No. 22-451

IN THE

Supreme Court of the United States

LOPER BRIGHT ENTERPRISES, ET AL.,
Petitioners,

v.

GINA RAIMONDO, SECRETARY OF COMMERCE, ET AL.,
Respondents.

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

BRIEF OF *AMICI CURIAE* AMERICAN CANCER SOCIETY, AMERICAN CANCER SOCIETY CANCER ACTION NETWORK, NATIONAL HEALTH LAW PROGRAM, ET AL. IN SUPPORT OF RESPONDENTS

MARY ROUVELAS
AMERICAN CANCER SOCIETY
CANCER ACTION NETWORK
655 15th Street, NW
Washington, DC 20004
(202) 899-5619
Mary.Rouvelas@cancer.org

JANE PERKINS
SARAH SOMERS
NATIONAL HEALTH LAW
PROGRAM
1512 E. Franklin St., Suite 100
Chapel Hill, NC 27514
(919) 968-6308
perkins@healthlaw.org

SCOTT P. LEWIS
Counsel of Record
MICHAEL J. PINEAULT
AUSTIN P. ANDERSON
PAUL M. KOMINERS
ANDERSON & KREIGER LLP
50 Milk Street, 21st Floor
Boston, Massachusetts 02109
(617) 621-6500
lewis@andersonkreiger.com

Counsel for Amici Curiae

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Regulations

Miscellaneous

INTEREST OF *AMICI CURIAE*[1]

Amici curiae American Academy of Pediatrics, American Cancer Society, American Cancer Society Cancer Action Network, American Heart Association, American Lung Association, American Public Health Association, American Thoracic Society, Bazelon Center for Mental Health Law, Campaign for Tobacco-Free Kids, Child Neurology Foundation, Epilepsy Foundation, Muscular Dystrophy Association, National Health Law Program, Physicians for Social Responsibility, The ALS Association, The Leukemia & Lymphoma Society, and Truth Initiative (collectively, "*Amici*") are public health, patient, and consumer advocacy organizations and professional medical associations that represent or work on behalf of millions of patients and consumers across the country, including those who lack access to adequate health care and those who face serious, acute, and chronic diseases and health conditions. *Amici* are committed to ensuring that everyone benefits from a high quality health care system and has access to comprehensive, affordable health insurance to prevent disease, manage health, cure illness, and ensure financial stability.

Publicly funded health insurance programs such as Medicare, Medicaid, and the Children's Health Insurance Program ("CHIP") play a critical role in providing that access. These programs, in turn, depend heavily on the transparency, accountability, and stability that result from the fact

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[1] Pursuant to Supreme Court Rule 37.6, *Amici* state that no counsel for any party authored this brief in whole or in part and no entity or person, aside from *Amici*, their members, or their counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

that the programs are administered by the Secretary of Health and Human Services ("Secretary"), acting through the Centers for Medicare & Medicaid Services ("CMS"), the expert agency with responsibility for implementing these famously complex statutes. Carrying out that responsibility requires making policy-laden interpretive determinations – including through formal rulemaking, adjudication, informal interpretation, and other means – concerning how each particular statute applies in countless unpredictable real-world settings and circumstances.

Like any other stakeholders in a federal program, *Amici* do not always agree with how the Secretary and CMS exercise their authority. But *Amici* all concur that it is constitutionally permissible and vastly preferable for such authority to lie with a centralized agency, staffed with subject matter experts and accountable to the President, Congress, and the courts, rather than expect that Congress or the courts would be willing or able to assume such a role.

The specific statute at issue in this case – the Magnuson-Stevens Fishery Conservation and Management Act, 16 U.S.C. § 1801 *et seq.* – does not, of course, implicate any health insurance programs, or public health generally. However, Petitioners' sweeping request for this Court to overrule *Chevron U.S.A., Inc. v. Natural Resources Defense Council, Inc.,* 467 U.S. 837 (1984), most definitely would – by overturning a doctrine that has long accorded appropriate deference to the competence and expertise of executive agencies in filling the statutory interstices that inevitably occur as complex public programs are administered in the real world. Acknowledgement of – and deference to – that

expertise, in turn, has facilitated the construction of the regulatory foundation on which the multi-trillion-dollar American health care system depends.

