No. 20-1162

In the Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS,

Petitioner,

v.

UNITED STATES,

Respondent.

COMMUNITY HEALTH CHOICE, INC.

Petitioner,

v.

UNITED STATES,

Respondent.

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

BRIEF FOR *AMICUS CURIAE* THE ASSOCIATION FOR COMMUNITY AFFILIATED PLANS IN SUPPORT OF PETITIONERS

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TABLE OF CONTENTS

Page

TABLE OF AUTHORITIES

Page(s)

Cases

Statutes and Regulations

Other Authorities

INTEREST OF *AMICUS CURIAE*[1]

The Association for Community Affiliated Plans (ACAP) is a national trade association representing community-based not-for-profit health plans, many of which participate in health insurance marketplaces pursuant to the Affordable Care Act (ACA). Collectively, ACAP's 78 Medicaid, Medicare, and ACA marketplace plans serve more than 21 million enrollees in 29 states. Many enrollees are among the nation's poorest and sickest people, who lack access to other health insurance. ACAP member health plans primarily participate in the lower-margin Medicaid market and do not participate in the higher-margin large group employer market.

Like petitioners, ACAP's members are owed hundreds of millions of dollars for cost-sharing reduction payments under the ACA. The government's failure to meet its obligations with respect to these payments has already had a significant impact on community-based health insurers and their insureds, undermining insurer confidence and participation in the ACA markets. ACAP files this brief to inform the Court of the significant practical harm the decision below will inflict on the broader group of community plans and to urge the Court to make clear that the United States' unambiguous promises can and should be enforced.

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[1] Counsel of record received timely notice of the intent to file this brief pursuant to this Court's Rule 37.2(a). All parties have consented to the filing of this brief. No party's counsel authored this brief in whole or in part, and no one other than *amicus*, its members, and its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

ACAP submits this *amicus* brief to emphasize the significant adverse practical consequences of the decision below on the proper operation of the individual health insurance markets contemplated by the ACA.

Section 1402 of the ACA requires insurers to offer cost-sharing reductions to certain eligible insured individuals covered by silver-level exchange plans and provides that the Secretary of Health and Human Services "shall make periodic and timely payments" to the insurer "equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A). Despite agreeing that the government violated this clear statutory language by refusing to make the required payments, the Federal Circuit concluded that insurers who complied with their obligations to offer cost-sharing reductions to eligible insureds were not entitled to reimbursement for the value of those reductions from the government. Rather, according to the Federal Circuit, the insurers had the burden to show that they had not received some or all of those amounts indirectly, through payments made under a very different provision of the ACA, Section 1401.

The Petition for Certiorari ably explains why Section 1401 does not circumscribe the government's unambiguous obligation to reimburse insurers for the full amount of their cost-sharing reduction payments under Section 1402. The Federal Circuit's decision flies in the face of *Maine Community Health Options* v. *United States*, which recognizes that payment-mandating, "shall-pay" provisions like Section 1402 "create[] a Government obligation to pay insurers the full amount set out" in the statute. 140 S. Ct. 1308, 1319

(2020); see also *id.* at 1321 ("without 'any indication' that [the statute] allows the Government to lessen its obligation, we must 'give effect to [Section 1342's] plain command'"). The Federal Circuit's contrary holding is inconsistent with the ACA's clear language, which creates two *independent* government obligations to pay, on two different grounds, and based on prices charged to two different groups of insureds. That decision rests on a purported "analogy" to contract law, but that analogy does not apply here and, regardless, fails on its own terms; there is no contractual duty to "mitigate" when, as in this case, a party has fully performed in reliance on a promise to pay a sum certain.[2]

ACAP fully agrees with the arguments in the Petition, which justify this Court's review and reversal of the decision below. Here, we discuss two additional points that further demonstrate the compelling practical reasons for this Court to consider the issue presented and to correct the Federal Circuit's error.

First, the decision below ignores the ramifications for the health insurance marketplace of the Government's refusal to meet its statutory obligations. As a result of so-called "silver-loading"—the complex workaround that the Federal Circuit deemed to be an effective "offset" to the Government's disregard of its shall-pay obligation under Section 1402—the insurance

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[2] Indeed, the principal authority that the Federal Circuit cited as support for its mitigation analogy (Pet. App. 16-17) explicitly disclaimed reliance on general contract-law principles, pointing instead to peculiarities regarding claims for government back-pay. See *Craft* v. *United States*, 589 F.2d 1057, 1068 (Ct. Cl. 1978) ("The deduction is not based on * * * mitigation of damages in the traditional sense," but rather "on the unusual jurisdiction of the Court of Claims in pay cases[.]").

market is greatly distorted in a manner that departs from Congress's intent when it enacted the ACA, changing the nature and undermining the availability of health insurance. These consequences are especially significant for smaller community plans, like ACAP's members, which are much less well-equipped to manage marketplace disruptions or absorb losses than larger insurance carriers.

