Nos. 18-1023, 18-1028, 18-1038

In The
Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS, *Petitioner*,
v.
UNITED STATES, *Respondent*.

MODA HEALTH PLAN, INC., ET AL., *Petitioners*,
v.
UNITED STATES, *Respondent*.

LAND OF LINCOLN MUTUAL HEALTH INSURANCE CO., *Petitioner*,
v.
UNITED STATES, *Respondent*.

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

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF PETITIONERS

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INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans, Inc. ("AHIP") is the national trade association representing health insurance providers. AHIP advocates for public policies that expand access to affordable health care 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 health care 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 health care 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 experience is that those systems can function as intended only when the government meets its obligations as a reliable

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[1] Counsel of record for all parties consent to the filing of this brief. S. CT. R. 37.3(a). No counsel for any party authored this brief in whole or in part, and no person or entity other than *amicus curiae* or its counsel made a monetary contribution intended to fund the brief's preparation or submission.

business partner.

AHIP writes to emphasize that all relevant stakeholders, including the responsible government agency, agreed that the risk corridors program represented an unambiguous commitment by the government to share in a portion of the losses incurred by health insurance providers in the first years of the health insurance exchanges. The Federal Circuit's decision permitting the government to walk away from that clear commitment based on ambiguous appropriations riders years later jeopardizes ongoing and future public-private partnerships that are critically important to the Nation's health care system.

INTRODUCTION AND SUMMARY OF ARGUMENT

Health insurance providers across the country decided to enter into the new and risky insurance exchanges because of a clear obligation Congress created in the ACA: "an obligation of the government to pay … the full amount indicated by the statutory formula … under the risk corridors program." Pet. App. 20.[2] Both the majority and dissenting judges on the Federal Circuit recognized that statutory obligation as unambiguous. The Federal Circuit nonetheless concluded that an appropriations rider precluding the use of only certain funding sources impliedly "suspended" that obligation, thereby depriving health insurance providers of billions of dollars in promised reimbursements.

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[2] All citations to the Petition Appendix are to the appendix in No. 18-1028.

AHIP agrees with Petitioners that the Federal Circuit's decision finds no support in this Court's precedents. AHIP writes separately to emphasize that the Federal Circuit's holding also casts serious doubt on the ability of private entities to rely on the federal government as a fair business partner. Given the extensive participation of health insurance providers in the Nation's health care programs, that concern is one of grave importance.

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 government's monetary commitments stem from statute or contract, courts have—until now—guaranteed them in the absence of explicit and clear congressional intent to repudiate them. But the Federal Circuit's decision, which lets the government "suspend" (*i.e.*, repudiate) its clear substantive obligations on the basis of an at-best ambiguous appropriations rider, makes it a risky business to rely upon the government's assurances.

This case is particularly egregious because the Federal Circuit approved the government repudiating its obligation *after* it had reaped the benefit of its bargain. When they started, the ACA exchanges represented a new and uncertain market. Congress supported that market—inducing health insurance providers to participate and set lower premiums—with an express statutory command for the government to share in any substantial losses those providers might suffer. All relevant stakeholders, including actuaries, health insurance providers, and the Department of Health and Human Services

("HHS"), understood that the risk corridors program would distribute risk between the federal government and health insurance providers—not just among providers. Health insurance providers reasonably relied on that understanding, and the agency repeatedly confirmed it.

As a result, in the early years of the exchanges, health insurance providers set lower premiums than market conditions would otherwise warrant, and many suffered significant losses. Indeed, even if the government had made full risk corridors reimbursements as the statute requires, those health insurance providers still would have borne substantial losses. As it stands, although health insurance providers did their part—saving the government billions in reduced premium tax credit expenditures—they have been left covering the additional $12 billion of losses that the government had promised to reimburse.

