2019-1290, -1302

United States Court of Appeals for the Federal Circuit

SANFORD HEALTH PLAN, MONTANA HEALTH CO-OP,

Plaintiffs-Appellees,

– v. –

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims in Nos. 1:18-cv-00136C-EDK and 1:18-cv-00143C-EDK, Judge Elaine D. Kaplan

BRIEF FOR *AMICUS CURIAE* COMMON GROUND HEALTHCARE COOPERATIVE IN SUPPORT OF PLAINTIFFS-APPELLEES

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MAY 8, 2019

FORM 9. Certificate of Interest **Form 9**
Rev. 10/17

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Sanford Health Plan, et al. **v.** United States

Case No. 19-1290, -1302

CERTIFICATE OF INTEREST

Counsel for the:
☐ (petitioner) ☐ (appellant) ☐ (respondent) ☐ (appellee) ■ (amicus) ☐ (name of party)

Common Ground Healthcare Cooperative

certifies the following (use "None" if applicable; use extra sheets if necessary):

1. Full Name of Party Represented by me	2. Name of Real Party in interest (Please only include any real party in interest NOT identified in Question 3) represented by me is:	3. Parent corporations and publicly held companies that own 10% or more of stock in the party
Common Ground Heathcare Cooperative	Common Ground Healthcare Cooperative	None

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 **(and who have not or will not enter an appearance in this case)** are:
Quinn Emanuel Urquhart & Sullivan, LLP: J.D. Horton; Adam B. Wolfson.

FORM 9. Certificate of Interest **Form 9**
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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. *See* Fed. Cir. R. 47. 4(a)(5) and 47.5(b). (The parties should attach continuation pages as necessary).

Please see Addendum hereto.

5/8/2019
Date

/s/ Stephen A. Swedlow
Signature of counsel

Please Note: All questions must be answered

Stephen A. Swedlow
Printed name of counsel

cc: Counsel of Record (via ECF)

Reset Fields

Addendum to Certificate of Interest

The following cases are 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:

Community Health Choice Inc. v. United States, No. 19-1633 (Fed. Cir.)

Blue Cross & Blue Shield of Vermont v. United States, No. 18-373 (Fed. Cl.)

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

Guidewell Mutual Holdings Corp v. United States, No. 18-1791C (Fed. Cl.)

Harvard Pilgrim Health Care, Inc. v. United States, No. 18-1820C (Fed. Cl.)

Health Alliance Medical Plans, Inc. v. United States, No. 18-334C (Fed. Cl.)

Local Initiative Health Auth. for L.A. Cty. v. United States, No. 17-1542C (Fed. Cl.)

Maine Community Health Options v. United States, No. 17-2057C (Fed. Cl.)

Molina Healthcare of California, et al. v. United States, No. 18-333C (Fed. Cl.)

Montana Health CO-OP v. United States, No. 19-568C (Fed. Cl.)

Noridian Mutual Ins. Co. v. United States, No. 18-1983 (Fed. Cl.)

Sanford Health Plan v. United States, No. 19-569 (Fed. Cl.)

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INTEREST OF *AMICUS*[1]

Amicus is a healthcare cooperative operating out of Brookfield, Wisconsin. As with the appellees, *amicus* has issued qualified health plans to eligible insureds since the Patient Protection and Affordable Care Act ("ACA") went into effect and believes that the Government owes it unreimbursed cost-sharing amounts pursuant to Section 1402 of that Act. *Amicus* has, like appellees, also brought suit against the Government under the Tucker Act. In *Common Ground Healthcare Cooperative v. United States*, No. 1:17-cv-00877-MMS (Fed. Cl.), *amicus* recently obtained summary judgment against the Government on behalf of a certified class of qualified health plan issuers for unreimbursed cost-sharing reduction amounts for 2017 and 2018. That case is procedurally behind the current appeal, but the issues it presents are virtually identical. *Amicus* therefore has an interest in assisting this Court in understanding the broader problems that a ruling for the Government in this case would create, both for *amicus* and for the class it represents. Specifically, although *amicus* agrees with and adopts the arguments in Appellees' brief, it writes separately to provide additional perspective on the

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amicus* represents that counsel and *amicus* authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amicus* or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Fed. R. App. P. 29(a) and Fed. Cir. R. 29(c), all parties have consented to the filing of this brief.

question of congressional intent behind the ACA and cost-sharing reduction payment program in particular.

