.App.70.

D. Allowing the Appropriations Riders to Eliminate the Government’s Clear Obligations Under §1342 Would Raise Grave Constitutional Concerns.

The conclusion that the appropriations riders did not repeal the government’s clear obligations under §1342 is reinforced by constitutional avoidance principles. It is one thing to rescind or revise a statutory commitment before it has induced reliance and reciprocal performance by private parties. It is quite another to wait until an existing government obligation has already induced private parties to set premiums and incur enormous real-world losses, and then purport to alter that commitment after private parties have performed just as the government intended. The latter scenario raises constitutional concerns with retroactive legislation and taking of private property that are not implicated when appropriations legislation makes purely prospective changes. Interpreting the appropriations riders here as abrogating the government’s commitment to make risk corridors payments long after premiums were set, services were provided, and losses were incurred—as opposed to merely specifying that a particular fund not be used prospectively to satisfy the government’s already incurred obligations—would raise grave constitutional concerns.

The clear statement rule therefore applies twice over here. The government’s interpretation implicates not just the presumption against implied repeals but

also the “very strong” presumption “that a statute was not meant to act retrospectively, and it ought never to receive such a construction if it is susceptible of any other.” *U.S. Fidelity & Guar. Co. v. Struthers Wells Co.*, 209 U.S. 306, 314 (1908). A retroactive impairment of rights thus cannot be found absent “clear congressional intent favoring such a result,” *Landgraf*, 511 U.S. at 280—a standard that the equivocal appropriations measures and scant legislative history here come nowhere near meeting.

That canon of construction flows not only from principles of basic fairness, but also from fundamental constitutional principles. The Due Process Clause “protects the interests in fair notice and repose that may be compromised by retroactive legislation,” and it prevents Congress from enacting retroactive laws that would infringe those protected interests without adequate justification. *Bank Markazi v. Peterson*, 136 S. Ct. 1310, 1325 (2016). Those “due process restrictions against severe retroactive legislation” protect “[b]oth stability of investment and confidence in the constitutional system.” *E. Enters. v. Apfel*, 524 U.S. 498, 549 (1998) (Kennedy, J., concurring in the judgment and dissenting in part). For that reason, “the Court has given careful consideration to due process challenges to legislation with retroactive effects,” and “treat[ed] due process challenges based on the retroactive character of the statutes in question as serious and meritorious.” *Id.* at 547-48.

Retroactive legislation also raises serious concerns under the Takings Clause, as government action that has significant “economic impact ... on the claimant” and “has interfered with distinct

investment-backed expectations” may constitute a taking that requires just compensation. *Penn Cent. Transp. Co. v. City of N.Y.*, 438 U.S. 104, 124 (1978); see, e.g., *Murr v. Wisconsin*, 137 S. Ct. 1933, 1943 (2017); *E. Enters.* 524 U.S. at 533-37 (plurality opinion) (finding legislation that imposed a “disproportionate and severely retroactive burden” contrary to the “fundamental principles of fairness underlying the Takings Clause”). Thus, under the Due Process Clause, the Takings Clause, or both, allowing the government to rescind prior commitments designed to spur costly private undertakings after they have already induced billions of dollars in reliance is constitutionally dubious in the extreme.

That presumably explains why *none* of this Court’s implied-repeal cases has permitted the government to rescind its prior commitments in an appropriations measure enacted *after* private parties had already rendered significant reciprocal performance. Instead, in nearly all of those cases, the appropriations measures at issue were passed at or before the time of reciprocal performance. See, e.g., *Mitchell*, 109 U.S. at 148, 150 (appropriation passed March 3, 1877; plaintiff began work July 1, 1878); *Dickerson*, 310 U.S. at 555 (appropriation passed June 21, 1938; plaintiff reenlisted July 22, 1938); *supra* n.6. The sole counterexample is *Will*, in which two of the four appropriations measures were enacted a grand total of 12 days into the fiscal year in which performance occurred and obligations were incurred, and those two laws were found unconstitutional under the Compensation Clause. See *Will*, 449 U.S. at 208, 230. The kind of extreme retroactivity the

government seeks to impose here thus is quite literally unprecedented.

The fact that the government has never previously invoked the superficially attractive power to make its obligations disappear retroactively after reliance has been induced and performance rendered strongly suggests that the power does not exist. See *Plaut v. Spendthrift Farm, Inc.*, 514 U.S. 211, 230 (1995); *Printz v. United States*, 521 U.S. 898, 905 (1997). Congress' "prolonged reticence would be amazing if such interference were not understood to be constitutionally proscribed." *Plaut*, 514 U.S. at 230. At a bare minimum, this Court should not lightly infer that Congress exercised such an unprecedented and constitutionally dubious power through the enactment of an appropriations rider that, by its terms, merely limits the source of funds for payment.