Affirming the Federal Circuit's rule, which offers a roadmap for the government to dodge its commitments through snippets of legislative history buried in an after-the-fact appropriations rider, will necessarily damage business relationships between health insurance providers and the government. Such partnerships extend well beyond the ACA exchanges and are vitally important. Those partnerships deliver health care to tens of millions of Americans, and they depend upon the ability of insurance providers to trust that the government will act as a fair partner. This Court should reverse the judgment below to avoid significant and lasting damage to those partnerships and the benefits they bestow.

ARGUMENT

THE FEDERAL CIRCUIT'S DECISION THREATENS THE DEEP PARTNERSHIP BETWEEN HEALTH INSURANCE PROVIDERS AND THE GOVERNMENT.

A. The Decision Below Undercuts The Government's Reliability As A Business Partner.

The Federal Circuit failed to hold the government to its "unambiguously mandatory" obligation to reimburse health insurance providers for over $12 billion in losses. Pet. App. 16. That failure evokes this Court's recognition of the serious damage that results from allowing the government to renege on its obligations. 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, 191-192 (2012).

The law thus 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.)—an interest that is all the more critical for major new programs that depend upon inducing private participation for their success. Were it otherwise, "willing partners [would become] more scarce." *Salazar*, 567 U.S. at 192. That is why, even in the absence of appropriated funds, it has been settled law—at least until now—that "the

Government's valid obligations will remain enforceable in the courts." *Id.* at 191 (citation and internal quotation marks omitted).

As recognized by the judges dissenting from denial of rehearing en banc, the Federal Circuit's decision creates just this sort of harm. By holding that "the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay," the ruling "severely undermines the Government's credibility as a reliable business partner." Pet. App. 83 (Wallach, J., dissenting). That, in turn, impairs "[o]ur system of public-private partnership," which "depends on trust in the government as a fair partner." Pet. App. 67 (Newman, J., dissenting). The resulting harm is widespread. It hurts not only those who partner with the government, but the government itself and, most critically, the consumers who depend upon vital services provided through public-private partnerships.

Whether the repudiated obligation is viewed as a contractual promise or a statutory command makes no difference. Statutory obligations, like contractual ones, bind the government despite Congress's failure to appropriate sufficient funds to satisfy them. *Belknap v. United States*, 150 U.S. 588, 594 (1893) ("mere failure to appropriate" is "not, in and of itself alone, sufficient to repeal the prior act"). And a congressional appropriations restriction does not alter the nature of the government's obligation unless it "modified or repealed the previous law" "expressly, or by clear implication." *United States v. Langston*, 118 U.S. 389, 394 (1886).

There was no such repeal here, only restrictions on particular sources of appropriated funds that were enacted in the context of unsuccessful efforts to repeal. *See* 18-1028 Pet. Br. 30-33, 37-38. Making matters worse, the Federal Circuit relied on inconclusive snippets of legislative history in construing the appropriations rider. *Id*. at 33-35; *see* Pet. App. 26. What's more, the appropriations restriction was first enacted in December 2014, *after* health insurance providers had already provided coverage for nearly all of 2014 and had set premiums and committed to participate in the ACA exchanges for 2015.[3] No matter the doctrinal lens, the upshot is that the Federal Circuit's rule allows the government to default on its obligations based on an at-best ambiguous appropriations rider, after receiving the direct financial and other benefits from the risk corridors program. *See* Part C, *infra*.

That default has real consequences: Some health insurance providers suffered the dire threat of insolvency from the government's retroactive repudiation. Petitioner Moda Health Plan is owed more than $210 million; it escaped receivership and was able to continue providing coverage in Oregon only by raising a major influx of private capital. 18-

[3] Although the precise deadline varies by state, insurers generally must file premiums for approval in the spring or summer preceding the year in which they intend to offer the coverage. *See, e.g.*, AHIP, *2017 QHP Rate Filing—Key Dates* (Apr. 18, 2016) ("Key Dates"), *available at* https://ahip.org/2017-qhp-rate-filing-key-dates. Final decisions regarding participation in the federal exchange must generally be made the September before the plan year starts. *Id.*

1028 Pet. Br. 18. Petitioner Blue Cross Blue Shield of North Carolina, too, suffered financial losses of over $300 million for just 2014 and 2015. *Id.* at 18-19.

