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

REPLY BRIEF FOR APPELLEE

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PRELIMINARY STATEMENT

The plaintiffs—two large, closely affiliated health insurers—fundamentally mischaracterize the New York-specific risk adjustment program at issue here as "unilateral" state action, taken "absent federal approval," that has the effect of "nullifying the federal [risk adjustment] program" established by the Affordable Care Act (ACA). Br. for Pls.-Appellants ("Pls.' Br.") at 3, 23, 33. To the contrary, as the opening brief of the New York State Department of Financial Services (DFS) explained, DFS instituted New York's risk adjustment program in consultation with the U.S. Department of Health and Human Services (HHS), with HHS's express approval, and for the purpose of advancing the core policy objectives of the ACA's risk adjustment provisions.

Specifically, DFS used its independent state statutory authority to promulgate temporary and narrowly targeted regulations that resolved distortions of New York's health insurance markets that were caused by the ACA Risk Adjustment Program. HHS not only acknowledged these distortions, but specifically encouraged and endorsed state-law approaches like New York's as appropriate interim measures, in addition to the ACA Risk Adjustment Program, to advance the underlying goals of the ACA.

The plaintiffs' preemption claims necessarily fail in light of HHS's express approval of New York's program.

The plaintiffs have also failed to establish that they have a right to seek equitable relief here. As the plaintiffs acknowledge, Congress vested HHS with "significant oversight authority" and "control" over the ACA Risk Adjustment Program—including supervision of state compliance with the federal statute. Pls.' Br. at 6, 10, 25-26. Congress's express dedication of regulatory, oversight, and enforcement authority to HHS alone necessarily precludes private actions like this one to obtain what the plaintiffs believe "belong" to them under federal law. *Id.* at 41.

ARGUMENT

POINT I

NEW YORK'S RISK ADJUSTMENT PROGRAM IS CONSISTENT WITH AND FURTHERS THE PURPOSES OF THE AFFORDABLE CARE ACT

A. Contrary to the Plaintiffs' Contentions, the U.S. Department of Health and Human Services (HHS) Expressly Approved New York's Actions.

Much of the plaintiffs' opening brief is based on two fundamentally mistaken assumptions: that the ACA Risk Adjustment Program is the only risk adjustment program the ACA permits to exist, and that DFS engaged in "unilateral" action "without obtaining the Secretary's approval" and thus "frustrate[d] federal oversight." Pls.' Br. at 12-13, 26, 34 (quotation marks omitted). As DFS's opening brief explained, however, HHS expressly acknowledged that the ACA Risk Adjustment Program had unintentionally led to harmful consequences, and the federal agency repeatedly encouraged state action under independent state legal authority to mitigate those consequences. *See* Br. for Appellee ("DFS Br.") at 12-16.

Specifically, HHS recognized States' need "to reduce the *magnitude* of risk adjustment charge amounts for some issuers" and "encouraged States to examine whether any local approaches under State legal

authority are warranted" to address this concern. 82 Fed. Reg. 51,052, 51,072 (Nov. 2, 2017) (emphasis added). HHS concluded that States could "take temporary, reasonable measures under State authority to mitigate [the] effects" of the ACA Risk Adjustment Program for the 2017 and 2018 plan years. 81 Fed. Reg. 94,058, 91,159 (Dec. 22, 2016). New York did exactly what HHS encouraged: it created, under state legal authority, a separate and temporary risk adjustment program to mitigate specific harms caused by the ACA Risk Adjustment Program. And HHS endorsed New York's approach in particular. When other stakeholders specifically asked HHS about New York's approach, HHS confirmed that States could permissibly act under their own legal authority to "take such actions *and make adjustments*" and did not "generally need HHS approval" to do so. 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018) (emphasis added). DFS also contacted HHS directly about its planned approach, and HHS expressed its support. *See* DFS Br. at 15.

