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IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF CALIFORNIA

THE STATE OF CALIFORNIA; THE STATE OF CONNECTICUT; THE STATE OF DELAWARE; THE DISTRICT OF COLUMBIA; THE STATE OF ILLINOIS; THE STATE OF IOWA; THE COMMONWEALTH OF KENTUCKY; THE STATE OF MARYLAND; THE COMMONWEALTH OF MASSACHUSETTS; THE STATE OF MINNESOTA; THE STATE OF NEW MEXICO; THE STATE OF NEW YORK; THE STATE OF NORTH CAROLINA; THE STATE OF OREGON; THE COMMONWEALTH OF PENNSYLVANIA; THE STATE OF RHODE ISLAND; THE STATE OF VERMONT; THE COMMONWEALTH OF VIRGINIA; and THE STATE OF WASHINGTON,

Plaintiffs,

v.

DONALD J. TRUMP, President of the United States; ERIC D. HARGAN, Acting Secretary of the United States Department of Health and Human Services; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; STEVEN T. MNUCHIN, Secretary of the United States Department of the Treasury; UNITED STATES DEPARTMENT OF THE TREASURY; and DOES 1-20,

Defendants.

Case No. 3:17-cv-05895-VC

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF PLAINTIFFS' MOTION FOR A TEMPORARY RESTRAINING ORDER AND TO SHOW CAUSE WHY A PRELIMINARY INJUNCTION SHOULD NOT ISSUE

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INTEREST OF *AMICUS CURIAE*

America's Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 years of experience in the industry. 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 hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's healthcare and health insurance systems, and a unique understanding of how those systems work.

Health insurance issuers are among the entities most directly and extensively regulated by 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 has participated as *amicus curiae* in other cases to explain the practical operation of ACA. *See, e.g.*, *King v. Burwell*, No. 14-114 (U.S.). Likewise here, AHIP seeks to provide the Court with its unique expertise and experience regarding the operation of health insurance markets, the changes made by ACA, the objectives those changes advance, and the consequences to consumers as well as to issuers of the Administration's recent decision stopping cost-sharing reduction payments. AHIP's perspective will provide the Court with a deeper and more comprehensive understanding of the serious and irreparable practical consequences of denying interim relief.

INTRODUCTION AND SUMMARY OF ARGUMENT

AHIP files this *amicus* brief to underscore the centrality of cost-sharing reduction payments to health insurance issuers' provision of affordable healthcare, and the considerable harm that the Administration's abrupt cessation of those payments has and will continue to inflict. The statutory mandate that cost-sharing reduction payments shall be made is a cornerstone of the Affordable Care Act's ("ACA") reforms that facilitated issuers' participation in ACA's Exchanges. As such, it is no surprise that the availability of cost-sharing reduction payments has been a vital issue for issuers deciding whether to participate in the individual market, designing healthcare coverage, and setting premium rates.

Cost-sharing reduction payments were structured to provide government funding to directly reduce consumers' out-of-pocket costs, with the monies for such cost-sharing provided by issuers and their actual costs reimbursed by the government. The federal government uses health plans to pass through these mandatory benefits to eligible lower- and modest-income consumers to help lower costs for patients who see a doctor to treat their cancer or fill a prescription for a life-saving medication. Issuers do not profit from this funding: They are reimbursed actual costs. These are not subsidies for issuers. They are direct benefits for consumers and patients. As such, ACA requires that "the [HHS] Secretary shall make periodic and timely payments to [QHPs] equal to the value of the [cost-sharing] reductions." 42 U.S.C. § 18071(c)(3)(A); *see* Eyles Decl. ¶ 5.

From the opening of the Exchanges for plan year 2014 through plan year 2016 (that is, operating on a calendar year basis starting January 1 and ending December 31), the Administration made cost-sharing reduction payments as required by ACA, and issuers priced the plans they offered on the Exchanges accordingly. Over the past year, however, the concern

that the Administration would stop making cost-sharing reduction payments caused significant uncertainty regarding the Exchanges and caused the states to develop various alternative approaches to the setting of premium rates for 2018. The result has been a patchwork of contingency plans, which became less and less adaptable as the deadlines for electing to participate in Exchanges and proposing rates for regulatory approval came and went.

