Appeal No. 18-10545

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS, ET AL.
Plaintiffs/Appellees/Cross-Appellants,
v.
UNITED STATES, ET AL.,
Defendants/Appellants/Cross-Appellees.

ON APPEAL FROM THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
THE HONORABLE REED CHARLES O'CONNOR, JUDGE
CASE NO. 7:15-CV-151

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS & BLUE CROSS BLUE SHIELD ASSOCIATION AS AMICI CURIAE IN SUPPORT OF APPELLANTS & REVERSAL

SARAH K. HOFSTADTER
ANNA-ROSE MATHIESON
CALIFORNIA APPELLATE LAW GROUP LLP
96 JESSIE STREET
SAN FRANCISCO, CA 94105
(415) 649-6700

Attorneys for Amici Curiae America's Health Insurance Plans & Blue Cross Blue Shield Association

CERTIFICATE OF INTERESTED PERSONS

In addition to those persons and entities listed by the parties in their Certificates of Interested Persons, the undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Fifth Circuit Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

- America's Health Insurance Plans (amicus)
- Blue Cross Blue Shield Association (amicus)
- California Appellate Law Group LLP (counsel for amici)
- Anna-Rose Mathieson (counsel for amici)
- Sarah K. Hofstadter (counsel for amici)

Respectfully Submitted,

Date: November 27, 2019 By: s/ Sarah K. Hofstadter

Sarah K. Hofstadter
Anna-Rose Mathieson
California Appellate Law Group LLP

Attorneys for Amici
America's Health Insurance Plans &
Blue Cross Blue Shield Association

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INTEREST OF THE AMICI

America's Health Insurance Plans, Inc. (AHIP) is a national association whose members provide coverage for health care and related services to hundreds of millions of Americans every day. These services improve and protect the health and financial security of consumers, families, businesses, communities, and the nation. AHIP advocates for public policies that expand access to affordable health care coverage through a competitive marketplace that fosters choice, quality, and innovation.

The Blue Cross Blue Shield Association ("BCBSA") is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield Plans ("Blue Plans"). Together, the 36 independent, community-based, and locally operated Blue Plans provide health insurance benefits to nearly 107 million people—almost one-third of all Americans—in all 50 states, the District of Columbia, and Puerto Rico. The Blue Plans offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses, and individuals.

Amici's members include numerous managed care organizations (MCOs) that provide health care services to patients enrolled in Medicaid or the Child Health Insurance Program (CHIP) (collectively, Medicaid MCOs). Amici's primary interest in the present case is to

ensure that their Medicaid MCO members' contracts with the states are based on actuarially sound rates, as required by statute, in order to provide services under their contract and meet the needs of Medicaid beneficiaries. This critical goal cannot be reached if the district court's ruling is upheld, because the ruling effectively allows states to avoid reflecting one particular expense—the Health Insurance Provider Fee (HIPF)—in their rates when contracting with Medicaid MCOs.

As a preliminary matter, amici agree with the plaintiffs that the HIPF has a detrimental impact on state budgets and consumers. The tax results in increased health insurance premiums for low-income and middle-income workers, seniors, and small businesses, and adversely impacts state Medicaid MCO budgets. The HIPF has made health care less affordable for those most in need of relief, and it should be repealed.

However, despite sharing this broad policy agreement with plaintiffs, amici file this brief on behalf of defendants because—given that Congress has chosen both to impose the HIPF on Medicaid MCOs and to require states to set actuarially sound capitation rates when using MCOs to deliver Medicaid services—those capitation rates for Medicaid MCOs must reflect the cost of the tax in order to remain actuarially sound.

This amici brief provides the Court with contextual information regarding the critical role Medicaid MCOs serve in improving access to and reducing the cost of delivering health care to Medicaid and CHIP beneficiaries, and describes the destabilizing impacts of the district court's ruling. Simply put, Congress could not have meant for Medicaid MCOs to take on the burden of the HIPF without being reimbursed for the cost of that tax; indeed, amici submit that Congress intended exactly the opposite.[1]

INTRODUCTION

States that choose to utilize a comprehensive, risk-based managed care model to deliver Medicaid services have benefited significantly from the quality and cost-effectiveness of Medicaid MCOs. However, in order to deliver those benefits, Medicaid MCOs must receive actuarially sound capitation rates, which can only be determined by qualified actuaries following established practice standards.