The plaintiffs argue that this pointed language from HHS was intended only to encourage States to address "the *effects*" of transfer payments under the ACA Risk Adjustment Program, and not "the amounts of those transfers." Pls.' Br. at 43 (emphasis in original). But there is no

substantive difference between "effects" and "amounts" here. HHS itself acknowledged that "the magnitude of [federal] risk adjustment charge amounts" is precisely the "effect" that States "may take temporary, reasonable measures under State authority" to address. 82 Fed. Reg. at 51,073. And the harms to New York's health insurance market that motivated DFS's regulations all stemmed from the disproportionate financial losses that certain insurers suffered under HHS's then-extant federal methodology. *See, e.g.*, Br. for Amicus Curiae CareConnect Ins. Co. ("Amicus Br.") at 1-2 (small insurer forced to withdraw from New York market after being required to pay as much as forty-four percent of its annual premiums to other insurers). It only makes sense that harms caused by excessive payments from certain insurers must be resolved by reallocating those payments.

The plaintiffs also err (*see* Br. at 45-46) in asserting that HHS expressed disapproval of temporary, reasonable state action by adopting a new procedure for States to request reductions to transfers under the ACA Risk Adjustment Program "[b]eginning with the 2020 benefit year." 45 C.F.R. § 153.320(d). To the contrary, this new procedure supports DFS's position here. The very fact that HHS considered this new procedure

to be necessary further confirms that the original methodology for federal transfer payments was faulty for not adequately reflecting local circumstances. Moreover, as the district court correctly recognized (*see* JA 170), the availability of adjustments within the ACA Risk Adjustment Program would not preclude adjustment pursuant to state authority.

Furthermore, in deciding not to apply this new procedure until the 2020 benefit year, HHS acknowledged that, in the interim, States may use temporary, reasonable measures to mitigate risk adjustment to "ease the transition" until the new procedures come into effect. 83 Fed. Reg. at 16,960. Indeed, HHS originally proposed to adopt the new procedure starting with the 2019 plan year, but ultimately postponed it until the 2020 plan year to give States more time to analyze risk-adjustment data. *See id.* at 16,956-57. It is implausible that HHS intended this delay to leave States helpless to address the acknowledged flaws in its original risk-adjustment methodology when both the new procedure and the one-year delay were intended to help the States.

B. HHS's Approval of New York's Program Eliminates the Plaintiffs' Claim of Conflict Preemption.

Because HHS specifically recognized the legality of, encouraged the use of, and endorsed state-specific risk adjustment programs such as New York's, the plaintiffs have failed to establish conflict preemption on the ground that DFS's regulations "frustrate federal oversight" or "prevent[] the HHS Secretary from carrying out his statutory responsibility to implement the [ACA's] requirements in New York." Pls.' Br. at 31, 34. To the contrary, HHS encouraged and approved of state-law adjustments for the 2017 and 2018 plan years precisely because it found that those adjustments would advance the underlying policy goals of the ACA Risk Adjustment Program.

As the plaintiffs acknowledge (*id.* at 5-6), the ACA Risk Adjustment Program is intended to ensure that insurance companies are not penalized for carrying relatively less healthy enrollees. 76 Fed. Reg. 41,930, 41,931 (July 15, 2011).[1] To accomplish this goal, the federal

[1] In the same rulemaking, HHS also announced the other two programs that along with risk adjustment make up the "Three Rs" of the ACA: reinsurance and risk corridors. *See* 76 Fed. Reg. at 41,931. But whereas risk adjustment is a permanent feature of the ACA designed to account for the known risk of insuring less healthy members, reinsurance

program requires each insurer with actuarial risk less than the average actuarial risk of all insurers in the State to contribute to a common pool; the funds in that pool are then distributed to insurers with actuarial risk above the statewide average. *See* 42 U.S.C. § 18063(a). HHS has emphasized that "[t]he credibility of risk adjustment" depends upon ensuring that plans "cannot inflate their risk score." 76 Fed. Reg. at 41,944.