In sum, 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 constitutional avoidance principles underlying it. While these concerns apply with particular force to the December 2014 appropriations rider (which the government claims retroactively abrogated the obligations it incurred from performance actually rendered from January 2014 on), they apply to the subsequent riders as well. In each instance, the government seeks to construe a rider that by its terms addressed only the prospective expenditure of funds appropriated for the next fiscal year as retroactively abrogating the obligations that the government had already incurred for services rendered during the

previous year. None of those riders textually suggested that it revisited, repealed, or suspended the obligations that the government had already incurred, and interpreting them in that extraordinary fashion would raise serious constitutional questions. It is not at all clear that Congress has the constitutional power to rescind prior obligations that have already induced significant private reliance and performance, even when it makes that intent explicit. At a bare minimum, that extraordinary result should not be lightly inferred from ambiguous appropriation riders, let alone from obscure legislative history.

E. If the Appropriations Riders Really Did Impliedly Repeal §1342, then the Government Has Committed a Breach of Contract.

If Congress really did intend to vitiate its payment obligation long after insurers set their premiums and long after insurers upheld their end of the bargain by insuring previously uninsured individuals, then it could not simply escape its payment obligations without consequence. The government is not free to make the kind of clear promise to pay embodied in §1342 and then wash its hands of the matter after performance by the counterparty has been rendered and the obligation to pay comes due. If the appropriations riders really were intended to have that unfair and dramatic effect, they would constitute a clear breach of contract.

The panel below unanimously agreed that §1342 imposes an “unambiguously mandatory” obligation on the government to make risk corridor payments, Pet.App.16—an obligation that is not conditioned on

the availability of sufficient payments in, or on the subsequent appropriation of funds to honor the government's commitments. That unambiguous obligation is precisely what the government used to induce insurers to participate on the exchanges. Indeed, given the uncertainties inherent in providing health insurance to previously uninsured individuals, the government knew that anything short of an unambiguous commitment to share downside risks would cause insurers to stay away from the exchanges or price premiums for the worst-case scenario. A commitment to share downside risks only to the extent of payments in would have done little to reassure, as the extent of payments in was no more predictable than the risk profiles of the new insureds. (The CBO's predictions, for example, were off by several orders of magnitude. *See supra* n.1). The government not only used its unambiguous promise to induce insurers to participate in the exchanges and lower premiums, but also directly benefited from the induced reliance, as the lower premiums translated into reduced tax subsidies and attendant savings for the federal fisc. In short, the government induced reliance to fulfill its policy goals and directly benefited from that reliance by reducing its outlays.

Thus, §1342 plainly 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). And the undisputed facts confirm that "the insurers and the [government] entered into mutual commitments with respect to the conditions of performance of the Affordable Care Act." Pet.App.59; *see supra* pp.7-11. Accordingly, even if Congress had

repealed its statutory obligation to make risk corridors payments, it still would remain contractually obligated to fulfill that obligation.

The government's refusal to acknowledge its own contractual commitment is at considerable odds with its view that §1342 bound—and continues to bind—its contracting partners. While the government insists that it is not bound to make payments *out* under §1342, it has never suggested that insurers are no longer bound to make payments *in*. If the insurers who turned a profit on the exchanges suddenly announced that they were not going to make risk corridor payments *to* the government, or were going to pay only a small pro rata share of the amounts they owed, it is hard to imagine the government would excuse the insurers from their reciprocal obligations under §1342. The law, however, does not permit the government to hold its private partners to their commitments while ignoring its own. *See Mobil Oil Expl. & Prod. S.E., Inc. v. United States*, 530 U.S. 604, 607-08 (2000); *United States v. Winstar*, 518 U.S. 839, 895-96 (1996) (plurality opinion).

Indeed, the government's position would impose a *double* double standard, since even after the government failed to live up to its own commitments, petitioners remained contractually bound to provide health coverage (and incur the corresponding costs) to consumers who had purchased their policies through the exchanges before the government reneged. In other words, the insurers remained bound to provide the very coverage that the government specifically induced petitioners to provide. The government cannot “renege on its legislated and contractual

commitments” yet leave private parties bound by their reciprocal contractual commitments to bear the consequences. Pet.App.68.

