United States Court of Appeals for the Federal Circuit

17-1224

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY,
An Illinois Non-Profit Mutual Insurance Corporation,

Plaintiff-Appellant,

v.

UNITED STATES,

Defendant-Appellee.

Appeal from the United States Court of Federal Claims in No. 16-744

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS, INC. AS *AMICUS CURIAE* IN SUPPORT OF REHEARING EN BANC

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CERTIFICATE OF INTEREST

As called for by Federal Circuit Rule 47.4, Counsel for *Amicus Curiae* America's Health Insurance Plans, Inc. certifies the following:

1. The full name of every party or amicus represented by me is:

   America's Health Insurance Plans, Inc.

2. The name of the real party-in-interest (if the party named in the caption is not the real party in interest) represented by me is: Not applicable.

3. All parent corporations and any publicly held companies that own 10 percent or more of the stock of the party or amicus curiae represented by me are:

   None. America's Health Insurance Plans, Inc. has no parent corporation and is a trade association whose members have no ownership interests.

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this Court are:

   AKIN GUMP STRAUSS HAUER & FELD LLP: Leslie B. Kiernan, Pratik A. Shah, and Robert K. Huffman.

   DEUTSCH HUNT PLLC: Hyland Hunt and Ruthanne M. Deutsch.

   Ralph C. Nash, Professor Emeritus, George Washington University Law School.

5. The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal:

   Federal Circuit

   Blue Cross and Blue Shield of North Carolina v. United States, No. 17-2154

   Maine Cmty. Health Options v. United States, No. 17-2395

   Moda Health Plan, Inc. v. United States, No. 17-1994

Court of Federal Claims

Alliant Health Plans, Inc. v. United States, No. 16-1491C (Braden, J.)

BCBSM, Inc. v. United States, No. 16-1253C (Coster Williams, J.)

Blue Cross and Blue Shield of Alabama v. United States, No. 17-347C (Campbell-Smith, J.)

Blue Cross and Blue Shield of Kanas City v. United States, No. 17-95C (Braden, J.)

BlueCross BlueShield of Tennessee v. United States, No. 17-348C (Horn, J.)

Blue Cross of Idaho Health Service, Inc. v. United States, No. 16-1384C (Lettow, J.)

Common Ground Healthcare Cooperative v. United States, No. 17-877C (Sweeney, J.)

EmblemHealth, Inc. v. United States, No. 17-703C (Wheeler, J.)

Farmer v. United States, No. 17-363C (Campbell-Smith, J.)

First Priority Life Ins. Co. v. United States, No. 16-587C (Wolski, J.)

Health Alliance Medical Plans, Inc. v. United States, No. 17-653C (Campbell-Smith, J.)

Health Net, Inc. v. United States, No. 16-1722C (Wolski, J.)

Health Republic Ins. Co. v. United States, No. 16-259C (Sweeney, J.)

HPHC Ins. Co., Inc. v. United States, No. 17-87C (Griggsby, J.)

Medica Health Plans v. United States, No. 17-94C (Horn, J.)

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Neighborhood Health Plan, Inc. v. United States, No. 16-1659C (Smith, J.)

New Mexico Health Connections v. United States, No. 16-1199C (Bruggink, J.)

Ommen v. United States, No. 17-712C (Lettow, J.)

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Dated: August 10, 2018

By: /s/Leslie B. Kiernan
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STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As a result, AHIP's members have broad experience working with other healthcare stakeholders, including medical providers as well as state and federal government agencies, to ensure that patients have access to needed treatments and medical services.

That experience gives AHIP extensive first-hand knowledge about the Nation's healthcare and health insurance systems and a unique understanding of how those systems work. Given the pervasive role of the federal government in those systems, including as a result of the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA"), AHIP's

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[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than the *amicus*, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief, which is accompanied by a motion for leave to file. *See* Fed. R. App. P. 29(b); Fed. Cir. R. 35(g).

experience is that those systems can function as intended only when the government meets its obligations as a reliable business partner. AHIP supports en banc review because the panel opinion, by upending decades of Federal Circuit and Supreme Court precedent, jeopardizes the reliability of health insurance providers' ongoing business relationships with the federal government.