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[1] Amici certify that no party's counsel authored the brief in whole or in part; that no party or party's counsel contributed money that was intended to fund preparing or submitting the brief; and that no person—other than amici and their counsel—contributed money that was intended to fund preparing or submitting the brief. All parties have consented to the filing of this amici brief pursuant to Federal Rule of Appellate Procedure 29(a).

Under the managed care capitation rate setting system at issue in this case, Medicaid MCOs enter into contracts with plaintiffs' Medicaid programs to provide health care services to certain beneficiary groups within each state.[2] In exchange, the state pays Medicaid MCOs a specific dollar amount per covered person per month, which is known as a capitation rate. Capitation rates are developed by each state (or its actuarial services contractor), subject to the review and certification of the Centers for Medicare & Medicaid Services (CMS), and presented to Medicaid MCOs who wish to enter into contracts with that state.[3] *See, e.g.*, CMS, *2019-2020 Medicaid Managed Care Rate Dev. Guide* 3 (March 2019), *available at* https://tinyurl.com/v7p2sur.

In order to be viable and ensure a stable market, capitation rates must be actuarially sound—that is, the capitation rate must accurately reflect the full anticipated cost of providing the contractually-required

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[2] References to Medicaid in this brief include CHIP because Medicaid and CHIP "operate virtually identically" for the purposes of this case. RE 64 n.8. Under both programs, MCOs' capitation revenues are subject to the HIPF. *Id.*; see also Actuarial Standards Board, *Actuarial Standard of Practice No. 49* § 1.2 (2015), *available at* https://tinyurl.com/ul3qh5g ("ASOP 49"). Thus, as did the district court, RE 64 n.8, this brief subsumes its arguments regarding CHIP into its discussion of Medicaid.

[3] In a few states, Medicaid MCOs propose rates within a rate range set by the state or its actuarial services contractor.

services to the covered patients, including taxes. This fundamental, common-sense principle of requiring states to set actuarially sound capitation rates is long-established under federal law.

Since 1981, federal law has acknowledged this central tenet by requiring state Medicaid programs to base their Medicaid MCO capitation rates on actuarially sound calculations of their expected costs.[4] This requirement protects all parties—Medicaid beneficiaries, providers, the federal government, states, and their contracted Medicaid MCOs—by promoting certainty and stability in the delivery and utilization of Medicaid managed care services.

Since 2002, the Department of Health and Human Services (HHS) has defined "actuarially sound capitation rates" to mean "capitation rates that— . . . [h]ave been developed in accordance with generally accepted actuarial principles and practices; . . . and [h]ave been certified, as meeting the [regulatory] requirements . . . , by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by

[4] "[T]he Omnibus Budget Reconciliation Act of 1981 (OBRA 1981, P.L. 97-35) added the requirement that capitation payments to risk-based managed care plans be made on an actuarially sound basis (§1903(m)(2)(A)(iii) of the Act)." Medicaid and CHIP Payment and Access Comm'n ("MACPAC"), *Managed Care Rate Setting*, https://tinyurl.com/qrlxsfy (last visited Nov. 26, 2019).

the Actuarial Standards Board." Former 42 C.F.R. § 438.6(c)(1)(i) (2002).

When Congress passed the Affordable Care Act (ACA) in 2010, it included a provision permitting the states to expand their Medicaid programs by broadening eligibility criteria. Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010). It also imposed a fee, or tax, on health insurance providers, referred to by the district court here as the HIPF (sometimes called the Health Insurance Tax or "HIT" in other contexts). Under the ACA, state and local governments are exempt from paying the HIPF when they offer Medicaid benefits directly through a fee-for-service (FFS) system; however, most health insurance providers, including Medicaid MCOs, are subject to the HIPF.[5]

[5] The HIPF applies to "any entity with net premiums written for health insurance for United States health risks during the fee year that is (1) a health insurance issuer within the meaning of section 9832(b)(2); (2) a health maintenance organization within the meaning of section 9832(b)(3); (3) an insurance company that is subject to tax under subchapter L, Part I or II, or that would be subject to tax under subchapter L, Part I or II, but for the entity being exempt from tax under section 501(a); (4) an insurer that provides health insurance under Medicare Advantage, Medicare Part D, or Medicaid; or (5) a non-fully insured multiple employer welfare arrangement (MEWA)." IRS, *Affordable Care Act Provision 9010—Health Ins. Provider Fee*, https://tinyurl.com/y8cgy3y6 (last updated Nov. 15, 2019).