SUMMARY OF THE ARGUMENT

In its opening brief, Defendant-Appellant the United States (the "Government") argues that, notwithstanding express language in Section 1402 of the ACA stating that the Government "shall" make cost-sharing reduction ("CSR") reimbursements to qualified health plan ("QHP") issuers, Congress did not intend to create a binding obligation to pay because QHP issuers can supposedly avoid their "injury" in such a situation by raising insurance premiums. As support for this proposition, the Government points to the inverse relationship between premiums and cost-sharing (*e.g.*, deductibles) with insureds, noting that lower amounts of costs paid by insureds typically lead to higher premiums, and vice versa. Given this relationship, the Government argues that Congress intended to leave the obligation to make CSR reimbursements open-ended, because QHP issuers could address the Government's failure to make CSR reimbursements after the fact by increasing premiums.

This congressional intent argument fails. The Government's position does not reflect the basic way in which premiums are set, nor is it in concert with the ACA's express purposes. Regarding the former point, health plan issuers set their premiums prospectively, focusing on the upcoming year of coverage. They must

therefore take into account *anticipated* costs and, by law, raise premiums *ahead of time* to account for any such costs that may not be reimbursed or subsidized. Under the Government's interpretation of the statute, QHP issuers could never be comfortable in advance that they will receive reimbursements for CSR payments. And without assurance that they will be reimbursed for CSR payments, QHP issuers will be obligated to raise annual premiums for low-income insureds (to whom CSR payments apply) as a matter of course.

But this argument flies in the face of two of the ACA's core purposes; *i.e.*, to *reduce* premiums (or at least keep them in check) and to *reduce* the Government's health care expenditures. Regarding the latter point, increased premiums will raise (and have raised) the Government's overall expenditures, because it is obligated to provide premium tax credits on "silver" plans and more insureds qualify for those credits than qualify for CSR amounts. The Government's congressional intent argument regarding CSR reimbursements therefore cannot be correct as a matter of basic logic, because it argues that, at the same time Congress created an Act aimed at lowering overall premiums and decreasing its federal health care expenditures, it also intended to create a system in which QHP issuers needed to increase premiums (particularly for the lowest-income insureds in the country) and increase federal health care expenditures. That makes no sense.

ARGUMENT

I. Health Plan Issuers Set Premiums For The Year Ahead, Taking Into Account Anticipated Costs

Health insurance, as with nearly any type of insurance, is an inherently forward-looking product. An insured pays a health plan issuer a set amount, known as the "premium," in exchange for typically a year of coverage, in which the health plan issuer will pay for certain (or all) of the insured's health care costs. The insured usually agrees to pay a pre-defined amount of the health plan issuer's actual costs. This amount is known as the "deductible," and the health plan issuer's obligations to pay the insured's costs do not typically kick in until the insured first pays up to the deductible amount.

As the Government concedes in its opening brief, there is typically an inverse relationship between how much a health plan issuer's costs its insureds cover and how much that issuer charges in premiums. "Holding other factors constant, an insurance plan with higher cost sharing [from its insureds] (such as a high deductible) will have a lower premium, and an insurance plan with lower cost sharing (such as a low deductible) will have a higher premium." Gov't Br. at 5. Furthermore, there is unquestionably a *direct* relationship between the amount of an issuer's unpaid costs and its premiums. Higher costs equal higher premiums.

What the Government omits from its opening brief, however, is that premiums are set ahead of time—*i.e.*, before the year of coverage to which they

apply. As relevant to ACA health exchanges, this pre-coverage price setting is required by both federal and state law. *See*, *e.g.*, ACA § 1003 [42 U.S.C. § 300gg-94] (establishing annual monitoring process for premium increases); Gov't Br. at 5 ("This inverse relationship between premiums and cost sharing occurs not only for business reasons, but also because insurance companies are subject to state regulations that require that an insurer's rates be high enough to cover the insurer's costs and ensure its solvency."). Given premiums' relationship to an issuer's costs, the issuer must therefore take into account ***anticipated costs*** when setting its premiums each year.

