18-2583

United States Court of Appeals for the Second Circuit

UNITEDHEALTHCARE OF NEW YORK, INC.,
OXFORD HEALTH INSURANCE, INC.,

Plaintiffs-Appellants,

v.

MARIA T. VULLO, in her official capacity as
Superintendent of Financial Services of the State of New York,

Defendant-Appellee.

On Appeal from the United States District Court
for the Southern District of New York

BRIEF FOR APPELLEE

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PRELIMINARY STATEMENT

In 2016, the U.S. Department of Health and Human Services (HHS) determined that the risk-adjustment program it operates under the Affordable Care Act (ACA) was having an exaggerated effect and unintended consequences in several States, including New York. This program ("the ACA Risk Adjustment Program") failed to account for state-specific factors and therefore had destabilizing effects on the health insurance markets in those States. Exercising its discretion over the program, HHS encouraged and authorized States, including New York, to "examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets," 81 Fed. Reg. 29,146, 29,152 (May 11, 2016), and to "take temporary, reasonable measures under State authority to mitigate effects under their own authority," 81 Fed. Reg. 94,058, 94,159 (Dec. 22, 2016); 82 Fed. Reg. 51,052, 51,073 (Nov. 2, 2017).

To address the problems that HHS had identified in the New York market, the New York State Department of Financial Services (DFS) did what HHS had said it could and should do. Exercising statutory authority that has existed under state law since 1992, DFS activated a New York-

specific risk adjustment program to mitigate the destabilizing effects of the ACA Risk Adjustment Program on the New York health insurance market.

In this case, the United States District Court for the Southern District of New York (Koeltl, J.) correctly rejected the plaintiffs' claim that New York's regulatory response to HHS's invitation was preempted by the ACA. As the district court found, this argument disregards HHS's repeated and express *approval* of state-law programs such as New York's that work in conjunction with the ACA Risk Adjustment Program. Indeed, HHS reiterated that approval just eight months ago, in response to direct questions about the validity of the New York program challenged here. As the district court further recognized, HHS's position is consistent both with the States' traditional role in regulating their own insurance markets and with provisions of the ACA that expressly preserve rather than preempt state insurance regulations. This Court should accordingly affirm the district court's dismissal of the plaintiffs' preemption claims.

This Court may also reject the preemption claims on the alternative ground that the plaintiffs have no private right of action or right to

equitable relief here. The Supreme Court has squarely held that the Supremacy Clause provides no basis for a private lawsuit. And there is no individual-rights-conferring language in the ACA's risk adjustment provisions that would support a private claim here. To the contrary, the ACA expressly vests HHS with discretion to determine whether a State is acting inconsistently with federal risk adjustment requirements, and provides that HHS may exercise specific remedies if it finds such a violation. Under settled Supreme Court precedent, the commitment of specific statutory remedies to a federal agency's discretion demonstrates Congress's intent to preclude private claims like the ones the plaintiffs bring here.

Finally, the plaintiffs' takings and exaction claims were properly dismissed. Those claims should have been dismissed altogether as unripe. In any event, the takings and exaction claims are meritless because (1) they rely on the incorrect premise that New York's risk adjustment is preempted, and (2) under state law, insurers have no protected property interest in receiving excessive risk adjustment payments.

ISSUES PRESENTED

1. Whether the ACA's risk adjustment provisions preempt New York's preexisting state risk adjustment authority, when HHS has repeatedly encouraged and endorsed state-law programs like New York's, and the ACA preserves rather than supplants state regulatory authority.

2. Whether the plaintiffs have a private right of action or a right to equitable relief on their claims that New York's state risk adjustment program is preempted by the ACA, when the federal statute vests enforcement discretion with HHS alone, and HHS has expressed support for the State's actions.

3. Whether DFS's exercise of its lawful authority under New York's risk adjustment statute constitutes an unlawful taking or exaction under the Takings Clause of the U.S. Constitution.

STATEMENT OF THE CASE

A. New York's Risk Adjustment Program

In health insurance markets, insurers will often face dramatically different costs from year to year based on unanticipated differences in the health of their insured populations. Risk adjustment programs help to reduce these disparities by requiring insurers with relatively healthier

enrollees to make payments into a common fund, which can then be disbursed to insurers with relatively unhealthier enrollees. By thus reducing the costs of insuring individuals who may be sicker than the average enrollee, risk adjustment programs deter insurers from "avoiding or failing to insure" such individuals or "avoiding or terminating coverage of persons whose health care costs are high." (Second Powell Decl. ("Powell 2d Decl."), ECF No. 40, ¶ 6 (quoting 11 N.Y.C.R.R. § 361.1(1)-(2).)

In 1992, the New York Legislature granted DFS broad authority to develop a risk adjustment program in New York.[1] *See* Insurance Law § 3233. DFS adopted implementing regulations that specified funding levels and formulas for risk adjustment for each year from 1993 to 2013. *See generally* 11 N.Y.C.R.R. pt. 361. Other States have also authorized similar programs to accomplish the same ends, and have given their insurance commissioners or equivalent officials broad authority to define

[1] DFS is authorized to create such a program in both the individual market and the small group market, which includes employers with one hundred or fewer employees. Insurance Law § 3221(h)(3).

the contours of the programs. *See, e.g.*, Utah Code Ann. § 31A-30-302(1)-(2) (West 2018); Minn. Stat. Ann. § 62Q.03(1), (6)-(10), (12) (West 2018).

B. Affordable Care Act (ACA) Risk Adjustment Program

In 2010, Congress enacted the ACA, which authorized HHS to create and operate an ACA-specific risk adjustment program. *See* 42 U.S.C. § 18063. The statute instructs HHS to "establish criteria and methods" for risk adjustment under the ACA "in consultation with States." *Id.* § 18063(b).