INTRODUCTION AND SUMMARY OF ARGUMENT

Insurers across the country made the decision to enter into, and continue participating in, the new, risky insurance exchanges because of a clear statutory promise that—as all members of the panel agreed—unambiguously "created an obligation of the government to pay … the full amount indicated by the statutory formula … under the risk corridors program." *Moda Health Plan, Inc. v. United States*, No. 17-1994, Docket No. 87, slip op. at 19 (Fed. Cir. June 14, 2018) ("Slip. Op."); *see* Slip Op., Docket No. 166. A divided panel nonetheless concluded that an appropriations rider precluding the use of only certain funding sources impliedly suspended this statutory obligation. *Id.* at 20. AHIP agrees with Judge Newman and the petitioning health plans that this holding conflicts with Federal Circuit and Supreme Court precedent. *See Moda Health Plan, Inc. v. United States*, No. 17-1994, Docket No. 87, dissent at 8, 14-17 (Fed. Cir. June 14, 2018) ("Dissent"); Land of Lincoln's Pet. for Reh'g En Banc at 6-14, Docket No. 167; Moda Health Plan, Inc.'s Pet. for Reh'g En Banc at 6-11, *Moda Health Plan, Inc. v. United States*, No.

17-1994, Docket No. 89 (Fed. Cir. filed July 30, 2018).[2] AHIP writes to emphasize the critical need for en banc review because the panel majority's holding calls into question years of precedent holding the government to its obligations, thereby casting doubt on whether private health care providers can rely upon the federal government as a fair business partner—a question of urgent and increasing importance given the government's recent conduct in connection with other ACA programs.

This Court has long recognized that no entity would partner with the government if it did not expect the government to adhere to its commitments. Whether the commitments stem from statute or contract, the ability to rely upon the government's word is of paramount importance to health care programs, which depend upon partnerships with private providers to serve the consumers, patients, and beneficiaries who receive needed medical care. Federal Circuit precedent has—until now—guaranteed those commitments in the absence of explicit and clear congressional intent to repudiate them. The panel majority's opinion, however, now makes it a risky business to rely upon the government's assurances. That deals a crippling blow to health insurance providers' business relationships with the

[2] AHIP also supports the rehearing petitions filed in *Maine Community Health Options v. United States*, No. 17-2395, and *Blue Cross & Blue Shield of North Carolina v. United States*, No. 17-2154.

government, which depend upon the providers' ability to trust that the government will act as a fair partner.

The risk corridors default is just one example among many where the government has not acted as a reliable and fair partner committed to promoting a stable and sustainable market. For example, in 2017 the government ceased making cost sharing reduction payments mandated by ACA—well into the plan year and long after plans had set premiums based on clear statutory terms mandating payment. And in June 2018, the government took the unusual step of declining to defend key provisions of ACA in litigation—again, long after health insurance providers had designed plans in reliance on clear statutory provisions the government has now abandoned. En banc rehearing is needed to forestall even greater harm.

ARGUMENT

EN BANC REVIEW IS NECESSARY BECAUSE THE PANEL OPINION JEOPARDIZES HEALTH INSURANCE PROVIDERS' ONGOING BUSINESS RELATIONSHIPS WITH THE GOVERNMENT

A. The Panel Majority's Decision Undercuts the Government's Reliability as a Business Partner, Which Is of Critical Importance in the Health Care Industry

The panel opinion has damaging effects that reach beyond the specific harm to the insurance market, the ACA exchanges, and consumers from the government's failure to meet its risk corridor obligations. As Judge Newman recognized, the panel majority's holding also "undermines the reliability of dealings with the government." Dissent at 19. That causes harm not only to those who partner with

the government, but also to the government itself, whose "ability to benefit from participation of private enterprise depends on [its] reputation as a fair partner." *Id.*

The harm caused by the government's failure to meet its obligations has long been recognized by the Supreme Court and this Court. If "the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 192 (2012). Accordingly, the law safeguards the "Government's own long-run interest as a reliable contracting partner in the myriad workaday transaction of its agencies." *United States v. Winstar Corp.,* 518 U.S. 839, 883 (1996) (plurality op.). Were it otherwise, "willing partners [would become] more scarce." *Salazar*, 567 U.S. at 192. For that reason, the law has long secured payment of governmental obligations even in the absence of appropriated funds, because "the Government's valid obligations will remain enforceable in the courts." *Id.* at 191 (internal citation and quotation omitted).