As DFS's opening brief explained (DFS Br. at 10-12), HHS's initial methodology for the ACA Risk Adjustment Program did not correctly estimate insurers' losses in New York because of specific features of the New York market that the federal methodology did not properly consider. As a result, HHS's methodology caused some insurers—particularly smaller, newer insurers trying to enter the market—to pay enormous

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and risk corridors were temporary programs designed to protect insurers from unpredictable risks associated with transitioning to a new set of health care markets. *Id.* Because the reinsurance and risk corridor programs stopped with the end of the 2016 plan year, *see id.*, the plaintiffs are mistaken in suggesting that this case (which involves only the 2017 and 2018 plan years) will create any conflicts with those programs. *See* Pls.' Br. at 42. Furthermore, because risk adjustment is applied on a State-by-State basis, with a separate risk pool for each State, *see* 83 Fed. Reg. at 16,960, the DFS regulations will not have any impact outside New York.

sums of money they could not have foreseen based on the true actuarial risk posed by their enrollees. *See* DFS Br. at 10-11; *see also* Amicus Br. at 1-2, 5-6, 15-16. Faced with the destabilizing effects of the ACA Risk Adjustment Program, including the effect of insurers suddenly quitting the market, DFS was "compelled" to act. Amicus Br. at 1.[2]

The plaintiffs claim to "vigorously dispute" (Br. at 37) whether New York's health insurance market in fact faces harmful consequences from the miscalculations caused by HHS's original federal risk-adjustment methodology, but provide no details whatsoever about the nature or basis of their disagreement. Their objections are immaterial in any event. Because HHS has agreed with DFS that the original methodology for the ACA Risk Adjustment Program is deficient and that state-law approaches may appropriately respond to that deficiency, New York's risk adjustment program promotes rather than undermines the purposes

[2] The plaintiffs incorrectly state that DFS has not explained the calculation of its adjustments, or that it has reserved to itself unbridled discretion to set the adjustments. *See* Pls.' Br. at 13, 35-36. To the contrary, DFS's regulation specifically provides the justification for New York's state-specific risk adjustment program and identifies the "identifiable, quantifiable and remediable" factors to be applied in calculating payments. 11 N.Y.C.R.R. § 361.9(a)(4), (b).

of the ACA and facilitates HHS's own efforts to ensure the proper functioning of ACA risk adjustment.

HHS's views deserve considerable deference here. Because of the complexity of administering massive health care programs, this Court has made clear that even informal HHS interpretations deserve "a significant measure of deference," and that "the various possible standards for deference—namely, *Chevron* and *Skidmore*—begin to converge" in this area. *Sai Kwan Wong v. Doar*, 571 F.3d 247, 260 (2d Cir. 2009) (quotation marks omitted). The plaintiffs are thus mistaken in urging (*see* Br. at 43-44) that HHS's views—which the agency has reiterated time and again in response to direct inquiries—are too informal to receive deference.

The deference owed to HHS is particularly appropriate here because the ACA not only charges HHS with oversight of the ACA Risk Adjustment Program but also explicitly commits to HHS the discretion to determine when its intervention is necessary to ensure state compliance. *See* 42 U.S.C. § 18041(c)(1)(B), (c)(2); *see also* DFS Br. at 24-25. That same discretion permitted HHS to encourage state-law responses to unexpected problems with the program. As the insurer supporting DFS

in this case accurately puts it, HHS's approval of New York's solution "is not an abdication of this oversight; it is a part of this oversight." Amicus Br. at 18 n.7.[3]