The present case results from a perceived—but illusory—conflict between: (1) the long-standing statutory requirement that the capitation rates set by the states when electing to utilize managed care must be actuarially sound—which means that such rates must take into account *all* of the Medicaid MCO's overhead costs, including the HIPF—and (2) the more recent provision of the ACA exempting states from paying the HIPF. As this brief explains, the district court erred in concluding that the two statutes conflict, rather than adopting an interpretation that harmonizes them in the service of Congress's intent.

The district court's decision places Medicaid MCOs in the untenable position of being required to deliver contractually mandated services in exchange for capitation rates that—contrary to statutory requirements—cannot be actuarially sound. This is because, under the district court's ruling, capitation rates set by the plaintiff states do not have to include any reimbursement to Medicaid MCOs for their HIPF liability—making such rates unsound under actuarial principles.

If upheld, the district court's ruling could potentially jeopardize the financial viability of Medicaid MCOs and destabilize the markets for the state Medicaid programs they serve. Thus, the district court's decision directly contradicts Congress's intent— both in providing for the utilization of Medicaid managed care and in adopting the ACA—to

provide quality health care services to financially disadvantaged and vulnerable populations in a cost-effective way.

ARGUMENT

I. MCOs Are a Critical Component of the Medicaid Program.

A. MCOs Are Responsible for Providing Care to the Majority of Medicaid-Eligible Patients.

From the inception of Medicaid in the mid-1960s until the early 1980s, Medicaid benefits were generally delivered on an FFS basis, under which state Medicaid programs paid individual health care providers directly. *See* Medicaid Rate Certification Work Group of the Am. Acad. of Actuaries, *Health Practice Council Practice Note* 4 (Aug. 2005), *available at* https://tinyurl.com/skqk9rk ("*Practice Note*"). Starting in the 1980s, and increasingly in the 1990s, states began shifting their Medicaid delivery systems to full risk-based contractual arrangements with MCOs. *Id.*

By the time the ACA was passed in 2010, over 70% of Medicaid beneficiaries nationwide were already enrolled in some form of managed care, and nearly half were enrolled in full-risk based comprehensive managed care systems (those whose contracts cover substantially all Medicaid services). CMS, *Medicaid Managed Care: Trends and Snapshots 2000-2013* 5 & fig.1, *available at*

https://tinyurl.com/yxy738x2; Lisa R. Shugarman et al., *White Paper: The Value of Medicaid Managed Care* 3-4 (Health Management Associates, 2015), *available at* https://tinyurl.com/tddxevz ("*HMA White Paper*"). By fiscal year 2017, Medicaid enrollment in comprehensive Medicaid MCOs was more than 55.6 million—over two thirds (69.3%) of all Medicaid beneficiaries. *See* CMS, *Medicaid Managed Care Enrollment & Program Characteristics, 2017* 11 (Winter 2019), *available at* https://tinyurl.com/yx5dyy7q. Enrollment in all managed care systems (including non-comprehensive MCOs and other forms of managed care) amounted to 65.8 million. *Id.* at 17.

The plaintiff states are no exception, and they do not dispute that they have decided to rely heavily on Medicaid MCOs. Medicaid managed care accounted for the following percentages of Medicaid expenditure and enrollment in the plaintiff states:[6]

[6] Expenditure figures are from Kaiser Family Found., *Total Medicaid MCO Spending*, https://tinyurl.com/vkafdhc (last visited Nov. 26, 2019); enrollment figures are from CMS, *2017 Medicaid Managed Care Enrollment*, *supra*, 26-30.

State	Percent of Total Medicaid Expenditure on Medicaid MCOs (FY2018)	Percent of Medicaid Enrollees (2017)	
		Managed Care (all)	Full Risk-Based Managed Care (only)
Indiana	40%	77.1%	77.1%
Kansas	85%	95.7%	95.7%
Louisiana	67%	91.8%	84.8%
Nebraska	46%	99.5%	99.5%
Texas	56%	96.7%	92.4%
Wisconsin	26%	66.7%	62.5%

Indeed, even as early as 2015, when this litigation was filed, "MCOs served around 87% of Texas's Medicaid population." RE 65.[7]

B. Medicaid MCOs Have a Proven Record of Improving the Affordability and Quality of Health Care Services.

Under a Medicaid managed care system, the state pays "a fixed amount for a defined package of benefits, usually paid on a per member per month basis. The [Medicaid MCO] assumes financial risk for the cost of covered services and plan administration. The combination of a fixed payment amount and financial risk is intended to create incentives for the managed care plan to coordinate care so that needed services are provided in the most cost-effective manner."[8]

[7] Plaintiffs state they "primarily use MCOs to deliver CHIP services as well." RE 65 n.11.