This is true for obligations created by statute as well as contract. The "mere failure of Congress to appropriate funds … does not in and of itself defeat a Government obligation created by statute." *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007). Nor does a congressional appropriations restriction, unless it "modified or repealed the previous law" "expressly or by clear implication."

United States v. Langston, 118 U.S. 389, 394 (1886); *see* Dissent at 7-8. There was no such manifest intent here, only temporary restrictions on particular sources of appropriated funds enacted in the context of unsuccessful efforts to repeal. *See* Dissent at 6. The upshot of treating such mere funding-source restrictions as an implied suspension of the obligation goes beyond contravening Federal Circuit precedent. Allowing the government to default on its obligations means that—after receiving the direct financial benefit from the risk corridors program—the government has walked away from billions owed to health insurance providers, who had set premiums and participated in the exchanges in reasonable reliance on the clear statutory mandate and the government's repeated assurances. *See* Dissent at 4-5.

Retroactively relieving the government of its clear statutory obligations based on funding-source restrictions directly harms health insurance providers that participated in the first years of the ACA exchanges, as well as the consumers they serve. Beyond that, it also puts at risk the government's long-term interest in being trusted to act as a reliable business partner. There are few industries in which that interest matters more than health care, where the government relies heavily upon partnerships with private providers for the delivery of services. Of $944.1 billion dollars spent by the federal government on health care in 2016, across all programs, more than $738.2 billion (78%) involved services delivered through partnerships

with doctors, hospitals, insurance providers, and other entities through programs such as Medicare, Medicaid, and the ACA health insurance exchanges.[3] Tens of millions of Americans receive health care through such programs, including over 9 million Americans who obtained subsidized health plans on ACA's exchanges,[4] over 20 million Americans who receive Medicare benefits through private health plans,[5] and over 65 million Americans who receive health care through Medicaid managed care programs.[6]

The panel decision imperils these sorts of partnerships in health care. As Judge Newman emphasized, the panel majority permitted the government to repudiate its obligations even *after* health insurance providers had performed their part of the bargain. Dissent at 17. If it is perceived that the federal government can walk away from statutory obligations made to encourage private sector participation in new programs—and the courts will not secure those relied-upon obligations through the Judgment Fund—partnering with the federal government becomes a venture fraught with risk.

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[3] *See* Ctrs. for Medicare & Medicaid Servs. ("CMS"), Nat'l Health Expenditure Data, Table 05-3 & n.2, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html.

[4] Ctrs. for Medicare & Medicaid Servs., Early 2018 Effectuated Enrollment Snapshot (July 2, 2018).

[5] Ctrs. for Medicare & Medicaid Servs., Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report, Monthly Summary Report (July 2018).

[6] Kaiser Family Found., *Total Medicaid Managed Care Enrollment* (2016).

B. Rehearing Is Vitally Important Now Because the Risk Corridors Program Is Only One of Many in Which the Government Has Not Acted as a Reliable Business Partner

Public-private partnerships in health care generally, and in the ACA individual and small-group markets specifically, depend upon clear, consistent, and consistently enforced rules governing the mutual obligations between private health insurance providers and the government. The need to safeguard the reliable performance of the government's part of the bargain is ever more pressing. The failure to pay risk corridors obligations was just one of several recent actions taken by the government that have undercut the strength of ACA's many public-private partnerships.