II. The ACA Created A New Cost Obligation For Health Plan Issuers: Cost-Sharing Reduction Payments

One of the ACA's key reforms (among several others) was to impose a new set of costs on health plan issuers: cost-sharing *reduction* payments. The CSR program specifically helps low-income insureds (*i.e.*, those whose household income is below 250% of the poverty level) bear the cost of medical and pharmaceutical expenses, because it requires QHP issuers to reduce out-of-pocket costs for those insureds by taking over their "cost-sharing" obligations. "Cost-sharing" in this context includes "deductibles, coinsurance, copayments, or similar charges." ACA § 1302(c)(3)(A)(i) [42 U.S.C. § 18022]. QHP issuers must reduce cost sharing for eligible insureds who enroll in "silver plans" through the exchanges, ACA § 1402(c)(2), and QHP issuers must offer at least one "silver"

plan in order to participate in the exchanges, ACA § 1301(a)(1)(C)(ii) [42 U.S.C. § 18021]. The Government then "shall make periodic and timely payments to the issuer equal to the value of the reductions." ACA § 1402(c)(3)(A) [42 U.S.C. § 18071].

Before the ACA, there was no such obligation for health plan issuers. As discussed above, insureds typically share a portion of the issuer's costs by paying deductibles, coinsurance, copayments, and other charges. However, the ACA changed this for the lowest-income insureds in the nation, prohibiting QHP issuers from requiring those specific insureds to make similar cost-sharing payments.

Given both the nature of the insurance business (forward-looking) and the legal requirements of operating such a business (setting premiums at levels state regulators are comfortable will cover annual costs), a QHP issuer must, by necessity, take into account the *anticipated* costs associated with CSR plans. If the QHP issuer cannot, ahead of time, count on reimbursement for those costs, then it must also, by necessity, raise its premiums to cover them.

III. Congress Could Not Have Intended To Incentivize Higher Premiums When The ACA Was Created To Achieve The Exact Opposite Result

The plain language of Section 1402 of the ACA is money-mandating. It states, in no uncertain terms, that the Government "shall" reimburse QHP issuers the cost-sharing amounts they reduce for low-income insureds. ACA § 1402(c)(3)(A) [42 U.S.C. § 18071]. As this Court recently noted in a lawsuit

regarding the risk-corridor provisions of the ACA, statutory language stating that the Government "shall" make certain payments is "unambiguously mandatory." *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1320 (Fed. Cir. 2018). The Government has never—whether in the Court of Claims, this appeal, or any of the dozen other cases raising the identical issue—identified a single plain statement in the ACA suggesting anything to the contrary.

Instead, the Government relies on a complicated congressional intent argument that cannot be squared with the plain statutory language. According to the Government, Section 1401 of the ACA creates tax credits that the Government must pay, meaning that, if the Government refuses to pay the CSR amounts it owes under Section 1402's plain terms, Congress intended for QHP issuers to shift those added costs to the premiums they charge the nation's lowest-income insureds; *i.e.*, the so-called "silver loading" the Government references in its brief. *See*, *e.g.*, Gov't Br. at 10. In other words, the Government says that by requiring cost-sharing but refusing to fund the mandatory CSR payments, Congress expressed an intention to *require* QHP issuers to *raise* premiums for low-income insureds.

But "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter." *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015). Congress sought to accomplish that goal by (among other

things) mandating health care coverage, which lowers premiums for all. *Id.* at 2486 (noting "Congress adopted a coverage requirement to … lower health insurance premiums"). Congress also expressly warned against raising premiums unreasonably, arming the Secretary of the Department of Health and Human Services ("HHS") with the authority to exclude QHP issuers that charged customers unreasonably high premiums.[2] Thus, as this Court has observed, Congress expected the ACA overall to reduce, not increase, the federal government's expenditures. *See Moda*, 892 F.3d at 1316 (noting that, prior to the ACA's passage, Congress received a Congressional Budget Office report estimating that the Act would save the federal government $143 billion over the next ten years).

Two points are clear from this precedent. First, Congress did not intend to establish a system whereby participation in ACA health exchanges would incentivize QHP issuers to *increase* premiums. Second, Congress similarly did not intend to establish a system that would increase the federal government's costs. The Government's proposed interpretation of the statute flies in the face of both of these congressional goals.

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[2] *See, e.g.*, ACA § 1003 [42 U.S.C. § 300gg-94] (ACA section entitled "Ensuring That Consumers Get Value For Their Dollars," which establishes an annual premium review process aimed at preventing "unreasonable increases in premiums for health insurance coverage").