By contrast, the plaintiffs' position, not DFS's, would obstruct the "accomplishment and execution of the full purposes and objectives of Congress." *Hillman v. Maretta*, 569 U.S. 483, 490 (2013) (quotation marks omitted). The plaintiffs essentially ask this Court (*see* Br. at 30-36) to override a joint determination by both federal and state regulators about the proper way to manage risk adjustment in New York, on the ground that the ACA itself mandates that result. But Congress enacted the ACA to stabilize health insurance markets, not disrupt them. *See King v. Burwell*, 135 S. Ct. 2480, 2492-93 (2015). It intended the ACA Risk Adjustment Program to calculate transfer payments based on accurate assessments of risk. 42 U.S.C. § 18063(a)(1)-(2). And it expressly conferred flexibility to both HHS and the States and required consultation between federal and state regulators to accomplish these

[3] For reasons that the amicus brief lays out in detail (*see* Amicus Br. at 17-18 & n.8), HHS's interpretation of its own regulations is also entitled to deference. *See Auer v. Robbins*, 519 U.S. 452, 461 (1997).

objectives. By tying both HHS's and DFS's hands here, the plaintiffs' position would undermine all of these congressional objectives.

C. HHS Is Not Forbidden from Approving State-Law Approaches Like New York's.

There is no basis for the plaintiffs' further assertion that HHS's approval here was unlawful. *See* Pls.' Br. at 43-45. Nothing in the ACA or in HHS's implementing regulations unambiguously precludes the agency from endorsing "temporary, reasonable measures under State authority" to fix acknowledged problems with the federal methodology and thereby preserve the stability of the States' health insurance markets. 81 Fed. Reg. at 94,159.

As an initial matter, the plaintiffs may not collaterally attack the validity of HHS's determination in a proceeding where HHS is not and has never been a party. *See, e.g.*, *Otwell v. Alabama Power Co.*, 747 F.3d 1275, 1282 (11th Cir. 2014); *Adams v. Resolution Tr. Corp.*, 927 F.2d 348, 354 n.15 (8th Cir. 1991); *cf. Merritt v. Shuttle, Inc.*, 245 F.3d 182, 187 (2d Cir. 2001) (applying similar analysis to exclusive-review provisions). To the extent that the plaintiffs' arguments rely on their underlying assertion that HHS was "compelled by law" (Pls.' Br. at 43) to reject

rather than approve DFS's temporary regulations, they should have brought an action against HHS under the Administrative Procedure Act to compel agency action or challenge HHS's approval as arbitrary and capricious or contrary to law. *See* 5 U.S.C. §§ 553, 702, 706. Having elected not to directly contest the agency's determination, the plaintiffs may not now collaterally attack that determination's validity as a basis for its current claims.

In any event, the plaintiffs are wrong to assert that HHS lacks statutory authority to approve temporary state-law approaches like New York's here. As the plaintiffs acknowledge (Pls.' Br. at 25-26), the ACA empowers HHS to "take such actions as are necessary" to implement the ACA Risk Adjustment Program, including by reviewing state action for consistency with the federal statute. 42 U.S.C. § 18041(c)(1)(B)(ii). Moreover, in administering the federal program, HHS is required to engage "in consultation with States" and with state regulators. *See id.* §§ 18041(a)(2), 18063(b). HHS's actions here—collaborating with DFS (and other States), reviewing DFS's proposal to address conceded problems with the federal methodology, and endorsing DFS's final

approach—were fully consistent with this cooperative-federalism model. *See* DFS Br. at 24-25.

HHS's approval of New York's risk adjustment program is also consistent with the statute's savings clause, which expressly preserves "any State law that does not *prevent the application* of the provisions" of the statute. 42 U.S.C. § 18041(d) (emphasis added). This provision demonstrates that Congress intended to override only state laws that pose an obstacle to the implementation of federal programs under the ACA—not, as the plaintiffs have argued, "to preempt even ostensibly nonconflicting state laws." Pls.' Br. at 23. Given this congressional judgment, it was perfectly appropriate for HHS to endorse DFS's regulations after determining that their temporary adjustments to federal transfer payments would advance rather than undermine the goals of the ACA Risk Adjustment Program.[4]