The Administration's late-breaking decision to cut off cost-sharing reduction payments after issuers had signed contracts for the upcoming 2018 plan year—and with little more than two weeks before individuals will begin buying plans during the open enrollment period—has left issuers and consumers in an impossible and untenable situation with inadequate time to implement the various contingency plans put in place earlier in the year. Despite the fact that premiums for 2017 were set and approved by state and/or federal regulatory officials in mid-2016 based on the understanding that monthly cost-sharing reduction payments would be made—as they had been since 2014—issuers will now be saddled with an estimated 1.75 billion dollars of unreimbursed 2017 cost-sharing reductions. On top of that, issuers are faced with difficult and challenging decisions on how to deal with the 2018 plan year and open enrollment, potentially even reconsidering their decision to offer coverage through the Exchanges. Participation in 2019 and beyond is at serious risk, and failure to make cost-sharing reduction payments now may irreversibly damage the individual market.

All of that creates serious and irreparable harm that would be avoided through the interim relief requested. In the immediate term, such relief would provide critical reassurance to issuers who are weighing whether or not to continue participating in Exchanges. Equally important, continued reimbursement for cost-sharing reductions would allow the markets to maintain critical stability on the cusp of open enrollment, and provide essential support for the long-term

viability of Exchanges and the availability of affordable health insurance options. Otherwise, the confusion engendered because of this late change in a fundamental aspect of the program will lead to decreased enrollment and coverage. That will, in turn, lead to a less healthy risk pool and cause a "death spiral" whereby insurance premiums escalate dramatically and only those individuals with the highest medical needs seek out and purchase health coverage. Because even potential recovery for cost-sharing reductions down the road (for example, in a Tucker Act suit) cannot stave off all of those consequences, the Court should at the very least grant the request for preliminary relief.

ARGUMENT

I. ACHIEVING AFFORDABILITY DEPENDS UPON ISSUERS' ABILITY TO PLAN FOR COST-SHARING REDUCTION REIMBURSEMENTS

A. Cost-Sharing Reduction Reimbursements Are A Central Component Of Issuers' Exchange-Related Decisions

For AHIP's members to offer plans on the Exchanges at affordable premium rates, it is imperative from an operational and business-planning perspective that they can rely on the availability of cost-sharing reduction payments from the federal government before filing premiums for state approval, committing to participate in ACA's Exchanges, and making off-Exchange individual market decisions. The absence of such certainty can have significant adverse effects on the affordability and range of options available to consumers.

Issuers' ability to design coverage and determine rates for "silver plans" required by Exchange participation depends upon knowing whether cost-sharing reductions will be reimbursed. That is because a see-saw relationship exists between premiums and cost-sharing. Generally, for the same set of benefits, the more an enrollee pays in premiums, the less she pays directly to providers in out-of-pocket cost-sharing payments (and *vice versa*). ACA's tiered "metal levels" (*i.e.*, bronze, silver, gold, and platinum plans) reflect that reality: enrollees who

choose a higher tier plan pay higher premiums but lower out-of-pocket costs for the same coverage. As such, to the extent issuers are statutorily required to reduce cost-sharing for enrollees, issuers (absent reimbursements) would need to charge higher premiums across all metal tiers or silver plans only. That premium increase would result in correspondingly higher premium subsidies for all premium-credit-eligible individuals (*i.e.*, individuals whose annual income is between 100% and 400% of the federal poverty level (FPL)), not just those eligible for cost-sharing reductions (*i.e.*, individuals whose annual income is between 100% and 250% FPL). *See, e.g.*, Pls. Mem. 24. This is because the premium tax credits are tied to the rate for the second-lowest cost silver plan in the Exchange.

Of the approximately 11.1 million people enrolled through Exchanges in 2016, nearly 6.4 million (~57%) were receiving cost-sharing subsidies. *See* Centers for Medicare & Medicaid Servs., March 31, 2016 Effectuated Enrollment Snapshot (June 30, 2016).[1] Given the mix of enrollees in silver plans, the Department of Health and Human Services estimated that silver-plan premiums would have to increase, in the first instance, by more than 20% in order to make up for a loss of cost-sharing reduction payments. *See* Dep't of Health & Human Servs., Office of the Ass't Sec'y for Planning & Evaluation, ASPE Issue Brief: Potential Fiscal Consequences of Not Providing CSR Reimbursements 2 (Dec. 2015).[2] Recent analyses by the Congressional Budget Office and Congress's Joint Committee on Taxation agree. *See* Eyles Decl. ¶ 13 (projecting 20% increase for 2018).