Second, the decision below will make it harder to achieve the ACA's purposes of encouraging robust participation on the ACA exchanges and lowering the cost of coverage. It is not consistent with the statutory goals to permit the government to break its promises to reimburse insurers so long as the insurers can raise their prices in an attempt to make up for the government's promise-breaking—an effort that often will not succeed and that will, in any event, have adverse collateral consequences for both insurers and insureds. Nor is it tenable to require small insurers to wait years without any assurance that they will receive promised recompense for reductions in receipts that follow from their provision of coverage under the ACA. Any private party would think twice about partnering with the government if the remedy for a breach of the government's obligations is expensive, uncertain, and years-long litigation. That is doubly true in a vast and complicated market like the individual health insurance market.

The petition for certiorari should be granted.

ARGUMENT

The ACA recognizes four tiers of coverage based on the actuarial value of healthcare benefits provided to participants: bronze (60%); silver (70%); gold (80%);

and platinum (90%). 42 U.S.C. § 18022(d)(1). Only silver plans, however, are eligible for cost-sharing reduction payments under Section 1402 of the ACA. Specifically, individuals enrolled in a silver plan and with a household income between 100% and 250% of the poverty line are considered "eligible insureds" who are entitled to a reduction in cost-sharing payments to defray out-of-pocket expenses like deductibles and copays. 42 U.S.C. §§ 18022(c)(3), 18071(c)(2). As noted above, Section 1402 obligates the United States to repay insurers for revenue forgone as a result of these cost reductions.

In addition to Section 1402's cost-sharing reduction subsidies for insurers, Section 1401 of the ACA creates a separate subsidy to lower the cost of health insurance: premium tax credits. As the name suggests, premium tax credits are offered to offset the cost of health-insurance premiums; individuals may choose to have all or some of their estimated tax credits paid in advance directly to their insurance company to lower monthly premiums. Separate from the Section 1402 cost-sharing reductions, tax credits are available on a sliding scale for individuals whose earnings place them between 100% and 400% of the poverty line. 26 U.S.C. § 36B(c)(1).

Unlike cost-sharing reduction payments, premium tax credits are available for individuals with any level of plan, not just silver, although their amount is determined by a complex formula that depends on both the cost of a silver-plan benchmark in their rating area and on that consumer's income. In essence, the amount of the tax credit depends on the spread between the individual's plan and the monthly plan premiums for the second-lowest-cost silver plan in the market, in conjunction with where the consumer falls

on the poverty line. 26 U.S.C. § 36B(b)(2). This is a completely different calculation involving a different subset of consumers than receive the cost-sharing reductions under Section 1402.

I. The Government's Refusal To Meet Its Obligations Has Distorted The ACA Marketplace.

In the decision below, the Federal Circuit agreed that the government's failure to reimburse insurers for required cost-sharing reductions violated the plain terms of the ACA, but held that the government could in effect receive an offset on its Section 1402 obligations against other, separately required payments that the government made to the insurers. That is wrong not only as a matter of statutory interpretation and contract law, but because the supposed "offset" the Federal Circuit relied on is not a true offset, and in fact distorts the operation of the individual insurance marketplace.

Every insurer that participates on an ACA exchange must offer at least one silver and one gold plan. 42 U.S.C. § 18021(a)(1)(C)(ii). Because only silver plans are eligible for Section 1402 cost-sharing reductions, such plans were very attractive to the lowest-income consumers whose out-of-pocket expenses would be reduced throughout the year. From an actuarial-value perspective, cost-sharing reductions could make silver plans more cost-efficient for some eligible enrollees than even a platinum plan. *See* 42 U.S.C. § 18071(c)(2)(A).

Once the government stopped reimbursing insurers for their cost-sharing reduction payments, however, the structure of the market changed. Deprived of the cost-sharing reduction revenue they were promised, many insurers raised prices on silver plans,

while others raised prices on all plans. This meant, as the Federal Circuit noted, that some insurers (and insureds) were able to collect higher premium tax credits under Section 1401. But even the Federal Circuit acknowledged below that this so-called "silver-loading" was "not a perfect solution" to the problems caused by the government's refusal to pay insurers what they were owed under Section 1402 of the ACA. Pet. App. 8.

As shown below, that Section 1401 is an "imperfect" substitute for Section 1402 is a euphemistic understatement: the government's disavowal of its statutory obligations under Section 1402 both unfairly burdens insurers and warps the operation of the ACA.