In 2017, for example, the government announced that it would no longer reimburse health insurance providers for the reductions in cost-sharing (e.g., co-pays and deductibles) that insurance providers are required to provide to certain low-income exchange beneficiaries, notwithstanding a clear statutory mandate to make these cost sharing reduction ("CSR") payments. *See* 42 U.S.C. § 18071(c)(3)(A); *Trump v. California*, 267 F. Supp. 3d 1119 (N.D. Cal. 2017). Once again, the abandonment of payment obligations occurred in the middle of a plan year and long after health plans had set premiums. The decision to terminate CSR payments caused immediate harm to health insurance providers, as evidenced by the cases pending in the Court of Federal Claims seeking to recover monies owed from 2017,

the year of the government's mid-year about-face. *See, e.g.*, *Common Ground Healthcare Coop. v. United States*, 137 Fed. Cl. 630 (2018) (certifying class).

Thus far, the harm to many (though not all) consumers—particularly for 2018—has been much less than it could have been. This is because states and insurance providers worked hard to implement a strategy centered around so-called "silver loading," which sought to lessen the costly effects for consumers associated with the government's termination of CSR payments. *See Trump*, 267 F. Supp. 3d at 1133-35. But the government—doubling down on its nonpayment of amounts owed under an unambiguous statutory mandate—has signaled an interest in eliminating or prohibiting such efforts. *See, e.g.*, Margot Sanger-Katz, *Republicans Couldn't Knock Down Obamacare. So They're Finding Ways Around It*, N.Y. TIMES, The Upshot (Apr. 11, 2018) (reporting that the Centers for Medicare & Medicaid Services is considering barring states from using silver loading); Katie Keith, *Insurers Can Continue Silver Loading for 2019*, Health Affairs (Jun. 13, 2018), https://www.healthaffairs.org/do/10.1377/hblog20180613.293356/full (reporting that at a June 2018 hearing before the House Education and Workforce Committee Department of Health and Human Services, Secretary Azar did not rule out banning silver loading in the future). These statements continue to inject significant uncertainty into the market and call into question the government's commitment to stable and reliable rules.

The continued uncertainty surrounding CSR payments is not the only recent development that raises questions regarding the long-term reliability of the government as a business partner in health care. In response to litigation by Texas and other states seeking to enjoin ACA in its entirety, the government in June 2018 took the highly unusual step of declining to defend a congressional enactment. Although opposing an injunction, the government agreed with the plaintiffs that zeroing out the penalty for noncompliance with the individual mandate rendered that provision unconstitutional and required the invalidation of two key ACA market reforms, guaranteed issue and community rating, as of 2019 (the effective date of zeroing out of the penalty).[7] *See* Fed. Defs. Br., *Texas v. United States*, No. 4:18-cv-167, Docket No. 92, (N.D. Tex. filed June 7, 2018). Once again, this development came only *after* plans had already developed products and submitted rates for 2019 that were based on the policies and rules that the government now jettisons.

The uncertainty and instability wrought by the government's repeated repudiation of prior positions and commitments, particularly in the health care context, shows the pressing need for en banc review here. This Court should restore Federal Circuit precedent recognizing that the government must act as a reliable

[7] Guaranteed issue "bar[s] insurers from denying coverage to any person because of his health," and community rating "bar[s] insurers from charging a person higher premiums for the same reason." *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015).

business partner and keep its promises, which in this particular case means the government must meet its risk corridor payment obligations.

CONCLUSION

The Court should grant rehearing en banc.

Dated: August 10, 2018

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g) and Federal Circuit Rule 32(b), the undersigned hereby certifies that this brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(b)(4) and Federal Circuit Rule 35(g).

1. Exclusive of the exempted portions of the brief, as provided in Federal Rule of Appellate Procedure 32(f) and Federal Circuit Rule 32(b), the brief contains 2,395 words.

2. This brief has been prepared in proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman font. As permitted by Federal Rule of Appellate Procedure 32(g), the undersigned has relied on the word count feature of this Microsoft Word in preparing this certificate.

Dated: August 10, 2018

/s/ Leslie B. Kiernan
Leslie B. Kiernan

CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing proposed brief with the Clerk of the United States Court of Appeals for the Federal Circuit via the CM/ECF system this 10th day of August, 2018, and served a copy on counsel of record by the CM/ECF system.

Dated: August 10, 2018

/s/ Leslie B. Kiernan
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