No. 18-1028

In The Supreme Court of the United States

MODA HEALTH PLAN, INC.,
Petitioner,
v.
UNITED STATES,
Respondent.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
Petitioner,
v.
UNITED STATES,
Respondent.

On Petition for 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

Hyland Hunt
Ruthanne M. Deutsch
DEUTSCH HUNT PLLC
300 New Jersey Ave. NW, Suite 900
Washington, DC 20001

Pratik A. Shah
Counsel of Record
Leslie B. Kiernan
Robert K. Huffman
AKIN GUMP STRAUSS HAUER & FELD LLP
1333 New Hampshire Ave. NW
Washington, DC 20036
(202) 887-4210
pshah@akingump.com

QUESTION PRESENTED

Whether Congress can evade its unambiguous statutory promise to pay health insurers for losses already incurred simply by enacting appropriations riders restricting the sources of funds available to satisfy the government's obligation.

TABLE OF CONTENTS

QUESTION PRESENTED i

INTEREST OF *AMICUS CURIAE* 1

INTRODUCTION AND SUMMARY OF ARGUMENT 2

ARGUMENT 4

THE FEDERAL CIRCUIT'S DECISION THREATENS THE DEEP PARTNERSHIP BETWEEN HEALTH INSURANCE PROVIDERS AND THE GOVERNMENT 4

- A. The Decision Below Undercuts The Government's Reliability As A Business Partner. 4
- B. The Government Reaped Substantial Benefits At The Expense Of Health Plans From Its Broken Promise On The Risk Corridors Program. 9
- C. The Federal Circuit's Ruling Implicates Public-Private Health Care Partnerships More Broadly. 15

CONCLUSION 18

TABLE OF AUTHORITIES

CASES:

Belknap v. United States,
150 U.S. 588 (1893) 6

Salazar v. Ramah Navajo Chapter,
567 U.S. 182 (2012) 5, 6

United States v. Langston,
118 U.S. 389 (1886) 6

United States v. Winstar Corp.,
518 U.S. 839 (1996) 5

STATUTES:

26 U.S.C.
§ 36B 14

42 U.S.C.
§ 18062(b)(1) 10
§ 18062(b)(1)(A) 10, 11
§ 18062(b)(1)(B) 11

Health Care and Education Reconciliation
Act of 2010, Pub. L. No. 111-152, 124
Stat. 1029 1

Patient Protection and Affordable Care Act,
Pub. L. No. 111-148, 124 Stat. 119 (2010)............. 1

OTHER AUTHORITIES:

78 Fed. Reg. 15,410 (Mar. 11, 2013) 12

80 Fed. Reg. 10,750 (Feb. 27, 2015) 13

2017 OFFICE OF THE SPECIAL DEPUTY RECEIVER ANN. REP. 8

AHIP, *2017 QHP Rate Filing—Key Dates* (Apr. 18, 2016) 7

Am. Acad. of Actuaries, *Fact Sheet: ACA Risk-Sharing Mechanisms* (2013)........................ 11

Am. Acad. of Actuaries, Issue Br., *Drivers of 2015 Health Insurance Premium Changes* (June 2014) 9

CMS, *Medicaid Managed Care Enrollment and Program Characteristics, 2016* (2018) 17

CMS, *Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report*, Monthly Summary Report (Feb. 2019)... 16, 17

CMS, *National Health Expenditure Data* 16

CMS, *Quarterly Marketplace Effectuated Enrollment Snapshots by State* 14

Jacobson, Gretchen et al., Kaiser Family Found., *A Dozen Facts about Medicare Advantage*, Nov. 13, 2018 .... 16, 17

Kaiser Family Found., *Marketplace Effectuated Enrollment and Financial Assistance* (2018) 17

Letter from Kevin J. Counihan, Ctrs. For Medicare & Medicaid Servs., to Insurance Commissioners (July 21, 2015) 14

MACPAC, MACStats: Medicaid & CHIP Data Book (2018) 17

Nat'l Org. of Life & Health Ins. Guar. Ass'ns, *The Safety Net at Work* 8

S. Ct. R. 37.2(a) 1

Sacks, Daniel W. et al., *The Effect of the Risk Corridors Program on Marketplace Premiums and Participation* (Nat'l Bureau of Econ. Research, Working Paper No. 24129, 2017) 13

Skopec, Laura et al, Dep't of Health & Human Servs., *Market Competition Works: Silver Premiums in the 2014 Individual Market Are Substantially Lower than Expected* (Aug. 19, 2013) 13

Wright, Aaron S. et al., Milliman, *Ten potential drivers of ACA premium rates in 2017* (Dec. 2015) 13

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

[1] Counsel of record for all parties received timely advance notice of the intent to file this brief and consented to the filing of the brief. S. CT. R. 37.2(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.

government meets its obligations as a reliable business partner. Beyond the billions of dollars in unexpected losses incurred by health insurance providers due to the government's failure to pay the promised risk corridors reimbursements, AHIP supports certiorari because the Federal Circuit's decision jeopardizes ongoing and future business relationships involving the federal government.