[4] The Superintendent of DFS raised her concerns about the effects of the federal program—and the scope of New York's authority to respond to those effects—in a letter to the HHS Secretary in June 2016. *See* Letter of Sup't Maria T. Vullo to Sec'y Sylvia M. Burwell (June 28, 2016), ECF No. 29-17. This letter demonstrates that HHS's repeated, express approvals of state action came after DFS had directly put the question of state authority before the federal agency. The plaintiffs thus are

Finally, there is no basis for the plaintiffs' argument that HHS's authority to approve state-specific approaches was limited to accepting state input into the federally certified risk adjustment methodology. *See* Pls.' Br. at 34-36. To be sure, the statute generally envisions that HHS will in the first instance "establish criteria and methods to be used in carrying out the risk adjustment activities" and expressly carves out a role for States in that process. 42 U.S.C. § 18063(b). But contrary to the plaintiffs' characterization (*e.g.*, Pls.' Br. at 2, 6), nothing in the statute requires HHS to follow a "uniform" approach for every State. Nor does anything in the statute or its implementing regulations expressly preclude HHS from reviewing and endorsing temporary state-law measures when the federal certified methodology fails, threatening the stability of the health insurance markets that the ACA Risk Adjustment Program was intended to preserve.

To the contrary, HHS's authority to act under those circumstances is well supported by the ACA's broad grant of authority to HHS to take "necessary" actions to implement risk adjustment and its specific

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mistaken in arguing (*see* Br. at 12) that DFS's expressed concerns in the letter reflect a determination that New York had no authority to act.

directive that the ACA Risk Adjustment Program smooth out disparities in insurers' risk pools. The state involvement outlined in the ACA and described in HHS's implementing regulations should thus be seen as a floor, rather than a ceiling, to the federal agency's collaboration with its coordinate state regulators to ensure the proper functioning of the ACA Risk Adjustment Program.

The plaintiffs' interpretation of the ACA as requiring HHS and the States to adhere to a particular federally certified methodology mechanically in every case, regardless of its defects (*see* Pls.' Br. at 35-36), would irrationally elevate form over function and improperly prioritize one feature of the statute—the development of a formula—over the statute's main goal of smoothing out risk. "It is implausible that Congress meant the Act to operate in this manner," where it would cause the very instability that the ACA Risk Adjustment Program was created to avoid. *King*, 135 S. Ct. at 2492, 2494.

Moreover, contrary to the plaintiffs' argument (Br. at 45), there is nothing inconsistent between HHS's actions here and its promulgation of detailed procedures for States to obtain federal approval for alternative risk-adjustment methodologies. What DFS did here (and HHS approved)

was not a permanent change to the federal methodology. Rather, DFS did exactly what HHS asked of States: consistent with HHS's instruction that any state-specific solution be "temporary" and "reasonable," 81 Fed. Reg. at 94,159, DFS dealt with specific distortions created by the ACA Risk Adjustment Program, and only on a year-by-year basis. This litigation involves regulations that apply to the 2017 and 2018 plan years, and DFS has not committed itself to action under state law in any future year. Nothing in the ACA or its implementing regulations precludes state-law measures to address transitional problems in the implementation of the ACA Risk Management Program.

D. *Gade* Is Inapposite.

Much of the plaintiffs' argument (*see* Br. at 18, 23-30) relies on an entirely inapposite case, *Gade v. National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88 (1992). Contrary to the plaintiffs' characterization, *Gade* did not involve a "nearly identical statutory scheme" or comparable facts. Pls.' Br. at 23.

First, the federal agency in *Gade* had taken the position that state laws *were* preempted, arguing that its enabling statute prohibited "concurrent state and federal jurisdiction over occupational safety and

health issues." 505 U.S. at 113-14 (Kennedy, J., concurring in part and concurring in the judgment). Here, HHS has taken precisely the opposite view, endorsing state action under state legal authority for the purpose of advancing the ACA's ultimate goals.