First, the Federal Circuit was wrong to label as a "windfall" the additional premium tax credit payments that some insurers obtained after certain states allowed for premium increases (Pet. App. 19), and to suggest that those payments—which have significantly altered the operation of the ACA—simply offset payments to which insurers are entitled by the plain text of Section 1402. Those separate payments under Section 1401 are not a "windfall." They are a consequence of the scheme *Congress* enacted, wholly independent of the amounts due under Section 1402.[3]

Perhaps the clearest indication that Section 1401 and Section 1402 are not identical in their impact on either insurers or insureds is that Congress provided

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[3] The Federal Circuit seemed to suggest that if the government had not breached its obligations, but the insurers had raised the premiums on their silver plans anyway, the government would have had to pay both obligations. See Pet. App. 5 ("The damages issue here does not turn on whether the states have required express approval of premium increases.").

for *separate* reimbursement obligations in the statute. Cf. *Republic of Sudan* v. *Harrison,* 139 S. Ct. 1048, 1058 (2019) (courts should not "adopt an interpretation of a congressional enactment which renders superfluous another portion of that same law"). Consistent with that approach, nothing in the text of the ACA makes the government's shall-pay obligation under Section 1402 conditional in any way on its obligation to pay premium tax credits under Section 1401.

Indeed, on the face of it, the tax credits paid under Section 1401 are not equivalent to the reimbursements that ought to have been paid to insurers for their cost-sharing reduction payments under Section 1402. Both sorts of payment aim to reduce the cost of healthcare for low-income individuals, but they do so in very different ways. Consider:

- Section 1401 creates tax credits owed to individuals; Section 1402 directly reimburses insurers for mandated cost-sharing reductions.
- Section 1401 targets the cost of plan premiums (*i.e.*, the cost to *get* insurance); Section 1402 targets cost-sharing, colloquially known as co-pays and deductibles (*i.e.*, the cost to *use* insurance).
- Section 1401 applies to consumers with incomes between 100% and 400% of the federal poverty line; Section 1402 applies to consumers with incomes between 100% and 250% of the federal poverty line.
- Section 1401 applies to all plans available on an ACA exchange; Section 1402 applies only to silver plans.
- The amount of the Section 1401 credit depends on the second-lowest-cost silver plan in

> the market; an insurer will not even know what the credit will be until insurance rates (from its competitors) are set in the middle of a calendar year. Under Section 1402, by contrast, an insurer is (ostensibly) guaranteed to receive precise reimbursement.

In short, Sections 1401 and 1402 are far from identical. As shown below, moreover, these differences make it impossible for insurers to accurately predict or use Section 1401 to offset Section 1402.

Second, even if tax credit payments were equivalent in substance to the cost-sharing reduction reimbursements—and, as just noted, they are not—tax credit payments are a very blunt and inexact tool with which to replace the amounts owed under Section 1402. The exact amount of the tax credits an insurer will receive is dependent on premiums that are set well before consumers utilize care and insurers incur cost-sharing reduction obligations, and will typically depend both on enrollment decisions of the consumer and on the decision of a third party—state insurance commissioners—approving rate increases. Those premiums must also take into account a host of other factors: the cost of services, other changes in federal rules governing plan offerings, the competitive landscape, and changes in forecast demand for consumer health care (including, most recently, due to the pandemic). And because consumers often change plans from year to year, relying on premium increases to make up for lost cost-sharing revenue may distort costs for an entirely different set of consumers than those for whom the insurer incurred the original cost-sharing obligation.

These difficulties are further magnified when there are several insurers in a market—which is the case nearly everywhere. No single insurer has the unilateral ability to set the premium for the second-lowest silver plan. Instead, each must guess in advance how their competitors will price *their* silver plans, and, based on that guess, predict what the tax credits for a given year will be.

If the insurer guesses wrong—if the benchmark premium, and hence the total tax credit the insurer can expect under Section 1401, is different than expected—the insurer may end up mispricing its own plans' premiums, either losing money, disadvantaging itself relative to its competitors, or both.

Particularly for small, not-for-profit insurers like ACAP's members, this constant guessing-game is a very difficult proposition. ACAP's members tend to compete in a small number of markets, generally do not sell group insurance (among the most lucrative markets for health coverage), and historically operated in the low-margin market for Medicaid plans. As a result, ACAP's members have extensive experience offering cost-effective health coverage to low-income individuals, and are well-positioned to offer competitive products on the ACA exchange. Indeed, theirs were among the cheapest silver options available in 2017, the year before the government announced it would stop making cost-sharing reeducation payments. K. Hempstead & J. Seirup, *Medicaid MCOs in the Individual Market: Past, Present . . . And Future?*, HealthAffairs (Aug. 30, 2018), https://bit.ly/3tKA9yj. But this also means that ACAP's members lack the ability to absorb large losses outside their core business. Smaller plans may also face larger premium

swings from year to year, which can drive away customers and place them at a disadvantage vis-à-vis larger issuers.