Nor is the harm limited to the Petitioners before the Court. Insurance providers in Illinois, for example, have been required to pay assessments levied by the state guaranty fund because of the insolvency of Petitioner Land of Lincoln Mutual Health Insurance Company.[4] *See, e.g.*, 2017 OFFICE OF THE SPECIAL DEPUTY RECEIVER ANN. REP. 12-13 (noting the Illinois guaranty association has paid out $45 million to cover medical care provided to Land of Lincoln's enrollees, and that the association can be reimbursed only if Land of Lincoln recovers the risk corridors reimbursements owed).[5]

It follows that if the Federal Circuit's holding is not reversed, health insurance providers and other private enterprises will doubt their ability to rely on the government's unambiguous promises. And that

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[4] In many instances, an insurance provider licensed in a state is required to join the state's guaranty association. When an insolvent company is liquidated, the state's guaranty association may be called upon to provide continuing coverage and benefits to the insolvent company's policyholders. In the event an insolvent company's assets are insufficient to cover the cost of providing those benefits (which is often the case), assessments may be imposed on insurance providers participating in the state's guaranty association. In this way, all insurance providers share the risk and costs of another provider's insolvency. *See* Nat'l Org. of Life & Health Ins. Guar. Ass'ns, *The Safety Net at Work*, *available at* https://www.nolhga.com/policyholderinfo/main.cfm/location/systemworks.

[5] *Available at* https://www.osdchi.com/PDF%20Files/Scanned%20Orders/osd/2017OSDAnnualReport.PDF.

doubt will deter future public-private partnerships—to the detriment of all, including consumers who depend on the vital services those partnerships make possible.

B. Both the Government And Health Insurance Providers Expected That Risk Under The Program Would Be Shared Between Them, Not Just Among Insurance Providers.

When they made decisions about participating in the ACA's new exchanges, there was no reason for health insurance providers to doubt the unambiguous risk-sharing commitment Congress made on behalf of the government in enacting the risk corridors program. Indeed, the government expected health insurance providers to rely on that commitment—despite the absence of an advance appropriation—because that is the only way the risk corridors program could achieve its objective. To that end, HHS repeatedly represented that it interpreted the statute in the same way that the industry did: mandating government reimbursement to insurance providers for partial losses per the statutory formula, regardless of amounts collected under the program.

Health insurance providers faced enormous uncertainty in deciding whether to participate in the exchanges and in setting premiums for 2014 "because insurers had only limited experience data on individuals who would be newly insured in the post-reform market." Am. Acad. of Actuaries, Issue Br., *Drivers of 2015 Health Insurance Premium Changes*,

at 2 (June 2014).[6] That uncertainty would ordinarily demand a higher premium due to a "risk margin"; under actuarial principles, "[g]reater levels of uncertainty typically result in higher risk margins and higher premiums." *Id.* at 5.

But insurance providers were induced to participate in the exchanges—and to set lower premiums than otherwise would have been warranted—by a promise that even the Federal Circuit recognized was unambiguous, Pet. App. 16-17: the government would reimburse health insurance providers (in part) for any losses resulting from higher-than-expected costs to cover patient care during the first three years of the exchanges. From the outset, all stakeholders understood that the risk corridors program would thereby share risk between health insurance providers and the government, not simply spread risk among health insurance providers.

As Petitioners explain (18-1028 Pet. Br. 5-6), the statute's plain text requires that the Secretary "shall pay" an amount dictated by a formula that is neither qualified nor capped by the amount collected from insurance providers under the program. 42 U.S.C. § 18062(b)(1). Because the payment amounts are not linked to amounts collected, the statute "permits the Federal government and [qualified health plans] to share in … losses resulting from inaccurate rate setting." 78 Fed. Reg. 15,410, 15,412 (Mar. 11, 2013). That is very different from the two other premium stabilization programs, which were expressly designed

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[6] *Available at* http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf.

to be limited to amounts of collections from health insurance providers or third-party administrators on behalf of group plans. *See id.* at 15,411 (describing risk adjustment as a program in which "funds are transferred from issuers with lower-risk enrollees to issuers with higher-risk enrollees"); 42 U.S.C. § 18061(b)(1)(A)-(B) (establishing reinsurance program whereby entity "collects payments under subparagraph (A)," *i.e.*, from "health insurance issuers, and … on behalf of group health plans," and "uses amounts so collected to make reinsurance payments to health insurance issuers").