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. 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.

AHIP agrees with Petitioners that the Federal Circuit's decision conflicts with this Court's precedents. Pet. 18-26. AHIP writes to emphasize the need for certiorari because the Federal Circuit's holding 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 urgent and increasing 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 ambiguous legislative history accompanying an 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. At the time of their inception, 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. During the early years of the exchanges, many participating health plans in fact 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 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.

The business relationships between health insurance providers and the government, which extend well beyond the ACA exchanges, are vitally important. Those partnerships deliver health care to tens of millions of Americans, and they depend upon the insurance providers' ability to trust that the government will act as a fair partner. This Court should grant certiorari 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.

As Petitioners explain (Pet. 33-34), the Federal Circuit's failure to uphold the government's "unambiguously mandatory" obligation to reimburse health insurance providers for more than $12 billion in losses, Pet. App. 16, directly harms the health insurance market, the ACA exchanges, and the consumers they serve. But the damaging effects of the Federal Circuit's decision reach far beyond that specific harm.

As recognized by the judges dissenting from denial of rehearing en banc, the Federal Circuit's

holding that "the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, 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.

This Court, too, has long recognized the 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).

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) ("[M]ere 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* Pet. 19-26. 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 participation in the ACA exchanges

for 2015.[2] No matter the doctrinal lens, the upshot is that the Federal Circuit has allowed 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 B, *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. Pet. 11. Petitioner Blue Cross Blue Shield of North Carolina, too, suffered financial losses of over $300 million for just 2014 and 2015. *Id.*

Such harm is not limited to Petitioners here. Insurance providers in Illinois, for example, have been required to pay assessments levied by the state guaranty fund because of the insolvency of a petitioner in a related case (*Land of Lincoln Mut. Health Ins. Co.*

---

[2] 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), *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.*

v. United States, No. 18-1038).[3] *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).[4] Additionally, of the 24 member-run non-profit insurers known as "co-ops," established under a new grant and loan program created by ACA, only 6 remained in operation two years after the government started defaulting on risk corridors reimbursements. Pet. App. 68, 84.

It follows that if the Federal Circuit's holding is allowed to stand, health insurance providers and other private enterprises will doubt their ability to rely on the government's unambiguous promises. And that doubt will deter future public-private partnerships—to the detriment of all, including consumers who

---

[3] 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.

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

depend on the vital services those partnerships make possible.

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

The damage done by the Federal Circuit's decision is particularly pronounced in this case because of the clarity of the government's promise, the ambiguity of any claimed repudiation, and the magnitude of the losses to health insurance providers—not to mention the corresponding benefit that the government extracted at the expense of those providers.

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).[5] 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

---

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

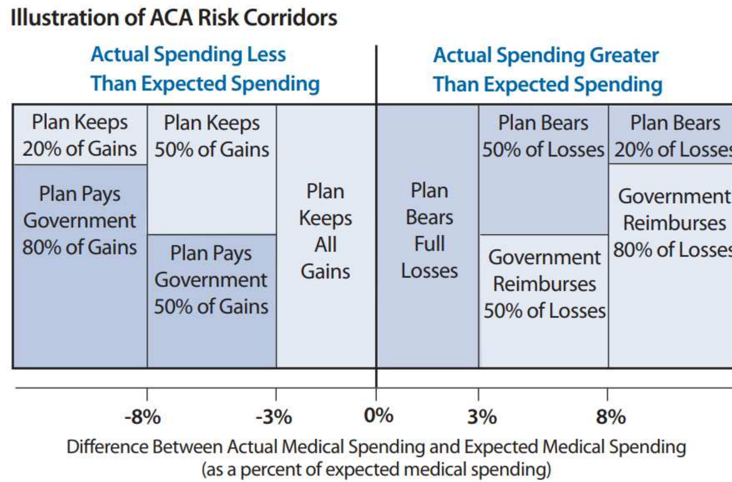
Circuit recognized was unambiguous, Pet. App. 16-17: the government would reimburse health insurance providers (in part) for any losses resulting from higher-than-expected costs to cover patient care during the first three years of the exchanges.