Second, the language of the statute at issue in *Gade* bears no resemblance to the ACA risk-adjustment statute. The Occupational Safety and Health Administration (OSHA) statute provides that state laws are preempted as to "any occupational safety or health *issue*" for which the federal agency had set a standard. 29 U.S.C. § 667(a) (emphasis added); *see Gade*, 505 U.S. at 102 (plurality op.); *id.* at 112-13 (Kennedy, J., concurring in part and concurring in the judgment). By contrast, the parallel provision in the ACA risk-adjustment statute is narrower: it generally saves "any State law that does not *prevent the application* of the provisions of this title." 42 U.S.C. § 18041(d) (emphasis added). In other words, unlike with the OSHA statute, the ACA expressly permits a state law to regulate the same "issue" as a federal law, so long as it does not thereby impose an obstacle to the achievement of the

federal law's objectives.[5] As explained above, HHS has determined that New York's risk adjustment program furthers rather than interferes with the ACA Risk Adjustment Program.

The plaintiffs are thus wrong to characterize *Gade* as establishing a general rule that States are prohibited from adopting "parallel regulations" where a federal regime is in place. Pls.' Br. at 27-30. *Gade* merely interpreted the specific statute before the Court. It does not control the distinct statutory and regulatory regime at issue here.

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[5] Because the four dissenting Justices in *Gade* found no preemption, the controlling opinion is Justice Kennedy's concurrence, which rejected conflict preemption and decided the case on the narrower ground that the particular statutory language before the Court expressly preempted state laws addressing the same issue as an existing federal standard. *See* 505 U.S. at 113 (Kennedy, J., concurring in part and concurring in the judgment). As Justice Kennedy explained, when the statutory text reveals that Congress has expressly considered preemption, a court's preemption "inquiry must begin and end with the statutory framework itself." *Id.* at 111. Here, that principle forecloses preemption, because the statute shows that Congress considered the question of preemption and affirmatively disclaimed preemption except when a state law will "prevent the application" of the ACA.

POINT II

THE PLAINTIFFS MAY NOT OBTAIN PRIVATE EQUITABLE RELIEF UNDER THE ACA'S RISK ADJUSTMENT PROVISIONS

The district court's dismissal of the plaintiffs' claims may be affirmed on the alternative ground that the plaintiffs lack any right to equitable relief here. The plaintiffs do not argue that they have a private right of action under the ACA; instead, they rely exclusively on the federal courts' equity jurisdiction as a basis for bringing this lawsuit. Pls.' Br. at 47-48. But the Supreme Court made clear in *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015), that a federal court may not grant equitable relief to a private party seeking an entitlement under federal law when Congress has dedicated enforcement of that law to a particular agency.

Here, by designating HHS as the supervisor of state compliance with the ACA's risk adjustment provisions, Congress made two things clear: first, that private enforcement of the risk-adjustment provisions is precluded, *see id.* at 1385; and, second, that Congress did not "leave these plaintiffs with no resort," instead requiring only that relief be sought "through the Secretary rather than through the courts," *id.* at 1387. As the plaintiffs admit, "HHS has not shrunk from its duty to provide

substantive oversight" over the ACA Risk Adjustment program. Pls.' Br. at 10. And the plaintiffs remain free to "ask [HHS] to interpret its rules to [their] satisfaction, to modify those rules, to promulgate new rules or to enforce old ones." *Armstrong*, 135 S. Ct. at 1389 (Breyer, J., concurring in part and concurring in the judgment). Allowing the plaintiffs to sue a state agency to enforce a statute entrusted to HHS's enforcement would circumvent Congress's decision to "vest broad discretion in [HHS] to interpret and to enforce" the ACA's risk adjustment provisions, including discretion "to decide when and how to exercise or to enforce statutes and rules." *Id.*

The plaintiffs' response to *Armstrong* largely restates the district court's mistaken reasons for not applying that decision and the plaintiffs' own prior arguments based on pre-*Armstrong* case law. *See* Pls.' Br. at 47-51. DFS has previously addressed those arguments (*see* DFS Br. at 32-40) and will discuss them only briefly here.