Congress was careful to emphasize that the ACA was not intended to interfere with or preempt State regulatory authority, expressly providing that "[n]othing in [the ACA] shall be construed to preempt any State law that does not prevent the application of the provisions of [the ACA]." *Id.* § 18041(d). Congress delegated to the Secretary of HHS the authority to supervise and enforce the implementation of the ACA's federal risk adjustment program, providing that "the Secretary determines" whether "a State law or regulation" on risk adjustment is consistent with the federal program. *Id.* § 18041(b)(2), (c)(1)(B)(ii)(I).

In 2013, HHS promulgated a federal risk adjustment program, which became operational for the 2014 benefits year. *See* 78 Fed. Reg.

15,410, 15,527-28 (Mar. 11, 2013); 42 U.S.C. §§ 18041(a)(1)(C), 18063(b). HHS has expressly acknowledged that the statutory and regulatory provisions governing the federal risk adjustment program do not preclude all state regulation in this area, particularly during the complex transition to the ACA's many market reforms. As explained more fully below, see *infra* at 12-16, HHS recognized that "local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets," and expressly endorsed programs like New York's that tailor risk adjustment to account for local circumstances, 81 Fed. Reg. 94,058, 94,159 (Dec. 22, 2016).

C. The Department of Health and Human Services's Endorsement of New York's Program to Address the ACA Risk Adjustment Program's Distortions

The ACA became fully operational on January 1, 2014. Both HHS and DFS quickly determined, however, that application of the ACA Risk Adjustment Program failed to account for certain New York-specific factors and thus led to substantial distortions in New York's health insurance markets. As HHS reviewed its data for 2014, it found that certain insurers owed substantially higher risk adjustment payments than expected—particularly "new, rapidly growing, and smaller issuers."

81 Fed. Reg. 29,146 29,152 (May 11, 2016). DFS identified similar distortions, finding that under the federal program many smaller insurers would have to pay tens of millions of dollars that would "represent a significant portion of their revenue" (Joint Appendix ["JA"] 77; *see also* Letter from Maria T. Vullo, Superintendent of Fin. Servs., to Sylvia M. Burwell, Secretary of HHS, at 2 (June 28, 2016) (ECF No. 38-13)).

There are several ways to measure the distorting effect of the ACA Risk Adjustment Program in New York as compared to other states. Powell 2d Decl. ¶ 22. The first is by comparing the aggregate dollar amount of the transfer—i.e., the size of the State's ACA Risk Adjustment pool—in New York as compared to other states. *Id.* This measure demonstrates the sheer magnitude of the transfers in New York. For the 2014 plan year, New York's ACA risk adjustment pool for the small group market was $195,038,660—by far the largest in the country. *Id.* ¶ 23. The State with the second-highest risk adjustment pool was California, at $42,543,626—approximately one-fifth the total amount of money transferred compared to New York, despite California's far larger population. *Id.* The state with the third highest risk adjustment pool

was Pennsylvania, at $31,567,964. *Id.* In short, New York's risk adjustment pool was materially larger relative to its population. *Id.* This distortion continued in future years. *Id.* ¶ 24.

A second measure of the impact of the ACA Risk Adjustment Program in New York is to compare States' average transfers per member per month. *Id.* ¶ 26. For the 2014 plan year, New York's per member per month transfer in the small group market was $23.91, compared to California's $9.21 or Pennsylvania's $12.93. *Id.* ¶ 27. The average per member per month transfer across all States was $12.73—approximately half of the New York rate. *Id.*

A third measure is a State's average plan liability risk score, which is determined by calculating each individual enrollee's health risk based on the diagnosis codes in claims data, and then averaging all enrollees in the market. *Id.* ¶ 29. Contrary to expectations, HHS has calculated New York to have the highest risk score in the nation in every single year that the ACA Risk Adjustment Program has been run. *Id.* ¶ 30. New York's risk score for 2014 was 7.5 percent higher than that of Oklahoma (the second-highest). *Id.* In 2015, New York's risk score was 14 percent higher than Alabama's. *Id.*

The distorted math of the ACA Risk Adjustment program is also evident from the plaintiffs' own data. The risk adjustment transfers calculated by the ACA Risk Adjustment Program far exceeded the estimates prepared by actuaries at both UnitedHealthcare and Oxford. *Id.* ¶ 31. Plaintiffs thus received hundreds of millions of more transfers under the ACA Risk Adjustment Program than even they had expected. Given that DFS relied on the plaintiffs' actuarial expectations in setting health insurance premiums, the excess risk adjustment transfers mean that they were permitted to charge and received far higher health insurance rates than they would have been allowed had the projected risk adjustment receivable equaled the actual amounts received. *Id.* ¶ 32.

These distorting effects of the ACA Risk Adjustment Program had significant negative consequences for the New York health insurance market. During the first two years of the ACA Risk Adjustment Program, one New York insurer became insolvent and another voluntarily withdrew from the New York market in part because of the large unanticipated payments they were required to make under the federal program. *Id.* ¶ 41. In consultation with HHS, DFS was able to identify the specific distorting features of the ACA Risk Adjustment Program. DFS's

actuarial team determined that thirty percent of the extraordinarily large federal risk adjustment transfers in New York could be attributed to two particular factors that had a disproportionate adverse effect in this State. *Id.* ¶ 38.

First, DFS determined that the federal program led to inflated risk scores—and thus inflated payment transfers—because it treats certain non-claims expenses by insurers (such as administrative expenses) as "losses." 38 N.Y. Reg. 63, 64-65 (Sept. 28, 2016). Under New York law, by contrast, only payments of claims are treated as losses for purposes of setting premium rates. *See* DFS, Insurance Circular Letter No. 15 (Dec. 22, 2011) (internet).[2] As a result, the methodology applied by HHS overestimated certain insurers' actual losses.

Second, New York has unique rules governing the coverage of children that the federal program disregards. DFS regulations require a plan that covers *any* children to cover *all* children in a family at the same rate—meaning that the rate does not increase even if a family has more children. *See* N.Y. State Dep't of Fin. Servs., *Instructions for the Filing of*

[2] For authorities cited as available on the internet, full URLs appear *supra* in the Table of Authorities.