The government’s contrary position not only is at odds with basic principles of government contracting, but paradoxically would make congressional promises the easiest commitments to break. There is no question that a clear contractual undertaking made by an authorized government contracting officer is binding on the government. *See, e.g., Mobil Oil*, 530 U.S. at 607; *Winstar*, 518 U.S. at 890-91. And as this Court has long held, “[w]hen the United States enters into contract relations, its rights and duties therein are governed generally by the law applicable to contracts between private individuals.” *Lynch v. United States*, 292 U.S. 571, 579 (1934); *see, e.g., Mobil Oil*, 530 U.S. at 607-08; *Winstar*, 518 U.S. at 895 (plurality opinion); *United States v. Bostwick*, 94 U.S. 53, 66 (1876) (“The United States, when they contract with their citizens, are controlled by the same laws that govern the citizen in that behalf.”). It would be nothing short of bizarre if the actions of a low-level contracting officer sufficed to bind the government, but Congress itself could make a clear and binding promise, induce reliance and reciprocal performance based on that promise, and then break that promise with impunity.

II. Allowing The Government To Evade Its Obligations Under §1342 Would Have Dire Consequences.

The government’s effort to shirk its obligations under §1342 not only lacks legal support, but would have devastating consequences, both for the

government’s “credibility as a reliable business partner,” Pet.App.83, and for the nation’s healthcare markets. A decision validating that effort would serve as 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.

A. Holding the Government to the Clear-Statement Rule Preserves Accountability.

At its core, this case is about “the integrity of government.” Pet.App.67. The rule that Congress must act clearly when it repeals its own laws and seeks to apply legislation retroactively 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 or renege on multi-billion-dollar promises, our democratic system requires it to do so through a “step-by-step, deliberate and deliberative process,” and “only after opportunity for full study and debate.” *Chadha*, 462 U.S. at 951, 959. That process ensures that the public can understand the changes being considered, and that Congress can be held politically accountable for its decisions.

The presumption against implied repeals effectuates that principle by preventing Congress from repealing legislation that satisfied bicameralism and presentment through mere implications. *See 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”); *Chadha*, 462 U.S. at 951 (noting “the Framers’

decision that the legislative power of the Federal government be exercised [only] in accord with a single, finely wrought and exhaustively considered, procedure”). The particularly strong presumption against implied repeals via appropriations legislation likewise serves those interests because appropriation bills are not where the public would naturally look for major changes to substantive requirements and appropriations bills typically address the funding for a wide variety of disparate programs. An appropriations rider, in short, is the perfect place to try to hide a substantive policy shift while avoiding any real accountability for the change. Indeed, the only better place to hide such a change would be the legislative history—perhaps deep in a 700-page “explanatory statement”—accompanying an appropriations bill. Allowing the government to evade its prior commitments through obscure legislative history rather than clear statutory text would threaten the basic structure of political accountability on which our constitutional system depends.

Equally problematic, that approach would undermine fundamental separation of powers principles by allowing Congress to divert responsibility for its choices onto the other branches of government. Our constitutional structure requires each branch of government to make its decisions “in full view of the public, and ... suffer the consequences if the decision turns out to be detrimental or unpopular.” *New York v. United States*, 505 U.S. 144, 168 (1992). The decision below, by contrast, allows Congress to make a clear promise to pay, only to ambiguously hamstring the ability of the Executive to cut a check and then force private parties to seek

redress in the courts. That somebody-else's-problem approach creates the very "diffusion of accountability" that the separation of powers is designed to prevent. *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 561 U.S. 477, 497 (2010). Allowing Congress and the Executive each to rely on ambiguous language and legislative history to blame the other for the government's failure to fulfill its obligations would make it well-nigh impossible for the public to "determine on whom the blame or the punishment of a pernicious measure ... ought really to fall." *Id.* at 498 (quoting *The Federalist* No. 70, at 428 (Clinton Rossiter ed. 1961) (A. Hamilton)).

In short, if Congress intends to adopt a dramatic about-face of the kind that the government claims here, it must do so in clear and express terms that take 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." Pet.App.47.

B. The Government's Position Threatens Future Government Partnerships with the Private Sector.

The government's position in this case is not only legally unfounded, but profoundly shortsighted. In practically every area in which it operates, the government "deals with non-governmental entities that carry out legislated programs." Pet.App.66. And its "ability to benefit from participation of private enterprise depends on the government's reputation as a fair partner." Pet.App.59-60; *cf.* 48 C.F.R. §1.102(b)(3) (committing Federal Acquisition System to "[c]onduct business with integrity, fairness, and

openness”). The government’s view that it “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,” fundamentally “undermines the reliability of dealings with the government.” Pet.App.60.