If it were not clear enough from the statute's text, the agency made clear in 2013 that the program required payments from the Treasury if collections were insufficient to cover amounts owed: The "risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payment as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. Health insurance providers shared this understanding of the program as "protect[ing] health insurance issuers against … pricing uncertainty of their plans, [by] temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government." Doug Norris, et al., *Risk Corridors under the Affordable Care Act*, Society of Actuaries, Health Watch at 5 (Oct. 2013).[7] Because the program shared risk between the government and health

[7] *Available at* http://us.milliman.com/uploadedFiles/insight/2013/Risk-corridors-under-the-ACA.pdf.

insurance providers, it was not "symmetric," and the industry recognized from the early days that having "losses … balance the gains … would be more a coincidence than a certainty." *Id.* at 6.

This shared understanding was so strong that after announcing for the first time—without opportunity for prior comment—that it intended to "implement this program in a budget neutral manner," 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014), the agency reversed course just two months later. As the American Academy of Actuaries explained, the budget neutrality proposal "changes the nature of the risk corridor program from one that shares risk between issuers and CMS to one that shares risk between competing issuers." Am. Acad. Actuaries, Comment Letter, Exchange and Insurance Market Standards for 2015 and Beyond, at 3 (Apr. 21, 2014). Without risk-sharing by the government, however, the program would "not fully achieve its goal of mitigating risk due to mispricing," and health insurance providers would need to "build in additional risk margin"—*i.e.*, raise premiums. *Id.* at 3-4; *see also* AHIP, Comment Letter, Exchange and Insurance Market Standards for 2015 and Beyond, at 5 (Apr. 21, 2014) (expressing "significant concerns with the impact that such a [budget neutrality] policy would have on the risk corridors program's statutory goal of stabilizing premiums").

Responding to these comments, the agency explained that budget neutrality meant that the agency would offset collections against payments over the three-year life of the program, but it returned to its considered prior view that in the "event of a

shortfall … the Affordable Care Act requires the Secretary to make full payments to issuers." 79 Fed. Reg. 30,240, 30,260 (May 27, 2014).[8] And the next year—even after the first appropriations rider was adopted—the agency again reiterated "that the Affordable Care Act requires the Secretary to make full payments to issuers," stating that it "will use other sources of funding for the risk corridors payments" in the event of a shortfall in collections. 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015).

As these statements reflect, no one in the industry or the government thought that the absence of an upfront appropriation for risk corridors within the ACA converted "shall pay" into "may or may not pay." In fact, the very uncertainty that led Congress to enact the risk corridors program made it impractical (if not impossible) to determine the amount of funds to appropriate in advance. All of "the values used in the risk corridor calculation are actual experienced values," meaning they could not be known for 2014 until well into 2015. Norris, *supra*, at 6 (noting plans were required to submit data by July 31 of the year following the benefit year). Accordingly, the total amounts owed under the program for just its first year of operation—and thus the amount of any appropriation needed for one year—could not be determined until late 2015.

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[8] The agency stated that its ability to make full payments would depend upon identifying "other sources of funding … subject to the availability of appropriations," but not that the statutory "obligation" was so constrained. 79 Fed. Reg. at 30,260.