2019 Premium Rates (internet). (In other States, by contrast, plans may offer different premium structures that cover specific numbers of children.) The federal risk adjustment formula "exclude[s] children who do not count toward family rates or family policy premiums" when calculating a plan's number of billable members. 81 Fed. Reg. at 94,104. Thus, the federal risk adjustment rules artificially treat all New York family plans as plans that cover a single child. The federal program's treatment of plans covering children thus leads to an anomaly that causes inflated plan liability risk scores in New York. 38 N.Y. Reg. at 64-65.

New York was not the only State to raise concerns about the ACA Risk Adjustment Program with HHS. In response to these concerns, HHS in May 2016 published a notice in the Federal Register in which it recognized that certain insurers "owed substantial risk adjustment charges that they did not anticipate" under the federal program. 81 Fed. Reg. at 29,152. HHS noted that it had consulted and was continuing to consult with "State regulators on . . . the effects of unanticipated risk adjustment charge amounts." *Id.* "[R]ecogniz[ing] that States are the primary regulators of their insurance markets," HHS expressly "encourage[d] States to examine whether any local approaches, under

State legal authority, are warranted to help ease this transition to new health insurance markets." *Id.*

HHS repeated this encouragement several more times over the next two years. In December 2016, HHS again acknowledged the problem of "certain issuers, including some new, rapidly growing, and smaller issuers, ow[ing] substantial risk adjustment charges [under the federal program] that they did not anticipate," and "continue[d] to encourage States to examine whether any local approaches, under State legal authority," could address this specific problem. 81 Fed. Reg. at 94,159. In November 2017, HHS once more "recognized some State regulators' desire to reduce the magnitude of [federal] risk adjustment charge amounts for some issuers," and again invited States to pursue "any local approaches under State legal authority" to accomplish that goal. 82 Fed. Reg. 51,052, 51,072 (Nov. 2, 2017).

New York responded in exactly the way HHS had encouraged it to do. In response to HHS's express invitation, DFS determined that it would exercise its state-law authority under Insurance Law § 3233 to utilize an additional state-run risk adjustment program for the 2017 plan year "on an emergency basis" in order to prevent "unnecessary instability

in the health insurance market." 38 N.Y. Reg. at 63. Under DFS's emergency regulations—which became final regulations this past summer—DFS will review the federal risk adjustment results after they are released, with a particular focus on the New York-specific factors discussed above: namely, the treatment of non-claims expenses as losses, and the failure to account for New York's rating tiers for children. *See* 11 N.Y.C.R.R. § 361.9(b)(1), (e)(1). Based on that review, DFS must identify a percentage of New York insurers' federal risk transfer payments (up to thirty percent) that should be collected in a risk adjustment pool "to correct any one or more of the adverse market impact factors." *Id.* § 361.9(e)(1). That pool will then be distributed to carriers that paid money into the federal risk adjustment program. *Id.* § 361.9(e)(2).[3]

DFS designed this additional risk adjustment program in close consultation with HHS. Before promulgating the emergency risk adjustment regulation for the 2017 plan year, DFS discussed its intended approach in detail with several high-level HHS officials who were supervising the federal risk adjustment program. Among other things,

[3] In July 2018, DFS promulgated a similar regulation for plan year 2018 and beyond. *See generally* 11 N.Y.C.R.R. § 361.10.

DFS held a telephone call in September 2016 with CMS officials, including its director of payment policy and financial management, in which DFS described both the form and the content of DFS's draft regulation reactivating New York's state risk adjustment program, how it would operate, and the state legal authority for the regulation (*see* Powell 2d Decl. ¶¶ 42-43; *see also* JA 101-102). The officials at no point objected to DFS's anticipated approach (JA 109; Powell 2d Decl. ¶¶ 42-43, 47). A year later, in September 2017—following a change in presidential administrations—DFS held another walkthrough call with HHS officials serving in similar roles in the new administration, and the federal agency continued to support DFS's actions (*see* Powell 2d Decl. ¶ 48). For example, in October 2017 a CMS payment policy official sent an e-mail to DFS in which she thanked DFS for its detailed explanation of the New York state risk adjustment program and offered to assist if "anything would be helpful on our end as you operationalize your regulation" (*see* Powell 2d Decl. ¶ 49).

In April 2018, HHS publicly endorsed New York's approach in its final rule implementing the federal risk adjustment program for 2019, and moreover cited it as an example for other States. As HHS observed,

a "few commenters noted that New York has already taken action to reduce transfers under the State's authority"—a reference to the DFS regulations being challenged here—"and requested clarification whether other States could continue to take steps under existing State authority." 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018). In particular, HHS noted that commenters had inquired whether States could "implement[] any State-specific adjustments" to risk adjustment payments like New York's without obtaining HHS approval. *Id.* HHS responded to these inquiries by again confirming its approval of "local approaches under State legal authority" to respond to distortions caused by the federal risk adjustment program, and concluded that "States that take such actions and make adjustments do not generally need HHS approval as these States are acting under their own State authority and using State resources." *Id.*

D. Procedural History

In October 2017, plaintiffs brought this action against DFS, claiming that the ACA preempts New York's 2017 and 2018 regulations (JA 3, 16-60). In August 2018, the district court dismissed the complaint (JA 144-180).

The district court rejected plaintiffs' arguments for both express and field preemption, relying on multiple provisions of the ACA that explicitly preserve rather than displace state laws in recognition of the States' traditional authority to regulate their insurance markets (JA 159-162). The court also rejected plaintiffs' assertion of conflict preemption. It held that the ACA and HHS's implementing regulations relate solely to the federal risk adjustment program, not to local state programs; and that "HHS has explicitly acknowledged that such local programs may be necessary and encouraged States to consider adopting them" (JA 166). The court thus concluded that "the fact that the agencies responsible for implementing" the federal risk adjustment program "have repeatedly stated that States may turn to their own authority to adjust for unintended consequences of the [federal program] . . . is strong evidence that the ACA does not preempt" New York's program (JA 170). Finally, the district court rejected the plaintiffs' takings and exaction claims, holding them meritless and also unripe to the extent that they challenged the application of the 2018 emergency regulation (JA 174-176).