Amici are uniquely positioned to assess – and to assist the Court in understanding – the tremendous disruption that overruling *Chevron* would cause to publicly funded health insurance programs specifically, to the stability of this country's health care system generally, and to the health and well-being of the patients and consumers we serve. *Amici* respectfully urge the Court not to go down that path. Irrespective of the Court's ultimate view on the validity of the challenged rule requiring an industry-funded at-sea monitoring program for the Atlantic herring fishery, the Court should decline Petitioners' request to use that narrow issue as a vehicle for jettisoning *Chevron* in its entirety, with all the far-reaching consequences such a ruling would have.

SUMMARY OF ARGUMENT

Overruling *Chevron* would have enormous impact on the administration of federal programs – including Medicare, Medicaid, and CHIP – that are critical to public health. Medicare provides health insurance coverage to approximately 65 million people in the U.S., comprising 57 million older adults and nearly 8 million younger people with disabilities. Medicaid and CHIP provide health and long-term care coverage to over 90 million low-income children, pregnant women, low-income adults, and seniors with disabilities. The competent and stable administration of these programs depends on the deep expertise of the agencies to which Congress has assigned the responsibility of promulgating rules and rendering interpretive decisions in connection with the implementation of these complex statutes, which serve nearly half the U.S. population, in every geographic region, of every income level, and with every kind of medical and care need.

Consistent with the doctrinal framework established by *Chevron* and its progeny, courts have long afforded deference to the Secretary's and CMS's reasonable exercise of this delegated authority, including the policy determinations that the agency necessarily makes when plugging the interstitial gaps that inevitably arise as it administers the health insurance statutes in a myriad of ever-changing real-world settings.

Petitioners squarely target this deference in the sweeping ruling they ask this Court to issue – a ruling whose impact would extend far beyond the narrow fisheries rule at issue in the case. In aid of their objective, Petitioners devote much of their opening brief to a stark, maximalist portrayal of the

Chevron doctrine and the way in which they claim courts have applied it. Petitioners assert that the doctrine has proven unworkable, is at odds with the Constitution's separation of powers, and should be overturned.

The Government and other *amici curiae* have undertaken to respond to Petitioners' doctrinal arguments. Through this brief, *Amici* public health, patient, and consumer advocacy organizations and professional medical associations address Petitioners' contentions regarding how *Chevron* works in the real world. Consistent with *Amici*'s missions, the brief focuses on courts' application of the *Chevron* doctrine to regulatory disputes involving the Medicare and Medicaid statutes and the impact that overturning *Chevron* would have on the competent, stable, and consistent administration of these critical health insurance programs.

Towards that end, *Amici* profile four circuit court decisions that applied the *Chevron* doctrine in resolving challenges to agency rulemaking under the Medicare and Medicaid statutes. These decisions demonstrate the straightforward, pragmatic way in which courts have understood and applied *Chevron*. Contrary to Petitioners' contentions, they exemplify how and why the *Chevron* doctrine, properly applied, is: (a) faithful to the Constitution and the Administrative Procedure Act; (b) eminently workable; and (c) promotes uniformity and stability in the interpretation and implementation of the complex statutory schemes that govern publicly funded insurance in this country.

The profiled decisions also illustrate why the relief Petitioners seek – that this Court overturn *Chevron* in its entirety – is fundamentally

impracticable and ill-advised. Just with respect to publicly funded health insurance alone, such an outcome would require the impossible from Congress – that it draft (and continuously update) the Medicare and Medicaid statutes with the speed, technical granularity, and prescience needed to anticipate and plug every conceivable statutory hole that might be revealed as the programs are implemented in myriad real-world settings. Petitioners' requested relief also would thrust generalist Article III judges into a role for which they are ill-equipped – rendering decisions on a case-by-case basis to try to fill the gaps that inevitably will still exist and to do so in connection with complex health care statutes whose interpretation and implementation are rife with policy judgments. The disruption to the health care system that would occur during the transition to such a post-*Chevron* world – as litigants seek to reopen disputes involving dozens of programs and billions of dollars that were previously resolved through application of the *Chevron* doctrine – would be enormous.