Because ACA preserves the historical role of states in conducting and approving health insurance premiums, premiums must be filed with state regulators as early as nine months in

[1] https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-30.html.

[2] https://aspe.hhs.gov/sites/default/files/pdf/156571/ASPE_IB_CSRs.pdf.

advance (*i.e.*, in April for coverage during the next calendar year) under schedules set by state law. *See, e.g.*, Kristi Wick, AHIP, 2017 QHP Rate Filing—Key Dates (Apr. 18, 2016) ("Key Dates").[3] And issuers begin the process of developing and pricing products up to a year before those deadlines.

Consistent with this structure—*i.e.*, the see-saw relationship between premiums and cost-sharing, the mandate that issuers offer plans with the cost-sharing reduction benefit to be reimbursed by the government, and the lead time needed for setting premiums given the states' role—the government during plan years 2014-2016 made the cost-sharing reduction payments to issuers out of the permanent appropriation provided by 31 U.S.C. § 1324(b)(2). The situation facing issuers today, indeed, illustrates why the statute provides for the permanent appropriation for cost-sharing reductions. If issuers had to rely on an annual appropriation for cost-sharing reductions through the typical yearly process, they would be unlikely to know whether cost-sharing reductions will be reimbursed until six months or more *after* they have filed rates with state authorities. That is because annual appropriations are typically enacted shortly before the beginning of the plan year that would include the relevant coverage—if then. *See, e.g.*, James V. Saturno & Jessica Tollestrup, Cong. Research Serv., R42647, Continuing Resolutions: Overview of Components and Recent Practices 10 (2016) ("CRS R42647") (tabulating that at least some of the "regular appropriations were enacted after October 1 in all but four fiscal years between FY1977 and FY2016," and that "in 14 out of the 40 years during this period, no regular appropriations bills were enacted prior to the start of the fiscal year," with "[n]ine of these fiscal years hav[ing] occurred in the interval since FY2001").[4]

[3] https://ahip.org/2017-qhp-rate-filing-key-dates.
[4] https://fas.org/sgp/crs/misc/R42647.pdf.

The deadlines for initial applications to participate in the federal Exchanges for the next calendar year are similarly inconsistent with the annual appropriations calendar as they must be made by May (or earlier in some state-established Exchanges), and final Exchange-participation decisions must be made by September, when contracts are signed with Exchanges just before the fall open enrollment period. *See* Key Dates, *supra*. Like for the premium rate filings, the Exchange deadlines typically will pass before any appropriations bill has been enacted for the fiscal year beginning in October. *See* CRS R42647, at 10, *supra*.

In sum, because an issuer that decides to participate in an Exchange must offer a silver plan that includes cost-sharing reductions for qualifying enrollees, *see* 42 U.S.C. § 18021(a)(1)(C)(ii), knowing whether cost-sharing reductions will be reimbursed is a significant factor in an issuer's decision to participate in Exchanges and, in turn, the off-Exchange individual market.[5] A system that allows cost-sharing reduction payments to cease without warning would be unworkable and cannot be what Congress intended in enacting ACA.

B. Issuers' Inability To Rely On Cost-Sharing Reduction Reimbursements Causes Uncertainty In The Marketplace That Impacts Exchange Participation And Enrollment Decisions And Leads To Reduced Coverage Options And Increased Costs

If issuers are unable to rely on reimbursement for cost-sharing reductions at the time they make premium and Exchange-participation decisions, the cost-sharing reduction program would be ineffective at achieving affordability for millions of people that do not have access to

[5] According to the Congressional Budget Office, cost-sharing reduction payments would increase from $7 billion to $16 billion per year from 2016-2026, and total $130 billion from 2017-2026. *See* CONGRESSIONAL BUDGET OFFICE, FEDERAL SUBSIDIES FOR HEALTH INSURANCE COVERAGE FOR PEOPLE UNDER AGE 65: 2016 TO 2026, at 8 tbl.2 (Mar. 2016), https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/51385-HealthInsuranceBaseline.pdf.

employer coverage and must purchase health insurance on their own through the Exchanges or elsewhere in the individual market.