In September 2018, the district court denied plaintiffs' request for an injunction, pending appeal, against enforcement of the 2017

regulation. *See* Mem. Order & Opinion, ECF no. 83. In November 2018, a motions panel of this Court granted a temporary injunction pending appeal but ordered expedited, simultaneous briefing. See Order, dkt. no. 18-2583, doc. no. 54 (2d Cir. Nov. 19, 2018).

STANDARD OF REVIEW AND SUMMARY OF ARGUMENT

This Court reviews *de novo* a grant of a motion to dismiss pursuant to Rule 12(b)(6) of the Federal Rules of Civil Procedure. *See Carpenters Pension Trust Fund of St. Louis v. Barclays PLC*, 750 F.3d 227, 232 (2d Cir. 2014).

I.A. The district court correctly concluded that the ACA does not preempt New York's risk adjustment program. HHS has repeatedly and unambiguously supported New York's program as a reasonable way to adapt federal risk adjustment payments to local circumstances. That consistent support forecloses the plaintiffs' argument that risk adjustment under New York's laws impermissibly conflicts with the ACA, especially given the extensive authority that the ACA confers on HHS to administer the federal risk adjustment program. By contrast, the relief plaintiffs seek would undermine the purposes of the ACA by preventing the

implementation of a fix to risk adjustment payments in New York that both federal and state regulators have agreed is necessary.

There is also no express preemption under the ACA or its implementing regulations. The statute expressly preserves state regulatory authority, and the regulations by their own terms do not foreclose the operation of state risk adjustment programs created under state statutory authority, as HHS has repeatedly recognized.

I.B. Alternatively, this Court may affirm the dismissal of the plaintiffs' preemption claims because the plaintiffs have no private right of action or right to equitable relief. The plaintiffs have no right of action under the Supremacy Clause, and the absence of individual-rights-creating language in the ACA's risk-adjustment provisions forecloses them from suing under that statute or through 42 U.S.C. § 1983. The plaintiffs also cannot seek equitable relief because, under the Supreme Court's decision in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), the comprehensive authority vested in HHS to enforce the ACA shows Congress's intent to preclude private equitable relief.

II. The district court also correctly dismissed the plaintiffs' takings and exaction claims. Under the ripeness doctrine first established

in *Williamson County Regional Planning Commission v. Hamilton Bank of Johnson City*, 473 U.S. 172 (1985), all of the plaintiffs' takings claims are unripe because there has been no final agency determination, and the plaintiffs have indisputably failed to pursue state-law relief for any alleged appropriation. The plaintiffs' takings challenge to risk adjustment for the 2018 benefit year are also unripe for the additional reason that no payments have been made for that year, as the district court correctly recognized.

In any event, the plaintiffs' takings and exaction claims are meritless since they are predicated on the erroneous view that the state adjustments are preempted and thus unlawful. Moreover, in light of DFS's comprehensive authority under New York law over the insurance industry, the plaintiffs cannot claim any property interest in being free from risk adjustment payments required by state regulations.

ARGUMENT

POINT I

THE DISTRICT COURT CORRECTLY DISMISSED THE PLAINTIFFS' PREEMPTION CLAIMS

A. New York's Risk Adjustment Program Is Not Preempted by the ACA.

The district court correctly held that the ACA does not preempt the DFS regulations at issue here. HHS's consistent and pointed endorsement of "local approaches under State legal authority" to address "the magnitude of risk adjustment charge amounts" under the federal program, *e.g.*, 82 Fed. Reg. at 51,072, forecloses the plaintiffs' claim of conflict preemption. And no provision of the ACA (or HHS's regulations) warrants overturning the agency's judgment that federal and state approaches to risk adjustment can work in tandem, particularly in light of the unusually strong presumption against preemption of state insurance regulation.

1. Plaintiffs' Conflict Preemption Arguments Fail in Light of HHS's Repeated Endorsements of New York's Risk Adjustment Program.

A court will find conflict preemption only when a state law or regulation "is an obstacle to the achievement of federal objectives." *New York SMSA Ltd. P'ship v. Town of Clarkstown*, 612 F.3d 97, 104 (2d Cir. 2010). As the district court correctly held (JA 166-170), plaintiffs' conflict preemption claims cannot be reconciled with HHS's specific, repeated, and recent approvals of state-law action such as New York has undertaken here.

HHS could not have been more direct. For more than two years, and most recently under the current presidential administration, HHS has actively encouraged States to take action under state law, in their capacity as "the primary regulators of their insurance markets," to mitigate "the effects of unanticipated risk adjustment charge amounts" under the federal program. 81 Fed. Reg. at 94,159; *see also* 81 Fed. Reg. at 29,152 (same). See *supra* at 12-16. In November 2017, HHS specifically acknowledged "State regulators' desire to reduce the *magnitude* of [federal] risk adjustment charge amounts for some issuers," and again "encouraged States to examine whether any local approaches under State

legal authority are warranted" to address this concern. 82 Fed. Reg. at 51,072 (emphasis added). In the fall of 2017, DFS fully disclosed to HHS officials its intent to take such action; the federal officials encouraged DFS to continue and offered their help. See *supra* at 14-16. And in April 2018, responding to questions about the validity of New York's action in particular, HHS reiterated its endorsement of such "local approaches under State legal authority," concluding that "States that take such actions and make adjustments do not generally need HHS approval as these States are acting under their own State authority and using State resources." 83 Fed. Reg. at 16,960.