[8] MACPAC, *Report to the Congress on Medicaid and CHIP* 155 (March 2013), *available at* https://tinyurl.com/ud35dly.

Using Medicaid managed care has significant benefits for the states. *See Practice Note*, *supra*, at 4. Thus, "[s]tates have pursued Medicaid [risk-based managed care] arrangements to achieve several important goals for the state and Medicaid-eligible populations including improving care coordination and quality of care, ensuring provider access for enrollees, improving program accountability, and making state budgets more predictable and potentially achieving administrative savings." *HMA White Paper*, *supra*, at 22.

As the district court acknowledged in its summary judgment ruling, Medicaid MCOs provide health care services more efficiently and less expensively than the traditional FFS health insurance model. RE 65. Indeed, the court found that the plaintiff states "have saved hundreds of millions of dollars by transitioning to MCOs." RE 65, 77. By transitioning from FFS providers to Medicaid MCOs, "Texas reduced its healthcare costs by six percent in the year 2013 alone." RE 77.

Medicaid MCOs not only reduce the cost of delivering health care, they also provide care coordination and prioritize the value and quality in the services delivered to beneficiaries. As the district court found, "managed care . . . provides better healthcare services to . . . Medicaid recipients" than FFS providers, so that transitioning back to those providers would negatively impact the patient population. RE 77.

States have seen a wide range of benefits after shifting their Medicaid programs from FFS providers to Medicaid MCOs. For example:

- New Mexico saw hospital admissions reduced by 19%, nursing facility use reduced by 17%, and emergency department visits reduced by 8% after implementing a managed long-term services and supports program for adults with disabilities and older adults.[9]
- In South Carolina, adults with diabetes covered by Medicaid MCO health plans were more likely to receive consistent monitoring and support for their condition. Sixty-three percent of adults covered by a Medicaid MCO health plan monitored their blood sugar levels, compared to 33% of adults covered by Medicaid FFS.[10]
- In Georgia, children enrolled in Medicaid MCO health plans are more than twice as likely to experience six or more well-child visits during the first 15 months of life.[11]

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[9] America's Health Ins. Plans, *The Value of Medicaid: 3 Questions & Answers About Managed Care* (Sept. 24, 2018), https://tinyurl.com/v6n9tkw.

[10] *Id.*

[11] *Id.*

- A detailed 2018 study compared results of Medicaid MCO-administered drug benefits and FFS prescription drug programs nationwide from 2011 through 2017, and determined that Medicaid MCOs paid for a significantly higher percentage of all drugs covered by the nation's Medicaid programs, but at a significantly lower average cost per prescription. If all Medicaid prescription drugs in 2017 had been paid by FFS carve-out arrangements instead of MCO-managed arrangements, Medicaid program costs would have increased by $7.4 billion dollars.[12]
- Similarly, a detailed 2015 study compared results of Medicaid MCO-administered drug benefits and FFS prescription drug programs, comparing data from 2011 and 2013-2014. Six states that began including prescription drugs in their Medicaid MCO administered benefits between 2011 and 2013—Ohio, Texas, Utah, West Virginia, Illinois, and New York—realized aggregate program savings of $1.2

[12] America's Health Ins. Plans, *Medicaid Prescription Drug Coverage: Carve-Ins Save Billions of Taxpayer Dollars* 1-2 (Feb. 2019), *available at* https://tinyurl.com/sljnyqx. Specifically, MCOs covered 71.9% of all Medicaid prescriptions at an average net cost of $36.62 per prescription, post-rebates. FFS programs covered 28.1% of Medicaid prescriptions at an average net cost of $50.15 per prescription. *Id.*

billion in 2014, as compared with seven states that continued administering their drugs through FFS programs through 2014.[13]

- Ohio Medicaid MCOs saved taxpayers up to $4.4 billion over 2016 and 2017, compared to what would have been spent on a traditional FFS program. Moreover, Ohio Medicaid is saving approximately $2.4 million per month as Ohioans are able to transition out of nursing home facilities into home and community-based settings through the state's managed care long-term services and supports program.[14]

These examples help illustrate the significant improvements states have realized when choosing to utilize Medicaid managed care, and why many states are increasingly transitioning away from the traditional FFS model in favor of working together with Medicaid MCO partners to provide Medicaid services to their residents.