Like the district court (*see* JA 156-159), the plaintiffs continue to misplace their reliance on this Court's decision in *Friends of the East Hampton Airport, Inc. v. Town of East Hampton*, 841 F.3d 133 (2d Cir. 2016). DFS has explained several reasons why that case is inapposite (*see*

DFS Br. at 38-40), and the plaintiffs' brief highlights another. Unlike the plaintiffs in *East Hampton*, the plaintiffs here are seeking "to enforce federal law themselves." 841 F.3d at 146. Specifically, the plaintiffs' claims expressly depend on their oft-repeated assertion that they are "entitled" to a specific sum of money under the ACA Risk Adjustment Program. Pls.' Br. at 1, 8, 14, 32, 41, 48. The plaintiffs are thus not merely seeking to prevent the application of a state law or regulation, as was the case in *East Hampton*, but also to enforce a specific federal entitlement that they claim "belongs" to them under the ACA's risk-adjustment provisions. Pls.' Br. at 41. *Armstrong* precludes equitable relief to enforce federal rights that the underlying statute has designated a specific agency to administer.

Furthermore, as the plaintiffs appear to acknowledge (*see* Br. at 49), neither *Armstrong* nor *East Hampton* held that both of the two factors present in *Armstrong*—the commitment of an exclusive remedy to a federal agency and the judicial administrability of the standard—must weigh in favor of preclusion in order to find congressional intent to prohibit an equitable remedy. As DFS has explained, *Armstrong* is not a formalistic test. *See* DFS Br. at 40. Nor could *East Hampton* have

answered a question that was not before it. Because this Court determined that *neither* factor favored preclusion in the *East Hampton* statute, *see* 841 F.3d at 145, the Court was not in a position to hold that both factors must always favor preclusion, or to address whether preclusion is implied where one factor strongly favors preclusion. *See* Pierre N. Leval, *Judging Under the Constitution: Dicta About Dicta*, 81 N.Y.U. L. Rev. 1249 (2006). 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," an equitable remedy is precluded. DFS Br. at 40.

Finally, the plaintiffs raise one new argument for the first time on appeal: they contend that even if the ACA precludes them from seeking equitable relief to enforce its terms as against DFS, they may place their entire case properly before this Court by characterizing it as a Takings Clause claim. *See* Pls.' Br. at 51-53. The plaintiffs are mistaken.[6] The

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[6] The cases on which the plaintiffs rely have no relevance to either the *Armstrong* standard or more generally to the existence of a private right of action to enforce a federal statute against a state agency. Instead, the cases merely address when a party bringing a Takings Clause against the *federal* government may do so in federal district court as opposed to the Court of Federal Claims. *See Eastern Enters. v. Apfel*, 524 U.S. 498, 520-22 (1998); *Duke Power Co. v. Carolina Envtl. Study Grp., Inc.*, 438 U.S. 59, 71 n.15 (1978).

district court dismissed the plaintiffs' takings and exaction claims as subsumed into their preemption claims: only if New York's regulations are in fact preempted would the plaintiffs be able to argue that the State has seized their property (JA 176). On appeal, the plaintiffs admit that the district court was correct to see their takings and exaction claims as derivative of their preemption claims. *See* Pls.' Br. at 23 n.2. Reliance on the Takings Clause for jurisdiction over the entire case is therefore bootstrapping. The plaintiffs' position would essentially allow any preemption claim to circumvent *Armstrong* by the simple expedient of rephrasing it as a takings or exaction claim. There is no indication that the Supreme Court intended its holding in *Armstrong* about the limitations of the federal courts' equity powers to be so easily avoided.

CONCLUSION

The district court's judgment should be affirmed.

Dated: New York, New York
December 20, 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 4,697 words and complies with the typeface requirements and length limits of Rule 32(a)(5)-(7).

/s/ Will Sager