ARGUMENT

I. Overruling *Chevron* Would Impact the Administration of Complex Health Insurance Programs Affecting Nearly Half of All Americans

Congress has tasked the Secretary of Health and Human Services, acting through CMS, with administering Medicare, Medicaid, CHIP, and other related programs. The Medicare program, established by Title XVIII of the Social Security Act, 42 U.S.C. § 1395 *et seq.*, provides primary or supplemental health insurance coverage to over 57 million seniors and eight million younger people with

disabilities. Gabrielle Clerveau et al., *A Snapshot of Sources of Coverage Among Medicare Beneficiaries*, Kaiser Family Found. (Aug. 14, 2023).[2] For a majority of seniors, Medicare is their primary or only source of healthcare coverage. *See id.* The Medicaid program, established by Title XIX, 42 U.S.C. § 1396 *et seq.*, together with CHIP, presently provides health and long-term-care coverage to over 41 million low-income children and over 51 million others, including pregnant women, low-income adults, seniors, and people with disabilities. Ctrs. for Medicare & Medicaid Servs., *May 2023 Medicaid & CHIP Enrollment Data Highlights* (last visited September 18, 2023).[3] Other CMS-administered programs affect millions more Americans. *Marketplace Enrollment, 2014-2023*, Kaiser Family Found. (accessed September 18, 2023).[4]

The breadth and complexity of these programs cannot be overstated. *See Azar v. Allina Health Servs.*, 139 S. Ct. 1804, 1808 (2019) (*Allina Health*) (commenting that "[o]ne way or another, Medicare touches the lives of nearly all Americans"). Together, the programs serve nearly half of the U.S. population, including Americans in every jurisdiction, of every income level, and with every kind of medical and care need. The programs must track emerging treatment practices, respond to changing circumstances at both

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[2] https://www.kff.org/medicare/issue-brief/a-snapshot-of-sources-of-coverage-among-medicare-beneficiaries

[3] https://www.medicaid.gov/medicaid/program-information/medicaid-and-chip-enrollment-data/report-highlights/index.html

[4] https://www.kff.org/health-reform/state-indicator/marketplace-enrollment/

national and local levels, and prevent fraud and waste. And that is not all: they must incorporate the often-conflicting needs of insureds, care providers, pharmaceutical and medical device companies, and all the other stakeholders who, from time to time, may comment, complain, or sue.

The Secretary and CMS take seriously their duties in administering these critical programs. Over the past year alone, they have published, on average, a new Notice of Proposed Rulemaking approximately every two weeks. The covered topics span the spectrum. They include proposed drug misclassification rules promulgated pursuant to new enforcement authority recently enacted by Congress,[5] annual payment rates for skilled nursing facilities,[6] and a clarification that newly developed powered support devices can qualify as "braces" for reimbursement purposes.[7]

Congress takes its responsibilities seriously as well. It regularly revisits and amends the statutory frameworks governing Medicare, Medicaid, CHIP, and CMS's other program areas. For example, the 115th Congress alone passed at least ten pieces of legislation amending the laws governing Medicare,

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[5] *See* Misclassification of Drugs, Program Administration and Program Integrity Updates Under the Medicaid Drug Rebate Program, 88 Fed. Reg. 34238, 34239-40 (proposed May 26, 2023).

[6] *See generally* Medicare Program; Prospective Payment System and Consolidated Billing for Skilled Nursing Facilities, 88 Fed. Reg. 21316 (proposed Apr. 10, 2023).

[7] *See* Medicare Program; Calendar Year (CY) 2024 Home Health (HH) Prospective Payment System Rate Update, 88 Fed. Reg. 43654, 43778-79 (proposed July 10, 2023).

Medicaid, and CHIP in ways large and small.[8] This tally does not include additional language in appropriations and other bills that directed the Secretary and CMS, without amending the U.S. Code, to take certain actions or use appropriated funds in certain ways.[9]

Congress also has embedded in the statutory schemes a variety of purpose-built mechanisms to ensure the Secretary's and CMS's ongoing accountability to Congress. For example, the President's choice of CMS Administrator is subject to the advice and consent of the Senate, 42 U.S.C. § 1317(a), as is, obviously, the President's choice of Secretary. If the Secretary appoints advisory groups, the Secretary must report to Congress annually on the

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[8] *See* SUPPORT for Patients and Communities Act, H.R. 6, 115th Cong. (2018) (enacting measures to address opioid abuse); H.R. 6042, 115th Cong. (2018) (extending timeline for implementing "electronic visit verification" requirements); Patient Right to Know Drug Prices Act, S. 2554, 115th Cong. (2018) (concerning *inter alia*, generic and biosimilar medications); H.R.J. Res. 123, 115th Cong. § 201 (2017) (addressing CHIP funding shortfalls); Know the Lowest Price Act, S. 2553, 115th Cong. (2018) (concerning disclosure of drug prices to Medicare Part D beneficiaries); H.R. 3823, 115th Cong. § 302 (2018) (extending Medicare demonstration project involving intravenous immunoglobin); Bipartisan Budget Act of 2018, H.R. 1892, 115th Cong. (2018) (making numerous changes); Consolidated Appropriations Act, H.R. 1625, 115th Cong. § 1301 (2018) (revising pass-through payment rules for certain drugs and biologicals); H.R. 1370, 115th Cong. § 3201 (2017) (extending and tweaking CHIP funding); H.R. 195, 115th Cong. §§ 3005-06 (2018) (concerning Medicaid and CHIP funding).