That bargain still left much risk on the shoulders of health insurance providers, who were owed payments only if they suffered substantial losses from setting premiums too low—and, even then, were often required to shoulder the majority of any loss. 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, whose "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, for health insurance providers that incurred losses between 3% and 8%, the government was required to reimburse insurers for 50% of the loss falling between those percentages. 42 U.S.C. § 18062(b)(1)(A). Stated

another way, insurance providers were reimbursed for half of the amount by which costs exceeded 103% of premiums, up to 108% of premiums. *Id.* For insurance providers who incurred losses exceeding 8%, the government was required to pay the above amount plus 80% of the 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).[6]

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 health

---

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

insurance provider for $4.1 million of its $10 million loss, reducing its 10% loss to a 5.9% loss.[7] As this example shows, an insurance provider incurring a loss that triggers the highest reimbursement rate would still often bear the majority of the loss—even if the government had satisfied its risk corridors obligations in full.

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

The stated purpose of this (limited) sharing of risk between health insurance providers and the government was to induce insurance providers to set lower premiums. 78 Fed. Reg. 15,410, 15,412-15,413 (Mar. 11, 2013) (stating that the risk corridors program requires "the Federal government and [qualified health plans] to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016," permitting "issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets"). Health insurance

---

[7] The $4.1 million payment is 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).

providers did their part, and the program achieved the desired effect.

Indeed, 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. 19, 2013).[8] Premiums in the exchange marketplace later increased significantly—by 37% from 2015 to 2017—with the sunset of the risk corridors 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);[9] Aaron S. Wright et al., Milliman, *Ten potential drivers of ACA premium rates in 2017,* at 4 (Dec. 2015).[10] An NBER paper found that premiums would likely have increased by only 10% over that period if the risk corridors program had been in place and allowed to operate as intended under the statute. Sacks, *supra*, at 36.

Even after the first appropriations rider was enacted, the government continued to encourage lower premiums in reliance on the program. *See, e.g.,* 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (stating the

---

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

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

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

agency "recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers"). In the summer of 2015, the government reassured state insurance commissioners—who are responsible for approving premiums and premium increases—that the agency "remains committed to the risk corridor program." Letter from Kevin J. Counihan, Ctrs. For Medicare & Medicaid Servs. ("CMS"), to Insurance Commissioners, at 2 (July 21, 2015).[11] The government reiterated that ACA "requires the Secretary to make full payments to issuers" and urged state regulators to hold the line against premium increases and to take risk corridors "payments *** into account before decisions are made on final rates" for 2016. *Id.*

The resulting lower premiums benefited the government and the new exchanges. Lower premiums directly reduced the amounts the government was required to pay in 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%).[12] The lower premiums thus saved the government billions more in reduced tax credits.

---

[11] *Available at* https://www.cms.gov/CCIIO/Resources/Letters/Downloads/DOI-Commissioner-Letter-7-20-15.pdf.

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

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.

All of those facts are undisputed. If left standing, the Federal Circuit's ruling thus 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, legislative history. That is untenable both as a matter of law and basic fairness.

C. The Federal Circuit's Ruling Implicates Public-Private Health Care Partnerships More Broadly.

Allowing the sort of maneuver the government undertook here will inject uncertainty into other vital health care programs. There are few industries in 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.[13]

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 nearly 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 (Feb. 2019);[14] Gretchen Jacobson et al., Kaiser Family Found., *A Dozen Facts about Medicare Advantage*, Nov. 13, 2018.[15]

Similarly, over 45 million people are enrolled in Medicare Part D coverage, a voluntary prescription drug benefit for Medicare beneficiaries that is

---

[13] *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*.

[14] *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-2019-02.html.

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

provided through private health insurance plans approved by the federal government. *Id.* 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).[16] 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 75% of their Medicaid populations enrolled in managed care organizations. MACPAC, MACStats: Medicaid & CHIP Data Book, Ex. 29 (2018).[17]

Finally, over 10 million Americans enrolled in health plans offered on ACA exchanges in 2018, of which nearly 9 million received subsidies. *See* Kaiser Family Found., *Marketplace Effectuated Enrollment and Financial Assistance* (2018).[18]

---

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

[17] *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.

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

The Federal Circuit's decision, 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—without at least doing so openly and clearly—partnering with the federal government becomes a venture fraught with risk. And then everyone—the government, private partners, and citizens alike—loses.

CONCLUSION

The Court should grant the petition for writ of certiorari.

Respectfully submitted.

Hyland Hunt
Ruthanne M. Deutsch
DEUTSCH HUNT PLLC

Pratik A. Shah
Counsel of Record
Leslie B. Kiernan
Robert K. Huffman
AKIN GUMP STRAUSS
HAUER & FELD LLP

March 8, 2019