HHS's explicit and pointed endorsement of state-law approaches such as New York's removes any suggestion that such programs conflict with federal law. Both the Supreme Court and this Court have declined to find conflict preemption when the relevant federal agency endorses, or even fails to object to, state regulation. *See Hillsborough Cty., Fla. v. Automated Med. Labs., Inc.*, 471 U.S. 707, 721 (1985) (declining to find conflict preemption "since the agency has not suggested that the county ordinances interfere with federal goals"); *Steel Inst. of New York v. City of New York*, 716 F.3d 31, 40 (2d Cir. 2013) ("[W]e are reassured by

OSHA's view . . . that the City regulations (and other municipal codes like it) do not interfere with OSHA's regulatory scheme."). These cases reflect the courts' understanding that agencies "have a unique understanding of the statutes they administer and an attendant ability to make informed determinations about how state requirements may pose an obstacle to the accomplishment and execution of the full purposes and objectives of Congress." *Wyeth v. Levine*, 555 U.S. 555, 577 (2009) (quotation marks omitted). An agency's view that state regulation is compatible with federal law merits particular respect when, as here, "Congress has delegated to [the agency] authority to implement the statute; the subject matter is technical; and the relevant history and background are complex and extensive." *Geier v. American Honda Motor Co.*, 529 U.S. 861, 883 (2000).

HHS's approval of state-law approaches such as New York's is also consistent with the ACA. The ACA expressly requires HHS to engage "in consultation with States" to establish the federal risk adjustment methodology. 42 U.S.C. § 18063(b). Moreover, the statute allows HHS to determine whether States are acting inconsistently with the ACA, and if so whether and how to bring federal and state approaches into alignment.

See id. § 18041(c)(1)(B), (c)(2). This language supports what HHS did here: consulting with the States—including with New York specifically—and concluding that state-law approaches to risk adjustment were compatible with the federal risk adjustment program.

By contrast, it is the plaintiffs' position that would prevent the "accomplishment and execution of the full purposes and objectives of Congress," *Hillman v. Maretta*, 569 U.S. 483, 490 (2013) (quotation marks omitted), by overriding HHS's judgment and disrupting the cooperative-federalism model that the ACA envisioned and that HHS and the States successfully implemented here. The plaintiffs' position would also prevent risk adjustment from working as Congress intended. The ACA states that risk adjustment payments and charges must reflect the real "average actuarial risk of all enrollees in all plans or coverage" in a given State in a given year. 42 U.S.C. § 18063(a). Here, HHS endorsed state approaches like New York's precisely because unforeseen defects in the methodology initially applied by HHS meant that risk adjustment transfers did *not* reflect real "average actuarial risk." Powell 2d Decl. ¶ 20. HHS and DFS thus furthered rather than undermined Congress's objectives by engaging in a collaborative effort to achieve more accurate

risk adjustment transfers and thus better stabilize the health insurance markets while they transitioned to the ACA's market reforms.

2. The ACA Does Not Expressly Preempt New York's Actions Taken Under State Legal Authority.

The plaintiffs are also wrong to assert that anything in either the ACA or in HHS's implementing regulations expressly preempt New York's actions here. As the district court correctly recognized (JA 160), far from abrogating state law, the ACA goes out of its way to *preserve* state laws and regulatory authority in 42 U.S.C. § 18041(d), which provides that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." Given HHS's determination that New York's program does not "prevent the application" of the federal statute, see *supra* Point I.A.1, the district court correctly rejected the plaintiffs' attempt below to invoke this savings clause as a source of express preemption (JA 159-160) At minimum, in light of the language of the savings clause and HHS's endorsement of local approaches like New York's, there is nothing close to the explicit overriding of state laws that is necessary to overcome the

traditional presumption against preemption of state insurance laws. *See Wadsworth v. Allied Prof'ls Ins. Co.*, 748 F.3d 100, 105 (2d Cir. 2014).

Likewise, nothing in HHS's regulations preempts New York's program. As the district court correctly understood (JA 170), HHS's regulations give States "two options for addressing any unintended negative impacts of the [federal risk adjustment program] in their local markets: (1) take action and make adjustments pursuant to state authority; or (2) request an adjustment to the federal risk adjustment transfers from HHS." Plaintiffs' argument that HHS's regulations prohibit state-law risk adjustments rests on a "misleading conflation" of these two options. Order Denying Injunction Pending Appeal (ECF No. 83) at 7-8. As the district court correctly held, the regulatory language cited by the plaintiffs concerns only state involvement with the *federal* risk adjustment methodology. *See id.* (*see also* JA 169).

The regulations are unambiguous on this score. HHS may approve a State "to operate risk adjustment *under a particular Federally certified* risk adjustment methodology." 45 C.F.R. § 153.310(d)(1) (emphasis added). If a State does not obtain approval to operate the federal risk adjustment methodology, then it "will forgo implementation of all State

functions *in this subpart*, and HHS will carry out all of the provisions *of this subpart* on behalf of the State." *Id.* § 153.310(a)(2), (3), (4) (emphasis added). The emphasized language plainly refers only to HHS's administration of the *federal* methodology.

None of this language applies to risk adjustments made by States "under their own State authority and using State resources," which HHS has expressly said are separate from the federal risk adjustment program and thus "do not generally need HHS approval." 83 Fed. Reg. at 16,960. New York chose to adopt this state-law approach for the 2017 and 2018 plan years, exercising its authority under a nearly thirty-year-old state program to order transfers that account for the "unique aspects of the small group health insurance market in New York." 38 N.Y. Reg. at 64.

While HHS has continued to engage "in consultation with States" to improve the "criteria and methods" used in the federal risk adjustment program, 42 U.S.C. § 18063(b), the plaintiffs are wrong to assert that any feature of that ongoing collaborative process precludes state-law risk adjustments. The plaintiffs focus in particular on HHS's announcement that, "[b]eginning with the 2020 benefit year," a State may request reductions to transfers directly under the federal risk adjustment

program, including to account for local circumstances. 45 C.F.R. § 153.320(d). Contrary to the plaintiffs' argument, this prospective change does not reflect any judgment by HHS that local approaches like New York's were unlawful as applied to benefit years *before* this new regulation comes into effect.