Indeed, *the Government itself* (namely, HHS) has observed on *multiple* occasions that failing to make CSR reimbursements *increases* both insurance premiums and (consequently) the Government's health-care expenditures. For example, in a December 1, 2015 paper entitled "Potential Fiscal Consequence of Not Providing CSR Reimbursements" (which the Government cites in its opening brief, *see* Gov't Br. at 5),[3] HHS explained that:

> [I]f the federal government did not reimburse insurers for CSRs, insurers would increase plan premiums to cover these costs. As a result of the ACA's structure, these higher premiums would translate into higher federal costs for Premium Tax Credits (PTCs). Moreover, ***because many more people are eligible for PTCs than for CSRs, the result would be a substantial increase in total federal costs***, compared to the current arrangement under which the federal government directly reimburses insurers for the CSRs they provide to eligible individuals.

Id. at 1 (emphasis added). Similarly, in litigation over the CSR program, HHS reiterated that a failure to make CSR reimbursements in a way that provided certainty about the "existence and amount of payments" would be "inefficient and destabilizing," and "would also ***inevitably lead to increased premiums—and correspondingly greater federal expenditures***," even if Congress ultimately appropriated funds for the payments. Br. for Defs. at 23, *United States House of*

[3] *Available at* https://aspe.hhs.gov/system/files/pdf/156571/ASPE_IB_CSRs.pdf.

Representatives v. Burwell, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (No. 1:14-cv-01967), ECF No. 55-1 (emphasis added).[4]

Given the fundamentals of the insurance industry discussed above, HHS's previous observations reflect simple logic. QHP issuers will take into account any costs for which they cannot reasonably expect reimbursement, and will increase their annual premiums in order to reflect those costs. Thus, if QHP issuers are not assured that they will receive reimbursement for CSR payments, then they must raise their premiums in anticipation of increased costs. Such a result reflects basic economics and good business sense, and, indeed, it is effectively required by law as described above.

Moreover, as HHS has acknowledged, increased premiums also mean increased federal expenditures ***and*** less stability in the health insurance markets, results that both the Supreme Court and this Court have noted are directly against Congress's intent in passing the ACA. With that in mind, the Government's

[4] The Government has also taken the position that portions of the ACA are "interdependent" and failing to implement some could lead to "skyrocketing premiums" or even "death spirals." *See* Br. for Resp't at 14-15, *King v. Burwell*, 135 S. Ct. 2480 (2015) (No. 14-114), 2015 WL 349885, at *14-15 (Jan. 21, 2015) ("the individual-coverage provision could not perform its market-stabilizing function in the absence of subsidies making coverage broadly affordable" and "[t]he denial of tax credits and the resulting loss of customers would thus have disastrous consequences for the insurance markets in the affected States"). The above arguments admittedly address different provisions of the ACA, but demonstrate that the Act is an interlocking statute designed to improve, not destroy, health insurance markets, and that full, annual payment regimes are critical to this functioning.

congressional intent argument falls apart. Even if there was ambiguity in the text regarding Section 1402's money-mandating nature—which, as discussed above, there is none—there is no conceivable way Congress could have intended to create a regime in which QHP issuers necessarily have to *increase* premiums (and federal costs) in order to offer health plans to low-income insureds.

The truth is the Government is now trying to create a congressional intent argument that is contrary to the statute's language, the realities of the health insurance industry, and any common sense understanding of the ACA and the problems it sought to address. When Congress stated that the Government "shall" make CSR reimbursements, the intent was clear—a plain reading of the statute tells us what is actually true in this case.

CONCLUSION

For the reasons discussed above, the government's arguments on appeal regarding congressional intent make no sense in light of the acknowledged (and express) purpose of the ACA and the realities of the health insurance industry. The decisions on appeal should be affirmed.

Dated: May 8, 2019

Respectfully submitted,

/s/ Stephen A. Swedlow

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CERTIFICATE OF SERVICE

I, Stephen A. Swedlow, hereby certify that on May 8, 2019, I caused the foregoing to be electronically filed with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Service will be accomplished on all counsel of record via the CM/ECF system.

Dated: May 8, 2019

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(g)(1), the undersigned certifies that this brief complies with the type-volume limitations of Federal Rule of Appellate Procedure 29(a)(5) and the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6).

1. Exclusive of the exempted portions, this brief contains 2,549 words.

2. This brief has been prepared in proportionally spaced typeface using Microsoft Word 2013 in 14 point Times New Roman font.

Dated: May 8, 2019

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