The need for *post hoc* calculations—and later corresponding appropriations—is not unique to the risk corridors program, which was enacted in 2010 but under which the amounts due could not be calculated until 2015. *See* 1 GAO, *Principles of Federal Appropriations Law*, at 2-54 (4th ed. 2016) ("Nor does organic legislation typically provide any form of an appropriation."). That practical timing reality does not render such statutory payment obligations illusory or contingent on later appropriations. All stakeholders so agreed here: the statute created a risk-sharing program health insurance providers could count on regardless of a later congressional appropriation.[9]

C. The Government Reaped Substantial Benefits At The Expense Of Health Plans From Its Broken Promise On Risk Corridors.

The bargain that health insurance providers had accepted—participating in the exchanges with the understanding that if they set premiums too low, there

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[9] Tellingly, when HHS announced the prorated payment amounts for 2014, it stated that it was "recording those amounts that remain unpaid … as … obligation[s] of the United States Government for which full payment is required." Ctrs. for Medicare & Medicaid Servs., *Risk Corridors Payments for the 2014 Benefit Year* (Nov. 19, 2015). The agency could record such obligations without violating the Antideficiency Act only by determining that the statute mandates payment regardless of available appropriations. *See* 2 GAO, *Principles of Federal Appropriations Law*, 6-91 (3d ed. 2006) (Congress "may implicitly authorize an agency" to "obligate in excess of the amounts appropriated … by virtue of a law that necessarily requires such obligations.").

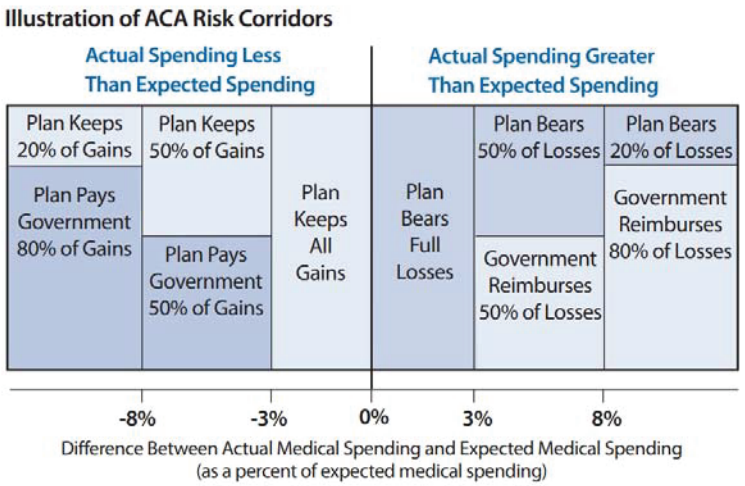
would be a federal backstop for part of their losses—still left much risk on their shoulders. For its part, the government received a substantial benefit in the form of lower premiums—and therefore reduced payments for premium subsidies—in exchange for agreeing to cover just part of the losses for some providers. The Court should not endorse a rule that allows the government to keep the sweet while dodging the bitter.

The statute sets forth a formula for determining when the government "shall pay" money to a health insurance provider, and how much. 42 U.S.C. § 18062(b)(1). The calculation is based on the ratio of the "target amount"—generally, premiums net of administrative costs—to "allowable costs"—generally, the cost of providing benefits. *Id.*

Any health plan that suffered losses of 3% or less—*i.e.*, in statutory terminology, its "allowable costs" were 103% or less of its "target amount"—bore the entirety of its loss, without any reimbursement by the government. Likewise, all plans—even those entitled to receive a risk corridors reimbursement—were required to cover that 3% loss in full. 42 U.S.C. § 18062(b)(1).

Any plan that suffered more than a 3% loss was entitled to government reimbursement for a portion of the loss exceeding 3%. Specifically, the government was required to reimburse plans 50% of any loss falling between 3% and 8%. 42 U.S.C. § 18062(b)(1)(A). And the government was required to reimburse plans 80% of any losses exceeding 8%. *Id.* § 18062(b)(1)(B).