Yet the district court's ruling, if upheld, would threaten such partnerships by jeopardizing the financial viability of Medicaid MCOs.

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[13] Joel Menges et al., *Comparison of Medicaid Pharmacy Costs and Usage in Carve-In Versus Carve-Out States* 1-2, 5, 11-12 (Apr. 2015), *available at* https://tinyurl.com/rgz5yjw.

[14] Ohio Ass'n of Health Plans, *Transforming Ohio Medicaid Through Managed Care* 7, 24 (Feb. 2019), *available at* https://tinyurl.com/yx5y34bt.

As explained below, that ruling ignores long-standing federal requirements that capitation rates, which are designed to cover all the ordinary and reasonable costs of doing business (including taxes), cover one of Medicaid MCOs' significant, unavoidable expenses—the HIPF.

II. States Cannot Meet Their Statutory Obligation to Pay Medicaid MCOs Actuarially Sound Capitation Rates If the HIPF Is Not Included in Their Capitation Rates.

A. Actuarial Soundness Is a Fundamental Principle of Insurance, Which Congress Has Long Required States to Follow in Setting Medicaid MCO Capitation Rates.

In order for an insurance program of any kind (including state Medicaid programs) to be financially viable, the amount the insurer collects from parties paying premiums must be equal to or exceed the anticipated cost the insurer will bear for the utilization of services covered by the policy as well as the insurer's operating costs and margin. The term "actuarially sound" simply means that an insurance program's rates have been determined by a professional actuary to meet these criteria. *See* American Acad. of Actuaries Actuarial Soundness Task Force, *Actuarial Soundness* 2 (May 2012), *available at* https://tinyurl.com/sb2lkgk.

Health insurance programs, including Medicaid MCOs, are no exception to the basic principle of actuarial soundness in the insurance

industry. The statutory requirement that Medicaid MCOs must be paid "actuarially sound" rates is perfectly in sync with normal business practices across the insurance industry. As detailed earlier, for nearly 40 years, Congress has required by statute that Medicaid MCO capitation rates be actuarially sound. RE 66. The district court itself recognized that the statute's use of "[t]he words 'actuarially sound' indicate[s] that Congress intended capitation rates to be economically sustainable according to principles of actuarial science." RE 109. And as already noted, HHS's definition of "actuarially sound" dates back to 2002.

In light of this history, when the ACA was adopted in 2010, Congress, HHS, and state governments had long understood that the capitation rates paid to Medicaid MCOs would have to pass actuarial muster. Indeed, one provision of the ACA makes express reference—albeit in a different context—to the actuarial soundness requirement. *See* 124 Stat. at 308 (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)).[15]

[15] As defendants explained below, "In § 2501 of the ACA, Congress provided strong evidence that it endorses the HHS regulation's reliance on the [Actuarial Standards Board], amending 42 U.S.C. § 1396b to provide that 'capitation rates paid to [Medicaid managed care organizations] shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates.' 124 Stat. at 308 (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)). In other words, Congress ratified the actuarial

Had Congress intended to modify HHS's definition of "actuarially sound" when it enacted the HIPF, it could have done so easily.[16] The fact that it chose not to do so must be taken into account in interpreting the intended scope and consequences of the ACA's exclusion of states from the reach of the HIPF. *See, e.g.*, *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 45 (1983); *J.H. Rutter Rex Mfg. Co. v. United States*, 706 F.2d 702, 711 (5th Cir. 1983).

Indeed, the district court was under an obligation to construe the statutes so as to harmonize them, if this was possible without doing violence to their language or Congressional intent. *Epic Sys. Corp. v. Lewis*, 138 S. Ct. 1612, 1624 (2018) (repeals by implication are disfavored, because when Congress wishes to suspend normal operations of existing law in later statute, it will specifically address the issue).

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soundness regulation HHS promulgated, including its reference to the [Actuarial Standards Board]." Dist. Ct. Dkt. 63 at 43-44 (italics omitted). The Actuarial Standards Board "sets practice standards for private actuaries certified by the American Academy of Actuaries[.]" RE 63.