Third, the silver-loading encouraged by the Federal Circuit's decision causes disruptions for insureds as well as for insurers.

Because of the way the ACA is structured, raising premiums on silver plans does not significantly affect the bottom-line cost of exchange plans for lower-income consumers who are tax-credit-eligible. But for middle- and upper-income individuals, who do not qualify for tax credits under Section 1401 because their income is more than 400% of the poverty level, raising premiums on these plans can effectively price them out of the market. (It can also cause problems for individuals whose income is close to the tax-credit threshold and who receive some, albeit small, tax credits). As the former Administrator for the Centers for Medicare and Medicaid Services noted, raising silver-plan premiums "does have an impact, not only on what the federal government is paying, but it also has an impact on the unsubsidized population. That is where we really continue to be concerned about the folks that are not being subsidized, where they are going." Kimberly Leonard, *Seema Verma won't say if Trump administration will limit insurers on Obamacare subsidies*, Washington Examiner (Mar. 22, 2018), https://washex.am/3caNUjM.

To compensate for this problem, some states decided to permit insurers to sell similar, but differently priced, ACA-exchange silver plans and non-exchange

versions of silver plans.[4] In states that allow it, individuals who do not qualify for the tax credits because of their higher income can purchase these non-exchange plans without the "loaded" silver premiums—if they are even aware of this option, since it is not offered on the "Exchange" where consumers typically go to shop for coverage. But adding another type of plan for consumers further complicates an already complex process and creates additional headaches for insurers. It also further fragments the exchanges, contrary to Congress's aim of building "a marketplace * * * to compare and purchase health plans." *King* v. *Burwell*, 576 U.S. 473, 479 (2015).

Finally, as a report commissioned by ACAP found, the prevalence of "silver-loading" following the elimination of federal funding for cost-sharing reductions in 2017 has inverted some markets, causing silver plan premiums in certain states to be comparable to, or even higher than, gold plan premiums, while causing bronze plans, in some cases, to be free. *See* Wakely Consulting Group, LLC, *Potential Change to ACA Benchmark Plan: Distributional Implications* 5-7 (Feb. 22, 2021), https://bit.ly/39bWUUc. This has its own distortionary effects. It complicates contemplated tweaks to the ACA, such as shifting to gold plans as the benchmark for calculating tax credits. *Ibid*. It may result in some individuals carrying bronze insurance when they would otherwise have selected a silver plan

[4] Because regulations require an issuer to charge the same premium rate whether or not the plan is offered on an exchange, 45 C.F.R. § 156.255, off-exchange variants cannot be identical to on-exchange silver variants. See generally Dep't of Health & Human Servs., Ctr. for Medicare & Medicaid Servs., *Offering of plans that are not QHPs without CSR "loading"* (Aug. 3, 2018), https://go.cms.gov/314ObP8.

with greater benefits. And it may result in individuals opting for gold or platinum plans but not obtaining as much care because cost-sharing reductions for non-silver plans are not available to defray out-of-pocket costs. These changes in consumer behavior again impact an insurer's ability to accurately price premiums, making it even less practical to use Section 1401 to "offset" losses from Section 1402, as the Federal Circuit imagines will happen.

* * *

In sum, the federal government's decision to pull the Section 1402 rug out from under insurance companies has resulted in a system that is very different from the one Congress envisioned when it passed the ACA. That underscores why it is inappropriate to use the Section 1401 payments as an "offset" to the government's failure to make statutorily required cost-sharing reimbursements under Section 1402.

Indeed, the Federal Circuit's decision is contrary to the very premise of the government's rationale for stopping reimbursements in the first place. In justifying a halt to cost-sharing reduction reimbursements in October 2017, the Attorney General reasoned that Section 1402 payments were not authorized under the permanent appropriation for Section 1401 payments, 31 U.S.C. § 1324, because Section 1401 and Section 1402 are separate and discrete parts of the statute. As the Attorney General observed, the programs are "distinct"—each is "authorized by a separate provision in a separate title of the U.S. Code," each "has a different focus * * * [and] functions differently," and each "has a different eligibility formula." Ltr. from Jefferson B. Sessions III, U.S. Att'y Gen., to Steven Mnuchin, Sec'y

of the Treasury, and Don Wright, M.D., M.P.H., Acting Sec'y of HHS (Oct. 11, 2017), at 2-3, https://www.hhs.gov/sites/default/files/csr-payment-memo.pdf. If that is so, it makes no sense to deduct payments made under Section 1401 from the government's "distinct" and "separate" obligation to make payments under Section 1402. The government cannot have it both ways.