The figure below graphically depicts the statutory formula:



Am. Acad. of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms* at 2 (2013).[10]

To illustrate, imagine a health plan that collects $100 million in premium revenue, net of administrative costs, and pays out $110 million to cover health care for its enrollees. Under the statute, the government promised to reimburse the plan for $4.1 million of its $10 million loss, reducing its 10% loss to a 5.9% loss.[11] As this example shows, a plan incurring a loss that triggers the highest

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[10] *Available at* https://www.actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf.

[11] The $4.1 million payment equals 50% of the amount representing the loss between 3% and 8% (50% of $5 million, or $2.5 million), plus 80% of the loss exceeding 8% (80% of $2 million, or $1.6 million).

reimbursement rate would still often bear the majority of the loss—even if the government had satisfied its risk corridors obligations in full. And, by definition, any plan with an 8% loss or less would bear well more than half of the loss on its own.

Conversely, by requiring health plans to pay the government an equivalent share of the amount of premium revenues exceeding allowable costs, the statute limited their upside return in situations where premiums exceeded costs. Needless to say, while failing to meet its own obligations, the government has held health plans to theirs, requiring payment of the mandated amounts in full. *See* Pet. App. 13-14.

As discussed above, the stated purpose of this (limited) sharing of risk between health plans and the government was to induce insurance providers to set lower premiums. 78 Fed. Reg. at 15,413 (stating that the risk corridors program permits "issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets"). Throughout the life of the program, the government stressed the link between its commitment to make payments and lower premiums. In the summer of 2015, for example, the government recited that the ACA "requires the Secretary to make full payments to issuers" when it urged state regulators to hold the line against premium increases and to take risk corridor "payments … into account before decisions are made on final rates" for 2016. Letter from Kevin J. Counihan, Ctrs. for Medicare & Medicaid Servs., to Insurance Commissioners (July 21, 2015).

Taking the government at its word (backed by the statute and precedent), health insurance providers delivered lower premiums that benefitted consumers and the government alike. At the outset of the new exchanges, health insurance providers set premiums at competitive levels that were ultimately lower than expected. Laura Skopec et al., Dep't of Health & Human Servs., *Market Competition Works: Silver Premiums in the 2014 Individual Market Are Substantially Lower than Expected*, at 1-2 (Aug. 9, 2013).[12] Premiums in the exchange marketplace later increased significantly—by 37% from 2015 to 2017, the first year after the end of the program—with the sunset of the program often cited as a major factor (particularly for 2017). *See* Daniel W. Sacks et al., *The Effect of the Risk Corridors Program on Marketplace Premiums and Participation,* at 36 (Nat'l Bureau of Econ. Research, Working Paper No. 24129, 2017, revised 2019);[13] Aaron S. Wright et al., Milliman, *Ten potential drivers of ACA premium rates in 2017,* at 4 (Dec. 2015).[14] An NBER paper found that premiums would likely have increased by only 10% over that period if the risk corridor program had been in place and allowed to operate as intended under the statute. Sacks, *supra*, at 36.

These lower premiums directly reduced the amounts the government was required to pay in

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[12] *Available at* https://aspe.hhs.gov/system/files/pdf/76701/ib_premiums_update.pdf.

[13] *Available at* https://www.nber.org/papers/w24129.

[14] *Available at* http://www.milliman.com/uploadedFiles/insight/2015/2140HDP_20160107.pdf.

premium tax credits, which are tied to the amount of premiums. *See* 26 U.S.C. § 36B. More than 85% of people who obtained health insurance on the exchanges received a premium tax credit in 2014, with similar percentages in subsequent years. *See* CMS, *Quarterly Marketplace Effectuated Enrollment Snapshots by State*, December 2014 Effectuated Tables; *id*. December 2015 Effectuated Tables (84%).[15] The lower premiums saved the government billions in reduced tax credits from 2014 to 2016. Lower premiums also encouraged more individuals who did not qualify for premium tax credits to sign up for coverage on the exchanges; that, in turn, increased the pool of participants and allowed them to obtain greater coverage at lower cost.

The Court should not adopt a rule that allows the government to reap the benefits of its bargain while repudiating billions of dollars of unambiguous obligations based on unclear language in an appropriations bill—or, worse yet, in legislative history accompanying that bill. That is untenable both as a matter of law and basic fairness.