[16] As the district court described the situation, "the HIPF did not exist when Congress enacted the 'actuarially sound' requirement in 1981, and when it enacted the ACA in 2010, Congress—presumably aware of the 'actuarially sound' requirement—plainly exempted the states from paying this tax." RE 80.

The path to such harmonization is readily apparent. The two statutes, when read together, reflect the long-standing choice states have enjoyed in determining how to provide Medicaid services to their residents. In exempting state and local governments (and certain non-profits) from paying the HIPF, Congress continued to give the states that same choice: They can avoid exposure to the HIPF by directly financing and administering coverage for their Medicaid-eligible populations (or by only using HIPF-exempt non-profit MCOs). However, if the states choose to continue to use higher quality, more cost-effective options by partnering with Medicaid MCOs (including those Medicaid MCOs that are subject to the HIPF), those states remain subject to the statutory obligation to pay actuarially sound rates for those services.

The district court rejected this analysis on the ground that it was the adoption of ASOP 49 in 2015, rather than the pre-existing statutory obligation to pay actuarially sound rates, that obligated the states to include the HIPF in the calculation of their Medicaid MCO capitation rates. As the next section explains, this is unfounded. Even before ASOP 49 was adopted, states were already obligated by actuarial standards to include the HIPF in Medicaid MCO capitation rate calculations.

B. Because the HIPF Is an Expense Incurred by Medicaid MCOs, Actuarial Soundness Requires State Capitation Rates to Include It.

There is no dispute in this case that actuarial soundness requires an accurate assessment of an insurance program's overhead costs, as well as its risk exposure, and that taxes are a necessary component of those overhead costs. HHS's regulations have reflected this since 2002. Those regulations provide, in relevant part, that "[i]n setting actuarially sound capitation rates, the State must . . . [¶] . . . [¶] (3) . . . develop the non-benefit component of the rate *to account for reasonable expenses related to* MCO . . . administration; *taxes*; licensing and regulatory fees; contribution to reserves; risk margin; cost of capital; and other operational costs associated with the MCO's . . . provision of State plan services to Medicaid enrollees." 42 C.F.R. § 438.5(b) (italics added).

Paragraph (e) of the same regulation, in turn, requires that "[t]he development of the non-benefit component of the rate must include reasonable, appropriate, and attainable expenses related to MCO . . . administration, *taxes*, licensing and regulatory fees, contribution to reserves, risk margin, cost of capital, and other operational costs . . . ." *Id.* at § 438.5(e) (italics added).

In 2010, when Congress passed the ACA, it deferred the initial implementation of the HIPF until 2014. *See* Office of the Legislative

Counsel, *Compilation of Patient Protection & Affordable Care Act* 811 (Jun. 9, 2010), *available at* https://tinyurl.com/7rhao67; *see also* 26 C.F.R. § 57.1(c). Thus, only one year elapsed between the actual implementation of the HIPF and the adoption of ASOP 49. Yet during that period, actuaries were guided by a Practice Note issued in 2005 by the Medicaid Rate Certification Work Group of the American Academy of Actuaries defining "actuarial soundness" for the purpose of MCO Medicaid capitation rate assessment. Significantly, even that Practice Note—which had been in effect for five years by the time the ACA was passed—required actuaries to consider a Medicaid MCO's expenses for "any state-mandated assessments and taxes" when determining actuarial soundness. *Practice Note*, *supra*, at 8-9.

Similarly, a private actuarial consultant's report issued in January 2014 stated unequivocally that the HIPF "is a cost that should be treated in a manner consistent with how premium taxes or other fees and assessments are now treated." Milliman, Inc., *ACA Health Insurer Fee Estimated Impact on State Medicaid Programs and Medicaid Health Plans* 10 (Jan. 2014), *available at* https://tinyurl.com/rgopt6n. Consistent with this approach, an informal guidance letter issued by CMS itself in October 2014 advised that the HIPF was "a reasonable business cost to health plans that is appropriate for consideration as

part of the non-benefit component of the [Medicaid MCO capitation] rate, just as are other taxes and fees." CMS, *Medicaid & CHIP FAQs* 1 (Oct. 2014), *available at* https://tinyurl.com/v44nr5o; *see also* RE 93-94, 102.