[9] *E.g.*, Department of Defense and Labor, Health and Human Services, and Education Appropriations Act, 2019 and Continuing Appropriations Act, 2019, H.R. 6157, 115th Cong. (2018).

groups' membership and activities. *Id.* § 1314(f). Congress requires the Inspector General of Health and Human Services ("HHS") to report to Congress annually on efforts to combat waste and abuse. *Id.* § 1320a-7g(2). Congress also has created other accountability mechanisms, such as a requirement that the government provide public notice and a 60-day comment period for any "rule, requirement, or other statement of policy (other than a national coverage determination) that establishes or changes a substantive legal standard governing the scope of benefits, the payment for services, or the eligibility of individuals, entities, or organizations to furnish or receive services or benefits . . . ." *Id.* § 1395hh(a)(2), (b)(1). Congress also enacted a requirement that any rule or regulation that "may have a significant impact on the operations of a substantial number of small rural hospitals" undergo a separate regulatory impact analysis. *Id.* § 1302(b).

The result of all this is a dense web of statutory and regulatory frameworks – encompassing dozens of program areas – that is unavoidably complex. This Court and many others have openly acknowledged this complexity. *See, e.g.*, *Wos v. E.M.A. ex rel. Johnson*, 568 U.S. 627, 648 (2013) (tallying the number of "federal-court opinions . . . [that] have reiterated Judge Friendly's observation that Medicaid law is 'almost unintelligible to the uninitiated') (Roberts, C.J., dissenting); *Shalala v. Ill. Council on Long Term Care, Inc.*, 529 U.S. 1, 13 (2000) (describing Medicare as "a massive, complex health and safety program . . . embodied in hundreds of pages of statutes and thousands of pages of often interrelated regulations"); *see also Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 916 (D.C. Cir. 2013) (describing the language of the

Medicare and Medicaid "fraction" provisions as "downright byzantine"). The complexities necessitate, in turn, that the Secretary and CMS be afforded interpretive and programmatic flexibility in implementing the statutes. "Perhaps appreciating the complexity of what it had wrought, Congress conferred on the Secretary exceptionally broad authority to prescribe standards for applying certain sections of the [Social Security] Act." *Wos*, 568 U.S. at 648 (Roberts, C.J., dissenting) (quoting *Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981)); *see also Wis. Dep't of Health & Family Servs. v. Blumer*, 534 U.S. 473, 496 n.13 (2002) ("We have long noted Congress' delegation of extremely broad regulatory authority to the Secretary in the Medicaid area . . . ."); *Good Samaritan Hosp. v. Shalala*, 508 U.S. 402, 418 & n.13 (1993) (noting broad delegation of authority to the Secretary in connection with challenge to Medicare regulation governing estimation of health providers' reasonable costs).

The capable and consistent administration of the country's publicly funded health insurance programs greatly depends on the subject matter expertise that the Secretary and CMS deploy in exercising this authority. *See* 42 U.S.C. § 1395b-9(b)(1)-(2) (requiring CMS management staff to have superior expertise in technical or operational areas such as health care contracting, actuarial sciences, compliance, or consumer education). Pursuant to *Chevron*, courts have afforded deference to that expertise and to the policy determinations that the agency makes as it implements Congress's statutory framework in the face of unforeseen and unforeseeable real-world circumstances.

Petitioners challenge this deference by asking the Court to reach far beyond the narrow fisheries rule at issue in this case and jettison the *Chevron* doctrine completely. *Amici* will not duplicate the work of others in responding to Petitioners' doctrinal arguments. Instead, *Amici* focus on how *Chevron* has worked in the real world. Specifically, and consistent with *Amici*'s public health missions, *Amici* discuss courts' historical application of the *Chevron* doctrine to regulatory disputes involving the Medicare and Medicaid programs.