After all, 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.” Pet.App.68-69 (quoting *Ramah Navajo*, 567 U.S. at 191-92). That shortsighted approach will make future public-private partnerships “more cumbersome and expensive for the Government,” causing significant damage to “the long-term fiscal interests of the United States.” *Ramah Navajo*, 567 U.S. at 191-92; *see also, e.g., Winstar*, 518 U.S. at 883-84 (plurality opinion) (recognizing “the Government’s own long-run interest as a reliable contracting partner in the myriad workaday transactions of its agencies,” and rejecting government arguments that would “undermin[e] the Government’s credibility at the bargaining table and increas[e] the cost of its engagements”).

Moreover, allowing the government to shed its commitments via equivocal appropriations riders and obscure legislative history would create terrible incentives. If the government really has the power to make its solemn commitments disappear after the fact, despite the serious constitutional questions that power would raise, the government should at least have to make it pellucidly clear that it actually intends

to invoke 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. The government should not be permitted to have its cake and eat it too, by making statutory promises disappear via mere implications in the legislative history of appropriations bills.

In short, the government may not make its reliance-inducing promises openly and clearly, and then issue its reliance-destroying reversals quietly and through indirection. As a matter of principle, such an approach "is hardly worthy of our great government." Pet.App.68 (quoting Pet.App.152); see *Winstar*, 518 U.S. at 886 n.31 (plurality opinion) ("[I]t is no less good morals and good law that the Government should turn square corners in dealing with the people than that the people should turn square corners in dealing with their government."). And as a matter of practice, it is a recipe for disaster.

C. The Government's Refusal to Abide by §1342 Had Devastating Effects on the Health Insurance Market.

If all of that were not enough, the government's refusal to live up to its risk corridor obligations has had devastating effects on the nation's health insurance market. The government enacted §1342 "to persuade the nation's health insurance industry to provide insurance to previously uninsured or uninsurable persons" by committing the government to share the "insurance risks of unknown dimension" created by the exchanges. Pet.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.” Pet.App.83. The government benefitted from lower premiums (via reduced outlays for tax subsidies) and increased the need for and amount of risk corridor 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, leaving insurers on the hook for more than \$12 billion in losses that the government had promised to reimburse.

Predictably, the effect on the insurers, who took the government at its word and responded to its incentives precisely as the government intended, and on their customers was 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.” Pet.App.84. Those collapses left almost a million Americans without health insurance. Nicholas Bagley, *Trouble on the Exchanges: Does the United States Owe Billions to Health Insurers?*, 375 *New Eng. J. Med.* 2017, 2018 (2016); see *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 89, 94 (Fed. Cl. 2016) (describing imminent cancellation of insurance to 50,000 customers on account of government’s failure to make \$74 million in risk corridors payments). In addition, “[s]everal health insurance companies withdrew from the ACA exchanges entirely,” reducing consumer choice and competition on those exchanges. Pet.App.84. By 2017, nearly one in five exchange

customers had only one insurer on their local exchange. Bagley, *supra*, at 2017; *see* State Amici Br. 7-9; *supra* pp.18-19 (describing how Moda was forced to stop offering insurance to ACA customers in Alaska, leaving only one insurer on that exchange).

The government's failure to carry out its obligations affected the insurers who remained on the exchanges, who "had to compensate for [the] uncertainty in payment by offering health plans at higher prices than before." Pet.App.84 (emphasis omitted). According to one study, the government's decision not to make risk corridors payments coupled with the eventual termination of the risk corridors program caused an estimated 86% of the rise in health insurance premiums from 2015 to 2017. Daniel W. Sacks, et al., *How Do Insurance Firms Respond to Financial Risk Sharing Regulations?*, Nat'l Bureau of Econ. Research, Working Paper No. 24129 at 4 (rev. 2019), <https://bit.ly/2FobV73>. The government's failure to meet its obligations thus "impact[ed] the cost of health care insurance for virtually all Americans," Pet.App.84, driving up prices across the board and undermining the stable and affordable healthcare markets that the ACA was designed to achieve.

* * *

In sum, the government's insistence that Congress can repeal substantive statutory obligations through ambiguous appropriations riders and legislative history is contrary to this Court's cases, settled principles of statutory construction, and core constitutional principles. It threatens basic principles of government accountability, undermines the government's ability to partner with the private

sector, and had devastating effects on the nation's health insurance market. The Court should reverse and hold the government to the unambiguous commitment that it made.

CONCLUSION

For the foregoing reasons, this Court should reverse.

Respectfully submitted,

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