Indeed, as the district court noted, "HHS has stated in multiple guidance letters that it prefers for states to include the HIPF in their capitation rates. First, in 2014, HHS issued a guidance letter encouraging states to do so. Then in 2015, HHS issued another guidance letter, referencing its 2014 letter and reiterating its view that states should pay the HIPF." RE 80 (citation omitted).[17]

It is therefore clear that the requirement that states include the HIPF in capitation rates derives from basic actuarial principles that predate ASOP 49. The adoption of ASOP 49 in 2015 did not create that actuarial requirement; it merely formalized the already obvious and common-sense proposition that the HIPF, as a cost to Medicaid MCOs, must be reflected in the calculation of capitation rates in order for them to be actuarially sound. The district court erred in concluding

[17] Even after the district court's summary judgment ruling in this case was issued, HHS reiterated its expectation that "[a]ny payment for the [HIPF] *must* be incorporated in . . . health plan capitation rates." CMS, *2019-2020 Medicaid Managed Care Rate Dev. Guide*, *supra*, at 26 (italics added).

otherwise, and essentially wrote the actuarial soundness requirement out of the statutory scheme.

Moreover, as the next section will show, if the district court's ruling allowing states to exclude the HIPF from their capitation rates is upheld, it will have adverse consequences for all stakeholders in the Medicaid program and will undermine Congress's intent in enacting the ACA.

III. Upholding the District Court's Ruling Would Create Significant Difficulty and Uncertainty.

One of the central purposes of requiring states to set actuarially sound capitation rates is to promote certainty and stability for the benefit of all parties. For states and the federal government, this includes, among other things, increasing predictability in the Medicaid budgeting process and helping to control spending under certain circumstances. Dkt. 00515207321 at 7. For states' residents, this means receiving better quality health care services. And for states' Medicaid MCO partners, this means ensuring those Medicaid MCOs, which operate under very narrow margins, are positioned to provide

those improved health care services in a reliable and predictable, manner as required under federal law and contract.[18]

Medicaid MCOs are partners with states in serving Medicaid beneficiaries by providing access to robust, high quality care through a public-private partnership funded largely by taxpayers. As such, Medicaid MCOs understand that narrow margins are emblematic of this market. The Society of Actuaries reports that average Medicaid MCO margins in 2015 were between 1.5% and 1.8%.[19] Another study by the Menges Group reviewed operations of 113 Medicaid MCOs for the period 2011 to 2016, and found that MCOs realized an average net margin of 1.5% of revenues.[20]

Yet the HIPF increases the average premium cost per Medicaid beneficiary by 1.6%.[21] Thus, requiring Medicaid MCOs to pay the HIPF without states taking that cost into account in their capitation rates would operationally compromise Medicaid MCOs and could result in

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[18] Soc'y of Actuaries, *Medicaid Managed Care Organizations: Considerations in Calculating Margin in Rate Setting* 13-14 (March 2017), *available at* https://tinyurl.com/smpmkp8.

[19] *Id*. at 5.

[20] The Menges Group, *Financial Performance of Medicaid-Focused Plans Across Several Years* 2 (Aug. 2017), *available at* https://tinyurl.com/qotpszx.

[21] Milliman, *supra*, at 2.

some becoming financially unstable or insolvent. Rates that are not actuarially sound can in turn adversely impact capital reserves, bonding capacity, return on investments, cash flow, and other measures of financial stability.

If the district court's decision were upheld and Medicaid MCOs were to assume the cost of the HIPF, it would be necessary to identify areas of costs that would need to be curtailed in order to continue operating under inadequate capitation rates. Such cost curtailment would have direct negative impacts on Medicaid beneficiaries, providers and states. For example, some Medicaid MCOs may have to pay providers reduced rates, which could decrease provider participation in the Medicaid program and infringe on beneficiaries' access to care. Some Medicaid MCOs may have to postpone upgrades of information and reporting systems and the adoption of new technology, and employ fewer staff to perform required administrative duties and processes. Finally, Medicaid MCOs may have to offer fewer value-added services (*i.e.*, services that are not mandated under a Medicaid MCO's contract but provide additional benefits to beneficiaries at no further cost to the state) which help states to address issues like social determinants of health, and community improvement and education.

Given the widely recognized benefits of using MCOs to deliver Medicaid services—including costs savings to both state and federal governments—this simply cannot be what Congress intended. Congress cannot have intended its exemption of states from the HIPF to result in fiscally confiscatory capitation rates for Medicaid MCOs, or to so profoundly alter the pre-ACA market-based incentives intended to promote these kinds of mutually advantageous public-private partnerships in the delivery of Medicaid services.