II. A Focused Review of Circuit Court Decisions Addressing Challenges to Medicare and Medicaid Rulemaking Demonstrates the Straightforward Manner in Which Courts Have Applied *Chevron*

In asking this Court to overturn *Chevron*, Petitioners use extreme terms to describe both the doctrine and the way in which courts purportedly have applied it. Petitioners' doctrinal assertions do not accord with the framework that *Chevron* and its progeny establish. *See* Brief of Professor Thomas W. Merrill as *Amicus Curiae* in Support of Neither Party at 8-20, *Loper Bright Enters. v. Raimondo*, No. 22-451 (July 21, 2023). Petitioners' portrayal also is at odds with the way in which courts have applied the *Chevron* doctrine to actual litigated disputes.

To illustrate the latter point, the remainder of this brief discusses four circuit court decisions that addressed challenges to agency rulemaking under the Medicare and Medicaid statutes. Contrary to Petitioners' contentions, the opinions issued by each of these four different circuits demonstrate that the doctrine, when applied consistent with *Chevron*'s

framework, is: (a) in accord with the requirements of the Constitution and the Administrative Procedure Act; (b) workable; and (c) promotes uniformity and consistency in the implementation of often complex statutory schemes.

The profiled decisions also illustrate why the relief Petitioners seek – that this Court overturn *Chevron* in its entirety – is impracticable. Among other reasons, such an outcome would demand the impossible – that Congress draft and continuously update the Medicare and Medicaid statutes with the speed, precision, and foresight needed to ensure the absence of interstitial gaps as the Secretary and CMS administer these complex programs in innumerable real-world settings. Overturning *Chevron* also would require that courts assume a role for which they are ill-suited – to try to resolve on a case-by-case basis the countless number of gaps that unavoidably exist in these statutory schemes, most of which implicate conflicting policy choices. And the upheaval caused by the transition to such a world – as litigants reopen disputes previously resolved through the application of *Chevron* deference – would be immense.

A. Four Illustrative Circuit Court Decisions

In *Bellevue Hospital Center. v. Leavitt*, 443 F.3d 163 (2d Cir. 2006) (Katzmann, J.) (*Bellevue*), the Second Circuit applied *Chevron* to uphold an agency rule defining "geographic area" under the Medicare statute for purposes of adjusting payment rates to reflect differences in wage levels between hospitals located in different "geographic areas."

In *Baptist Memorial Hospital v. Azar*, 956 F.3d 689 (5th Cir. 2020) (Higginbotham, J.) (*Baptist*

Memorial), the Fifth Circuit applied *Chevron* to uphold an agency rule defining "costs incurred" for purposes of calculating Disproportionate Share Hospital payments under the Medicaid statute as net of payments that hospitals receive from third parties, including private insurers. *See also Children's Hosp. Ass'n of Tex. v. Azar*, 933 F.3d 764, 767, 769 (D.C. Cir. 2019) (construing same statutory term and reaching same result); *Mo. Hosp. Ass'n v. Azar,* 941 F.3d 896, 897-98 (8th Cir. 2019) (same).

In *Southeast Alabama Medical Center v. Sebelius*, 572 F.3d 912 (D.C. Cir. 2009) (Garland, J.) (*Southeast Alabama*), the District of Columbia Circuit applied *Chevron* to uphold most of an agency rule defining "Proportion" and "Factor" under the Medicare statute for purposes of adjusting hospital payment rates to reflect area differences in wage-related costs. The court rejected one facet of the rule as inadequately explained and potentially unreasonable. *Id.* at 920.

In *Resident Councils of Washington v. Leavitt*, 500 F.3d 1025 (9th Cir. 2007) (Hawkins, J.) (*Resident Councils*), the Ninth Circuit applied *Chevron* to uphold an agency rule clarifying that the provision of feeding assistance to nursing home patients without complicated feeding problems did not constitute the provision of "nursing or nursing-related services" under the Nursing Home Reform Law, as incorporated into the Medicaid statute.

B. Each Decision Applied *Chevron* Consistent with the Doctrinal Framework This Court Has Established

All four circuit courts conducted a straightforward *Chevron* analysis and did so consistent with the framework established by this Court in *Chevron* and its progeny.