To the contrary, when HHS first announced in May 2016 that it was exploring "ways to improve the [federal] risk adjustment methodology" to avoid insurers being subjected to "substantial risk adjustment charges that they did not anticipate," it expressly endorsed "local approaches, under State legal authority," to deal with the problem in the interim. 81 Fed. Reg. at 29,152. And HHS recognized both the fact and validity of such local approaches in November 2017 when it proposed what ultimately became 45 C.F.R. § 153.320(d), explaining that "allowing certain State-by-State adjustments to the HHS risk adjustment program" under the new regulatory provision "can account for . . . State-specific differences in risk without the necessity for States to undertake operation of their own risk adjustment program." 82 Fed. Reg. at 51,073. In other words, far from rejecting or even questioning what state risk adjustment programs like New York's had done in the early years of the

ACA, HHS instead acknowledged that those programs legitimately sought to accomplish the same goals that the agency's new regulations also sought to further.

Contrary to the plaintiffs' argument, there is nothing irrational about HHS's promulgation of detailed procedures for States to obtain federal approval for future risk-adjustment reductions while recognizing that the States had properly exercised their prerogative to make such reductions under their own state-law authority. Given the States' concrete experience and traditional authority in regulating their own insurance markets, it made sense for HHS to defer to the States' views on tailoring risk adjustment to local circumstances to address a genuine and conceded problem with the federal methodology, while HHS attempted to devise a federal solution. That respect for state experience and regulation in an area of traditional state authority is a core attribute of cooperative federalism, and a familiar feature not only in the ACA but across a number of federal regulatory schemes. *See, e.g.*, *King v. Burwell*, 135 S. Ct. 2480, 2487 (2015) (ACA health care exchanges); *Environmental Prot. Agency v. EME Homer City Generation, L.P.*, 572 U.S. 489, 497 (2014) (Clean Air Act programs).

B. The Plaintiffs Do Not Have a Private Right of Action to Challenge New York's State Risk Adjustment Program as Preempted by the ACA.

This Court may also affirm the dismissal of plaintiffs' preemption claims on the alternative ground that plaintiffs have neither a cause of action nor a right to relief under the ACA. The provisions of the ACA at issue here provide for enforcement solely by the States and HHS. By mandating enforcement by a federal agency and giving that agency discretion to choose the appropriate response, Congress has precluded both a private right of action and any private right to equitable relief to enforce the statute's terms. *See Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. at 1385; *accord Davis v. Shah*, 821 F.3d 231, 245-46 (2d Cir. 2016) (summarizing *Armstrong*). This Court may accordingly affirm on this alternative ground. *See Flood v. Just Energy Mktg. Corp.*, 904 F.3d 219 (2d Cir. 2018) (court of appeals "may affirm on any grounds that are supported in the record").

1. The plaintiffs have no private right of action under federal law or the Supremacy Clause.

In their complaint (*see* JA 47-59), the plaintiffs cite two sources of authority for their preemption cause of action: the Supremacy Clause of the federal Constitution and 42 U.S.C. § 1983. Neither provides a cause of action here.

First, the Supremacy Clause does not create a cause of action or give rise to any rights; it merely provides a "'rule of decision'" for a court to apply once a cause of action is properly before it on some other, valid basis. *Davis*, 821 F.3d at 245 (quoting *Armstrong*, 135 S. Ct. at 1383). Although in some pre-*Armstrong* cases this Court recognized claims arising "under the Supremacy Clause," *Western Air Lines, Inc. v. Port Auth. of N.Y. & N.J.*, 817 F.2d 222, 225 (2d Cir. 1987), this Court has held that those cases do not survive *Armstrong*'s express statement that there is no such thing as a Supremacy Clause claim, *see Davis*, 821 F.3d at 245.

Second, a cause of action under 42 U.S.C. § 1983 is available only to remedy a violation of a separate federal statute that, in its own right, evinces "an unambiguous intent to confer individual rights." *Id.* at 244 (quotation marks omitted). Accordingly, § 1983 relief would be available here only if the ACA conferred a right on insurers like the plaintiffs to

compel state regulators to comply with federal risk adjustment requirements. But the relevant statutory provisions here lack "the type of rights-creating language" that would allow a § 1983 suit. *Id.*; *accord Armstrong*, 135 S. Ct. at 1387.

Instead, like the Medicaid provision at issue in *Armstrong*, the ACA's risk-adjustment provisions are "phrased as a directive to the federal agency charged with" regulating risk adjustment, "not as a conferral of the right to sue" upon insurers. *Armstrong,* 135 S. Ct. at 1387. Specifically, the statute directs "[t]he Secretary, in consultation with States" to develop the "criteria and methods to be used in carrying out the risk adjustment activities under this section." 42 U.S.C. § 18063(b). And when "the Secretary determines" that a State is not properly implementing federal risk adjustment, "the Secretary shall take such actions as are necessary to implement" the program. *Id.* § 18041(c)(1). This kind of language—which focuses not on "individuals protected" or on "funding recipients," but on "the agencies that will do the regulating," *Alexander v. Sandoval*, 532 U.S. 275, 289 (2001)—does not create a private right of action, *Armstrong*, 135 S. Ct. at 1387.

2. Congress foreclosed equitable relief to private parties by vesting HHS with exclusive authority to supervise the ACA's risk-adjustment provisions.

The plaintiffs also may not seek equitable relief here. Although a federal court of equity "may in some circumstances grant injunctive relief" to prevent a state or federal officer from violating federal law, that power "is subject to express and implied statutory limitations." *Armstrong*, 135 S. Ct. at 1384, 1385 (citing *Ex parte Young*, 209 U.S. 123 (1908)). Here, for two reasons, the statutory scheme "establish[es] Congress's intent to foreclose equitable relief." *Id.* at 1385 (quotation marks omitted).