D. Permitting The Government To Renege On Its Clear Statutory Obligations Would Harm Public-Private Health Care Partnerships.

Allowing the sort of maneuver the government undertook here will inject uncertainty into other vital health care programs. There are few industries in

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[15] *Available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/Marketplace-Products/Effectuated_Quarterly_Snapshots.html.

which the government acting as a reliable business partner matters more than health care. Aside from a few specialized examples (such as military treatment facilities), the federal government rarely delivers health care services itself. Instead, the government relies heavily on public-private partnerships to do so. Of the $982 billion spent by the federal government on health care in 2017, more than $764 billion (78%) involved services delivered through partnerships with doctors, hospitals, insurance providers, and other non-federal entities through programs such as Medicare, Medicaid, and the ACA health insurance exchanges.[16]

Health insurance providers are essential and reliable partners in public programs offering coverage to nearly 100 million Americans. For instance, the Medicare Advantage program serves more than 22 million Medicare beneficiaries—one in three—through private health plans that partner with the federal government. *See* CMS, *Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report*, Monthly Summary Report (Aug.

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[16] *See* CMS, *National Health Expenditure Data*, Table 05-3 & n.2, https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical.html. The table reports $217.7 billion of spending on "Other Federal Health Insurance and Programs" that covers some additional private partnerships (like the Children's Health Insurance Program), but also some health care services delivered directly by the government (such as some Department of Defense and Department of Veterans Affairs expenditures). *Id.*

2019);[17] Gretchen Jacobson et al., Kaiser Family Found., *A Dozen Facts about Medicare Advantage*, Nov. 13, 2018.[18]

Similarly, nearly 46 million people are enrolled in Medicare Part D coverage, a voluntary prescription drug benefit for Medicare beneficiaries that is provided through private health insurance plans approved by the federal government. CMS, Monthly Summary Report, *supra.* That number includes over 25 million individuals enrolled in stand-alone prescription drug plans and more than 19 million individuals enrolled in drug benefit coverage through a Medicare Advantage plan. *Id.*

In addition, states and private Medicaid health plans depend on the federal government's Medicaid funding commitments to provide coverage to almost 55 million Medicaid beneficiaries. CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2016*, at 5 (2018).[19] For example, in 2016, 38 states utilized Medicaid managed care arrangements for at least some portion of their Medicaid programs, and 21 of those states saw at least

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[17] *Available at* https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/MCRAdvPartDEnrolData/Monthly-Contract-and-Enrollment-Summary-Report-Items/Contract-Summary-2019-08.html.

[18] *Available at* https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage/.

[19] *Available at* https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2016-medicaid-managed-care-enrollment-report.pdf.

75% of their Medicaid populations enrolled in managed care organizations. MACPAC, MACStats: Medicaid & CHIP Data Book, Ex. 29 (2018).[20]

Finally, over 10 million Americans enrolled in health plans offered on ACA exchanges in 2019, of which over 9 million received subsidies. *See* Kaiser Family Found., *Marketplace Effectuated Enrollment and Financial Assistance* (2019).[21]

Permitting the government to repudiate its obligations even after health insurance providers did what was asked of them imperils these sorts of health care partnerships. If the federal government can walk away from statutory obligations made to encourage private sector participation in new programs, at least without repealing those obligations openly and clearly, partnering with the federal government becomes a venture fraught with intolerable risk. And then everyone—the government, private partners, and citizens alike—loses.

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[20] *Available at* https://www.macpac.gov/wp-content/uploads/2018/05/EXHIBIT-29.-Percentage-of-Medicaid-Enrollees-in-Managed-Care-by-State-July-1-2016.pdf.

[21] *Available at* https://www.kff.org/other/state-indicator/effectuated-marketplace-enrollment-and-financial-assistance/.

CONCLUSION

This Court should reverse the judgment of the Federal Circuit.

Respectfully submitted.

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