First, each court employed traditional tools of statutory construction to assess whether the statutory language underpinning the agency rule at issue was ambiguous or open-ended and concluded that it was. *See Bellevue*, 443 F.3d at 175 (observing that "the statute leaves considerable ambiguity as to the term 'geographic area'"); *Baptist Memorial*, 956 F.3d at 693-95 (finding ambiguity in the term "costs incurred" and rejecting hospitals' contention that the statute was unambiguous); *Southeast Alabama*, 572 F.3d at 917-23 (discussing a myriad of different ways to define and apply the terms "Proportion" and "Factor"); *Resident Councils*, 500 F.3d at 1031, 1033 (concluding that the operative statute failed to define the phrase "nursing or nursing-related services" and that Congress also provided no elaboration in the legislative history).

Second, the courts addressed whether Congress, either expressly or impliedly, delegated to the agency authority to construe the statutes in question. *See Baptist Memorial*, 956 F.3d at 693 (finding delegation to agency of "gap-filling authority" based on statutory language identifying Secretary as the person tasked with determining the "costs incurred"); *Bellevue*, 443 F.2d at 175-76 (noting "clear" congressional awareness and acquiescence in agency's longstanding approach to filling the "statutory gap" in

the meaning of "geographic area"); *Southeast Alabama*, 572 F.3d at 921 ("Congress, through its silence" in "not specify[ing] how the Secretary should construct the [Factor], nor how often she must revise it . . . delegated these decisions to the Secretary") (quoting in parenthetical *Methodist Hosp. of Sacramento v. Shalala*, 38 F.3d 1225, 1230 (D.C. Cir. 1994)). Notably, in *Resident Councils*, the Ninth Circuit rejected plaintiffs' argument that no delegation should be found absent explicit authorization specific to the statutory language at issue, stating: "[i]t strains credulity to accept the argument that the Secretary may only define terms when expressly authorized to do so by Congress, given that Congress made no attempt to define the generic, yet vital, phrase 'nursing or nursing-related services.'" 500 F.3d at 1033 (and also noting that the statute gave specific rulemaking authority to the Secretary with respect to nursing homes).

Third, the courts analyzed the reasonableness of the agency rules at issue, including whether the agency had sufficiently explained its reasoning and any policy choices it had made in formulating the rules. Relatedly, the courts also assessed under the APA whether the agency's decisions were "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A). *See Resident Councils*, 500 F.3d at 1036-37 (finding that agency's explanation "clearly reveals the agency's reasoning in determining that feeding residents without complicated feeding problems does not constitute a nursing-related service"); *Bellevue*, 443 F.2d at 175-78 (discussing agency's balancing of "somewhat contradictory" policy considerations); *Southeast Alabama*, 572 F.3d at 917-20 (assessing reasonableness of agency's construction of ambiguous

statutory terms, including "wages" and "wage-related"); *see also Children's Hosp. Ass'n of Tex*, 933 F.3d. at 773-74 (describing agency's articulated policy reasons for its new rule defining "costs incurred"). Notably, where the agency's reasoning was inadequate or incomplete, no deference was afforded to the agency's determination. *See Southeast Alabama*, 572 F.3d at 919-20 (concluding that Secretary had failed adequately to explain its decision to include postage costs in calculating the "Proportion").

C. None of the Decisions Support Petitioners' Articulated Concerns

In addition to the comprehensiveness of the courts' analyses and the fidelity of those analyses to *Chevron*'s framework, none of the decisions support any of the concerns advanced by Petitioners as supposedly warranting the overturn of *Chevron*.

First, nothing about the statutory provisions or rules at issue – or the way in which the courts applied *Chevron* to review them – is inconsistent with the Constitution's separation of powers among the three branches of government. Contrary to Petitioners' assertions, there was no indication that the statutory ambiguities identified in these Medicare and Medicaid cases resulted from congressional laziness or an attempt to "punt" difficult legislative issues to the executive branch in violation of the authority delegated to Congress under Article I. To the contrary, the courts' discussions make clear the attention given by Congress to the Medicare and Medicaid programs, including the frequency with which Congress has amended the statutory language governing both. *See Bellevue*, 443 F.3d at 176 (finding no lack of congressional interest or knowledge and

noting the frequency with which Congress has "tinkered with the statutory scheme in question"); *Southeast Alabama*, 572 F.3d at 916, 922 (discussing two sets of statutory amendments made by Congress to the provisions at issue).

The courts likewise did not reflexively and unthinkingly defer to the agency's actions, and thus did not abdicate their responsibility for statutory interpretation under either Article III or the Administrative Procedure Act. Rather, as summarized above, the courts examined the disputed statutory language to determine, first, whether it possessed a sufficiently clear meaning. *See* discussion at p. 15, *supra*. If it did not, they next assessed whether Congress had delegated authority to the agency to construe the statutes at issue. *See* discussion at p. 15-16, *supra*.