First, when a statute gives a federal agency an express remedy for enforcing a substantive rule, it implies Congress's intent to exclude other remedies. *Id.* at 1385. Here, the only express remedy under the ACA when a State does not properly implement the ACA's risk-adjustment requirements is for HHS to intervene and implement those requirements itself. See *supra* at 6, 24-25. The provision of this specific administrative remedy "suggests that Congress intended to preclude others," including private lawsuits. *Sandoval*, 532 U.S. at 290.

Second, when compliance with a federal statute depends on the application of a "judgment-laden standard" administered by a federal agency, courts have inferred that Congress intended for enforcement to depend not on private lawsuits, but rather on the designated agency's supervision. *Armstrong*, 135 S. Ct. at 1385. Here, the express terms of the ACA's risk-adjustment provisions are inherently "judgment-laden": a State fails to comply with those provisions only if it "has not taken the actions the Secretary determines necessary," after which "the Secretary shall take such actions as are necessary" to rectify any noncompliance. 42 U.S.C. § 18041(c)(1). By delegating supervisory and enforcement authority to HHS, Congress expressed its intent to rely on that agency's expertise to the exclusion of "private enforcement of [the statute] in the courts." *Armstrong*, 135 S. Ct. at 1385.

Allowing private parties to obtain equitable relief under such circumstances would undermine the federal agency's ability to pursue the policy goals that Congress charged it with accomplishing. Here, for example, the plaintiffs assert the need for equitable relief to prevent New York's alleged frustration of "the risk adjustment program administered by HHS pursuant to the ACA" (JA 47, 49, 53, 55). But since HHS has

endorsed (and relied on) New York's risk adjustment program to address conceded problems in the federal risk adjustment methodology, granting equitable relief to the plaintiffs here would prevent HHS from accomplishing what it has determined would best achieve Congress's goals in the ACA. In other words, the destabilizing threat to health care markets comes not from New York's program, but rather from the plaintiffs' efforts to ask this Court to unwind a process that both HHS and DFS have determined is appropriate based on their expertise.

The district court erred in finding *Armstrong* inapplicable here. Contrary to the district court's view (*see* JA 157), it is immaterial that the statute at issue in *Armstrong* provided HHS with only the single option of cutting off funding, while the ACA allows HHS broader power to "take such actions as are necessary" to bring a State into compliance, 42 U.S.C. § 18041(c)(1)(B)(ii)(I). The dispositive question under *Armstrong* is not the scope of available relief, but rather the identity of Congress's designated enforcer. So long as federal law envisions agency action as the exclusive means of enforcing a substantive requirement, such an

administrative remedy—however narrow or broad it may be—forecloses private remedies. *See Armstrong*, 135 S. Ct. at 1385.[4]

The district court was also mistaken in holding that the judiciary is equipped to determine when a State has violated the requirements of the ACA's risk adjustment provisions (*see* JA 157-159). As explained above, a State acts inconsistently with those provisions only when the State "has not taken the actions *the Secretary determines* necessary to implement" risk adjustment. 42 U.S.C. § 18041(c)(1)(B)(ii) (emphasis added). By its plain terms, the statute vests with HHS the initial determination of whether a State's actions (or inaction) conflict with federal risk adjustment standards. Allowing private parties to override that determination through litigation is inconsistent with Congress's specific delegation of enforcement authority. *See Armstrong*, 135 S. Ct. at 1385.

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[4] The district court also mistakenly relied (*see* JA 157) on a provision of the ACA that allows HHS to impose civil penalties for violations of the terms of the risk-adjustment program. *See* 42 U.S.C. §§ 18041(c)(2), 300gg-22(b)(2)(A). That provision applies only to statutory violations by an *issuer*. It is not a "remedy" that "Congress provided for a state's failure to comply," *Friends of the East Hampton Airport, Inc. v. Town of East Hampton*, 841 F.3d 133, 145 (2d Cir. 2016), and therefore is not relevant to the *Armstrong* analysis here.

The case principally relied on by the plaintiffs and the district court is inapposite. *See Friends of the East Hampton Airport, Inc. v. Town of East Hampton*, 841 F.3d 133, 145-47 (2d Cir. 2016), *cert. denied*, 137 S. Ct. 2295 (2017) ("*East Hampton*"). That case involved the Airport Noise and Capacity Act (ANCA), which, unlike the ACA, contains a sweeping express preemption clause that preempts any state or local law placing noise or access restrictions on an airport, unless the jurisdiction first obtains either a waiver from the Federal Aviation Administration (FAA), or consent from all aircraft operators at the airport. *See id.* at 138-39.[5] The dispute in the case arose when the Town of East Hampton attempted to impose local restrictions on airport use to address noise problems from an airport located within its boundaries. This Court found that the plaintiffs in that case could seek to enjoin enforcement of the Town's local laws on preemption grounds because the ANCA imposed a judicially administrable standard: the Town's law was invalid unless the Town had either received an FAA waiver or obtained consent from all operators. *Id.* at 146-47; *see also* 49 U.S.C. § 47524(c) (automatically

[5] Aviation in general is an area of especially broad preemption. *See Morales v. Trans World Airlines, Inc.*, 504 U.S. 374, 383-84 (1992).

preempting any local "airport noise or access restriction" unless agreed to by all operators or "submitted to and approved by" the FAA).

No such straightforward test is available here because, unlike the ANCA, the ACA leaves to HHS the initial determination of whether a State has violated federal risk adjustment provisions, rather than providing objective standards intended to be applied by the courts in the first instance. Moreover, whereas the ANCA contains an express preemption clause that automatically preempts all local laws unless a local government affirmatively applies for a waiver or obtains consent, the ACA contains an express *non*-preemption clause. The ACA's default preservation of state law and commitment of discretionary enforcement to HHS demonstrates Congress's intention to preclude a court from using equitable powers to enforce state compliance in the agency's stead.