Moreover, to the extent that bearing the cost of the HIPF affects the stability of the Medicaid managed care market, states may have to consider reverting to FFS models of health care delivery directly financed by the states.[22] This would not only place a considerable administrative burden on the states, but also diminish the quality of care and increase the cost to both state and the federal governments.[23]

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[22] The only other option would be for a state to contract solely with HIPF-exempt non-profit providers if available in the state, although that would significantly reduce available choices and the competitive landscape.

[23] *See* Section I-B above. The federal government has a stake in the cost of Medicaid, because it reimburses states for a portion of their Medicaid expenses. During fiscal year 2019, the federal match rates for the plaintiff states ranged from 52.58% to 65.96%. The overall average federal match rate is 62%. MACPAC, *Public Meeting Transcript* Exh. 6 (Apr. 19, 2018), *available at* https://tinyurl.com/tnhp46e.

To the extent states shift away from managed care and instead revert to relying on FFS models—and the HIPF remains law—then states will see a reversal of the kinds of cost savings and improvements in access to care and care outcomes achieved by Medicaid MCOs. This will result in states paying more in direct Medicaid expenditures and reassuming greater administrative costs.

Such a shift would also increase costs across other health insurance market segments. This is due exclusively to the nature of the HIPF itself, which under statute is a fixed, annual amount apportioned across covered entities based on the number of lives each entity covers.[24] To the extent fewer lives are covered under a Medicaid managed care model, then those covered entities subject to the HIPF in other markets (*e.g.*, the individual market) will be forced to shoulder a higher HIPF burden. This increasing tax burden means higher costs in those respective markets.

Finally, should the district court's ruling stand, the plaintiff states (and any other states wishing to take advantage of the ruling) could be precluded from relying on Medicaid MCOs at all. If a state insists on

[24] *See supra*, n.5 detailing those covered entities subject to the HIPF (citing IRS, *Affordable Care Act Provision 9010*, *supra*, also detailing how the annual HIPF is calculated and apportioned among those covered entities).

excluding the HIPF from the calculation of its Medicaid MCO capitation rates, actuaries assisting that state with its rate development may be unable to certify that the state-submitted rates meet the tests for actuarial soundness without a disclosure outlining deviations from standard practice. Furthermore, CMS actuaries charged with reviewing such state capitation rate proposals may not deem the proposed rates actuarially sound because they do not meet federal Medicaid regulatory standards or follow standard actuarial practices.

In sum, the district court's decision would cause significant harm to Medicaid beneficiaries, the federal government, and ultimately the plaintiff states themselves, with destabilizing effects that could reverberate well beyond the Medicaid managed care market. Meanwhile, the plaintiff states, in addition to other states with Medicaid managed care delivery systems, have realized significant benefits from their use of Medicaid MCOs, including cost savings as well as improved access and quality of care for their covered populations. Those benefits could be placed in jeopardy if the plaintiff states insist on compromising long-standing statutory actuarial soundness requirements by excluding the HIPF from their Medicaid MCO capitation rates. That is not what Congress intended when it enacted the ACA and exempted states from paying the HIPF.

CONCLUSION

The district court's orders granting partial summary judgment in favor of the plaintiff states should thus be reversed, and the case remanded to the district court for entry of summary judgment in favor of the United States.

Respectfully Submitted,

Date: November 27, 2019

By: s/ Sarah K. Hofstadter

Sarah K. Hofstadter
Anna-Rose Mathieson
California Appellate Law Group LLP

Attorneys for Amici America's Health Insurance Plans & Blue Cross Blue Shield Association

CERTIFICATE OF COMPLIANCE

I certify this brief complies with the type-volume limitation set forth in the Federal Rules of Appellate Procedure. This brief uses a proportional typeface and 14-point font and is 5,581 words. Fed. R. App. P. 29(a)(5) & 32(a)(7)(B). This brief was prepared using Microsoft Word.

Respectfully Submitted,

Date: November 27, 2019

By: s/ Sarah K. Hofstadter
Sarah K. Hofstadter
Anna-Rose Mathieson
California Appellate Law Group LLP

Attorneys for Amici America's Health Insurance Plans & Blue Cross Blue Shield Association

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Respectfully Submitted,

Date: November 27, 2019

By: s/ Sarah K. Hofstadter
Sarah K. Hofstadter
Anna-Rose Mathieson
California Appellate Law Group LLP

Attorneys for Amici America's Health Insurance Plans & Blue Cross Blue Shield Association