Nor did the rules at issue in any of these decisions suggest the agency had exceeded its authority under Article II. In that regard, all of the challenged rules served to fill (or construe) interstitial gaps in the pertinent Medicare and Medicaid statutory provisions, not to create new requirements divorced from the statutory language. *See* discussion at pp. 13-14, *supra* (summarizing nature of challenged rules). Moreover, the courts carefully considered and concluded that the agency rules at issue were reasonable, fell within the scope of the authority delegated to the agency by Congress, and were not arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law. *See* discussion at pp. 16-17, *supra*.

Finally, in reaching their decisions, the courts applied a uniform analytical approach consistent with *Chevron*'s framework. Contrary to Petitioners'

contentions, none of the decisions reflected uncertainty or any hint of a "struggle" concerning how to apply *Chevron* in a workable way.[10]

III. The Profiled Circuit Court Decisions Demonstrate the Impracticability of Petitioners' Requested Relief

Rather than casting doubt on the workability of *Chevron*, the profiled circuit court decisions serve to demonstrate the impracticability of the relief sought by Petitioners, which would shift onto Congress and the courts the gap-filling duties currently performed by the Secretary and CMS in administering the country's publicly funded health insurance programs.

Even a cursory consideration of the statutory provisions at issue in the four decisions makes clear the unrealistic nature of any expectation that Congress would be able to draft (or amend) the Medicare and Medicaid statutes with the precision needed to avoid the types of interstitial gaps addressed in the decisions. Given the breadth and complexity of both programs, it is unavoidable that

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[10] Other circuits likewise have had no difficulty applying *Chevron* in a consistent, straightforward manner to regulatory disputes involving the Medicare and Medicaid statutes. *See, e.g.*, *West Virginia v. Thompson*, 475 F.3d 204, 212-14 (4th Cir. 2007) (Wilkinson, J.) (applying *Chevron* doctrine to reject challenge to agency decision disapproving proposed State Medicaid Plan Amendment based, in part, on agency's reasonable interpretation of ambiguous statutory language); *Baptist Health v. Thompson*, 458 F.3d 768, 773-76 (8th Cir. 2006) (applying *Chevron* doctrine to uphold agency regulation requiring that "approved educational activities" be directly operated by the provider for the costs of such activities to qualify for "pass-through treatment" under the Medicare program's Prospective Payment System), abrogated on other grounds by *Allina Health*, 139 S. Ct. at 1804.

terms such as "geographic area," "costs incurred," and "nursing or nursing-related services" – and many dozens of others – will need to be fleshed out in the course of the agency's application of the statutes to real-world settings and circumstances. *Kisor v. Wilkie*, 139 S. Ct. 2400, 2410 (2019) (plurality opinion) (noting that "often, ambiguity reflects the well-known limits of expression or knowledge").

Nor, given the variability of real-world circumstances, is it reasonable to expect Congress to conduct the type of comprehensive monitoring of the Medicare and Medicaid programs that would be needed to stay abreast of, identify, and plug – through timely legislation – every statutory gap that becomes apparent. *See Baptist Memorial*, 956 F.3d at 694-95 (observing that it "makes sense" to afford to the Secretary the discretion to define the third-party payments that should be subtracted when calculating "costs incurred," "given the array of private and public payers . . . and the potential for unforeseeable changes in how these payers reimburse hospitals").

It likewise is neither practicable nor prudent for courts to try to assume this gap-filling role themselves. As the profiled health insurance decisions illustrate, the gaps in the Medicare and Medicaid statutes generally implicate policy choices, which cannot be addressed through traditional tools of statutory construction. *See Resident Councils*, 500 F.3d at 1036-37 (discussing patient-related treatment considerations that underpinned the agency's determination that feeding residents without complicated feeding problems does not constitute a "nursing-related service"); *Bellevue*, 443 F.2d at 175-78 (discussing competing policy considerations that led to agency's choice of one approach (over others) for

defining hospitals' "geographic area"); *see also Children's Hosp. Ass'n of Tex*, 933 F.3d. at 773-74 (describing agency's policy reasons when deciding which third party payments to subtract in calculating "costs incurred").