II. The Decision Below Will Dissuade Insurers And Other Businesses From Working With The Federal Government.

The Federal Circuit's decision also further damages the federal government's credibility as a partner for community insurers. Review by this Court is imperative not just to correct the Federal Circuit's legal errors, but to ensure that insurers can rely on the government as they take steps to expand the availability of health insurance for long-underserved populations.

Just like the risk-corridor payments that this Court addressed in *Maine Community*, Section 1402 is crystal-clear. Insurers "shall" offer cost-sharing reductions to eligible insured individuals on silver-level exchange plans. 42 U.S.C. § 18071(a). Then, they "shall notify" the Secretary of Health and Human Services of such cost-sharing payments and the Secretary, in turn, "shall make periodic and timely payments" to the insurers "equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A); see also *Sanford Health Plan* v. *United States*, 969 F.3d 1370, 1381 (Fed. Cir. 2020) (calling § 18071(c)(3) "materially indistinguishable" from the "triple mandate" at issue in *Maine Community*). It is undisputed that insurers, including ACAP's members, upheld their end of this

bargain. Yet despite the statute's unambiguous language, the government has now refused for several years to make billions of dollars of cost-sharing reduction payments to which insurers are entitled under the terms of the ACA.

This is no way to run a public-private partnership, let alone one as consequential as that created by the ACA. Since 2015, the federal government has spent roughly $1 trillion a year on health care expenditures, the vast majority through public-private partnerships. CMS, *National Health Expenditure Data* (2019), Tbl. 05-3, https://go.cms.gov/3vZmYLW. If the government is to be an attractive business partner in the health care sector (and more broadly), it is crucial that the courts hold the government to the terms of its agreements.

Unfortunately, uncertainty over the government's willingness to make good on its promises has been endemic from the very beginning of the ACA exchanges. In 2014, the D.C. Circuit struck down the payment of tax credits on federal- as opposed to state-operated exchanges, *Halbig* v. *Burwell*, 758 F.3d 390 (D.C. Cir. 2014), before this Court ultimately upheld those payments in *King*, 576 U.S. 473.

In 2016, a district court enjoined the Secretary of Health and Human Services and the Secretary of the Treasury from reimbursing cost-sharing reduction payments under the permanent appropriation in 31 U.S.C. § 1324. *U.S. House of Representatives* v. *Burwell,* 185 F. Supp. 3d 165 (D.D.C. 2016). From 2014 to 2016, the government underfunded the risk-corridor program Congress created to induce insurers to enter into the new exchange markets. *Maine Com-*

munity, 140 S. Ct. 1308. Finally, in 2017, the government announced that it would not reimburse cost-sharing reductions without a specific appropriation.

Faced with repeated uncertainty and refusals to pay, many insurance companies and other businesses are liable to conclude that doing business with the government is not worth the risk. One can hardly blame them. Some insurers exited the market as a result of the failure to make risk-corridor payments. And even insurers who stayed in business have been forced to sue the government, undertaking often years-long litigation to receive the amounts they are due. The more confusing and burdensome enforcement of the government's promises becomes, the more likely it is that smaller insurers like ACAP's members will simply decide to stay away.

The decision below exemplifies the problem. Although the Federal Circuit rested its decision on the premise that insurers ought to be able to make up under Section 1401 what they lost under Section 1402, its decision in this case does not end the multi-year saga to recover payments promised under Section 1402. Instead, it announces another convoluted chapter. According to the lower court, determining the amount of premium tax credits paid to each insurer and "attributable to the government's failure to make cost-sharing reduction payments" will be a "fact-intensive task." Pet. App. 29-30. Among the unresolved issues are the extent to which silver-level premium increases are caused by "other factors," see *supra* p. 9, and to what extent increases in non-silver plan premiums should reduce the government's liability. Pet. App. 30-31. Adding to the difficulty, the lower court held that the *insurers* will bear the burden of proof on these issues—meaning that the government

may end up avoiding its shall-pay obligation simply because the insurers cannot prove that a separately authorized payment was not in "mitigation" of the government's failure to pay. *Id*. at 31-33.

In *Maine Community*, the Court declared that the proposition that "[t]he Government should honor its obligations" is "as old as the Nation itself." 140 S. Ct. at 1331. The Court should make clear, once again, that this principle still has force.

CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted.

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