East Hampton is inapposite for the further reason that the ANCA expressly contemplates a direct role for private parties under the statute even when the FAA is not involved: specifically, by allowing a local government to seek consent from all operators in lieu of obtaining an FAA waiver. The ACA provides no similar role for private parties, instead

committing enforcement solely to HHS. *See Sandoval*, 532 U.S. at 289-90; *see also Armstrong*, 135 S. Ct. at 1385 (quoting *Sandoval*).

Ultimately, the inquiry under *Armstrong* is not a formalistic one, but rather a practical assessment of whether providing private equitable relief would be consistent with the "characteristics of the federal statute" before the court. *Armstrong*, 135 S. Ct. at 1388 (Breyer, J., concurring in part and concurring in the judgment); *see also Coalition for Competitive Elec. v. Zibelman*, 272 F. Supp. 2d 554, 566 (S.D.N.Y. 2017) ("There is no indication in *Armstrong* that both factors must be satisfied in order to conclude that Congress intended to foreclose equitable relief to private parties."). Here, in light of all the indications in the statute that Congress intended to confer on HHS the discretion to operate the ACA Risk Adjustment Program—including by supervising the States' involvement in that program—it would make no sense to allow private parties to obtain equitable relief that would interfere with the federal agency's own administration of a complex insurance program.

POINT II

THE DISTRICT COURT CORRECTLY DISMISSED THE PLAINTIFFS' TAKINGS AND EXACTION CLAIMS

The district court also properly dismissed the plaintiffs' only other claims, brought under the Takings Clause of the U.S. Constitution. As an initial matter, the district court should have dismissed the plaintiffs' takings and exaction claims under the *Williamson County* doctrine, which provides that a federal Takings Clause claim is not ripe until two prerequisites are satisfied: "(1) the state regulatory entity has rendered a 'final decision' on the matter, and (2) the plaintiff has sought just compensation by means of an available state procedure." *Dougherty v. Town of N. Hempstead Bd. of Zoning Appeals*, 282 F.3d 83, 88 (2d Cir. 2002); *see also Daniel v. County of Santa Barbara*, 288 F.3d 375, 381-82 (9th Cir. 2002) (applying *Williamson County* to exaction claims). Neither prerequisite is satisfied here. DFS has not yet assessed, let alone collected, any risk adjustment payments from the plaintiffs under either the 2017 or 2018 emergency regulations. *See Sherman v. Town of Chester*, 752 F.3d 554, 561 (2d Cir. 2014). And it is undisputed that the plaintiffs have not sought any relief through available state procedures for any appropriation here—instead, contrary to *Williamson County*'s

requirements, they brought their takings and exaction claims first to federal court.

The plaintiffs' takings and exaction claims with respect to the 2018 emergency regulation (JA 174) are also unripe for another reason, as the district court correctly held. HHS will not even announce federal risk adjustment payments for the 2018 plan year until 2019, and it is unknown whether the plaintiffs will be recipients of federal risk adjustment for 2018 and thus become subject to the 2018 DFS regulation. Any claim regarding the 2018 year is thus "premature for review because the injury is merely speculative and may never occur." *In re Methyl Tertiary Butyl Ether (MTBE) Prods. Liab. Litig.*, 725 F.3d 65, 110 (2d Cir. 2013) (quotation marks omitted).

In any event, the plaintiffs' takings and exaction claims fail on the merits, with respect to both the 2017 and 2018 plan years. As the district court correctly observed (JA 176), the takings and exaction claims are predicated on the plaintiffs' assertion that state risk adjustment is unlawful because it has been preempted (*see, e.g.*, JA 50-52). Because the plaintiffs' preemption claims fail, their takings and exaction claims necessarily fail as well.

Plaintiffs identify no other valid basis for a takings or exaction claim. Nor could they. New York has not "physically invade[d] or permanently appropriate[d] any of the [plaintiffs'] assets for its own use." *Connolly v. Pension Ben. Guar. Corp.*, 475 U.S. 211, 225 (1986). Rather, New York's risk adjustment program merely "adjusts the benefits and burdens of economic life to promote the common good"—here, ensuring the stability of the health insurance market. *Id.* Regulations that impose financial obligations for these ends are not takings or exactions at all. *See id.* at 221, 227-28 (rejecting takings challenge to federal statute requiring employers to make monetary deposits to resolve pension liabilities).

Moreover, the plaintiffs can claim no protected property interest in risk adjustment payments. "Property interests are created, and their dimensions defined, by state law." *RR Vill. Ass'n v. Denver Sewer Corp.*, 826 F.2d 1197, 1201 (2d Cir. 1987). Under New York law, "the conduct of the business of writing insurance is not a right but a privilege granted by the State subject to the conditions imposed by it to promote the public welfare." *Blue Cross & Blue Shield of Cent. N.Y., Inc. v. McCall*, 89 N.Y.2d 160, 165 (1996) (citing *Health Ins. Ass'n of Am. v. Harnett*, 44 N.Y.2d 302, 309 (1978)). Because of that principle, insurers operating in

New York can claim no entitlement to be excused from state regulations imposing financial obligations on them. Indeed, the New York Courts have squarely rejected a takings challenge to New York's risk adjustment program, reasoning that an insurer has no protected interest in reaping any benefit from differences in the health of its risk pool compared to other insurers'. *See In re Colonial Life Ins. Co. of Am. v. Curiale*, 205 A.D.2d 58, 63-64 (3d Dep't 1994). The plaintiffs' takings and exaction claims thus necessarily fail.

CONCLUSION

The district court's judgment should be affirmed.

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December 10, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 32(a) of the Federal Rules of Appellate Procedure, Will Sager, an employee in the Office of the Attorney General of the State of New York, hereby certifies that according to the word count feature of the word processing program used to prepare this brief, the brief contains 8,384 words and complies with the typeface requirements and length limits of Rule 32(a)(5)-(7).

/s/ Will Sager