Not only do such policy determinations fall outside the judiciary's role, but generalist judges lack the expertise that agency personnel possess to make such determinations. *See, e.g.*, *Wis. Dep't of Health & Family Servs.*, 534 U.S. at 497 (noting that "reliance on [the] Secretary's significant expertise [also is] particularly appropriate in the context of a complex and highly technical regulatory program" like Medicaid) (internal quotation marks omitted); *Thomas Jefferson Univ. v. Shalala,* 512 U.S. 504, 512 (1994) (observing in the context of the Medicare program that deference to the Secretary is "all the more warranted when . . . the regulation concerns a complex and highly technical regulatory program" that "require[s] significant expertise and entail[s] the exercise of judgment grounded in policy concerns") (internal quotation marks omitted).

Further, placing the responsibility on individual judges to wrestle with such issues – rather than on an experienced centralized agency – risks creating a patchwork scheme of potentially conflicting judicial interpretations, as different judges across the country come to different conclusions regarding the meaning of terms such as "geographic area," "costs incurred," and "nursing-related services." *See Kisor*, 139 S. Ct. at 2414 (plurality opinion) (observing that "Congress's frequent preference for resolving interpretive issues by uniform administrative decision, rather than piecemeal by litigation . . . may be strongest when the interpretive issue arises in the

context of a complex and highly technical regulatory program.") (quotation marks omitted).

IV. The Selected Decisions Demonstrate the Considerable Disruption that Overturning *Chevron* Would Cause

Even if the post-*Chevron* world envisioned by Petitioners were feasible – which it is not – the circuit court opinions profiled in this brief comprise but a sliver of the many appellate and district court decisions that have upheld agency rules pursuant to *Chevron*'s analytical framework. For every one of those disputed rules that remains in place, overturning *Chevron* would open the door for the losing parties to relitigate the issue. Indeed, given the amount of money often at stake in challenges to Medicare and Medicaid rules, a post-*Chevron* litigation tsunami would seem all but guaranteed. *See Bellevue*, 443 F.3d at 167 (involving claim by 76 plaintiff hospitals that they would receive $812 million less in reimbursements over the next 10 years as a result of challenged rule); *Southeast Alabama*, 572 F.3d at 914 (involving claim by 113 plaintiff hospitals that a challenged reimbursement rule "deprived them of millions of dollars"); *see also Allina Health*, 139 S. Ct. at 1816 (observing that "even minor changes to the agency's approach [to insurance payments] can impact millions of people and billions of dollars in ways that are not always easy for regulators to anticipate"). The resulting uncertainty would be extraordinarily destabilizing, not just to the Medicare and Medicaid programs but also – given the size of these programs – to the operational and financial stability of the country's health care system as a whole. *See* pp. 6-11, *supra* (summarizing facts regarding magnitude of programs).

Petitioners have put forth no basis – legal or otherwise – to support such a disruptive result. Contrary to Petitioners' stark depiction of the alleged perils and pitfalls of *Chevron*, the reality – as exemplified by the circuit court decisions profiled in this brief – is quite different. Properly applied, the *Chevron* doctrine is, in fact: (a) faithful to the Constitution and the Administrative Procedure Act; (b) workable; and (c) promotes uniformity and stability in the interpretation and implementation of often complex statutory schemes. As a result, whatever the Court's ultimate conclusion regarding the fisheries rule at issue in this case, the Court need not and should not use Petitioners' appeal on that narrow issue to overturn *Chevron* in its entirety. *See Allina Health*, 139 S. Ct. at 1814 (acknowledging the "well-worn path of declining 'to issue a sweeping ruling when a narrow one will do'") (quoting *McWilliams v. Dunn*, 582 U.S. 183, 198 (2017)).

CONCLUSION

For the foregoing reasons, *Amici* respectfully request that the Court decline Petitioners' invitation to overturn *Chevron*.

Respectfully submitted,

MARY ROUVELAS
AMERICAN CANCER SOCIETY CANCER ACTION NETWORK
655 15th Street, NW
Washington, DC 20004
(202) 899-5619
Mary.Rouvelas@cancer.org

JANE PERKINS
SARAH SOMERS
NATIONAL HEALTH LAW PROGRAM
1512 E. Franklin St.
Suite 100
Chapel Hill, NC 27514
(919) 968-6308
perkins@healthlaw.org

SCOTT P. LEWIS
Counsel of Record
MICHAEL J. PINEAULT
AUSTIN P. ANDERSON
PAUL M. KOMINERS
ANDERSON & KREIGER LLP
50 Milk St., 21st Floor
Boston, MA 02109
(617) 621-6500
lewis@andersonkreiger.com

Counsel for Amici Curiae

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