For starters, certain issuers may decline—and indeed, have already declined, *see* Eyles Decl. ¶ 17—to take on the risk of participating in Exchanges in the absence of guaranteed reimbursement for cost-sharing reductions, among other factors. Such decreases in Exchange participation reduce competition and limit coverage options for consumers. *See* Dep't of Health & Human Servs., Office of the Ass't Sec'y for Planning & Evaluation, ASPE Research Brief: Health Plan Choice and Premiums in the 2016 Health Insurance Marketplace 11 (Oct. 2015).[6]

For those issuers that continue participating in Exchanges, the actual 2017 experience illustrates how critical the availability and reliability of cost-sharing reduction payments are to rate-setting, with some states permitting issuers to file two sets of rates to allow premium increases should cost-sharing reduction payments not be paid; other states requiring one set of rates (including states that required issuers to assume, as a factor in developing premiums, that cost-sharing reduction payments would be made in 2018); and still others spreading the rate increases across all metal levels. *See* AHIP 2018 State Regulator Approaches to Individual Market Rates Map ("AHIP Map"), attached hereto as Exhibit A.

For many customers, the termination of advance cost-sharing reduction payments will result in increased premiums and increased costs—including for those individuals who do not qualify for any subsidy and remain enrolled in plans that have higher premiums to cover unreimbursed cost-sharing reduction subsidies. Such termination will also increase costs for the federal government because of increases in premium subsidies. In addition, rising premiums used to cover unreimbursed cost-sharing reduction subsidies in such plans will cause some of the

[6] https://aspe.hhs.gov/sites/default/files/pdf/135461/2016%20Marketplace%20Premium%20Landscape%20Issue%20Brief%2010-30-15%20FINAL.pdf.

healthiest individuals to decline this now more expensive insurance, spurred in part by the fact that the higher cost of coverage will trigger in more instances the 8% household-income threshold for avoiding the tax penalty for non-compliance with the individual mandate, *see* 26 U.S.C. § 5000A(e)(1)(A).

II. THE TERMINATION OF COST-SHARING REDUCTION PAYMENTS WILL CAUSE IMMEDIATE, SIGNIFICANT, AND IRREPARABLE HARM TO ISSUERS AND THEIR CUSTOMERS, PARTICULARLY GIVEN THE SUDDEN TIMING AND UPCOMING OPEN ENROLLMENT PERIOD

Issuers across the country made the decision to participate in the new, risky insurance Exchanges starting in 2014 on the basis of clear statutory terms, and would not have offered coverage on the Exchanges that include the cost-sharing reduction benefit at the premiums set absent ACA's mandate that the Administration reimburse them through monthly advance payments. The Administration's announcement that it will terminate these payments will cause immediate financial harm to issuers with respect to 2017 payments due, thereby potentially forcing some issuers to face insolvency or tap reserve funds to cover the shortfall.

Even worse, the timing of the decision—after issuers had committed to participating in the Exchanges for 2018 and just two weeks before the 2018 open enrollment period that begins on November 1—creates substantial disruption and uncertainty in the Exchanges regarding the availability and price of products. Absent immediate relief, the Administration's decision to end cost-sharing reduction payments will lead to reduced enrollment, will cause issuers to reconsider participation in the individual market, and is likely to prompt additional issuer withdrawals from the Exchanges, thereby potentially leading to further destabilization of the market. These harms cannot be undone by subsequent litigation to recoup cost-sharing reduction payments down the line.

A. The Failure To Make Advance Payments For Cost-Sharing Reductions Will Have An Immediate And Substantial Impact On Issuers That Participate In The Exchanges

The Administration's October 12, 2017 announcement that it would stop making cost-sharing reduction payments means a substantial loss to issuers in immediate 2017 funding to all Exchange participants. The amount of this loss has been estimated at $1.75 billion or more, depending upon a variety of factors that include an individual issuer's enrollment during those months, claims incurred by enrollees, and the annual process to reconcile advance payments with actual reductions in cost-sharing amounts paid on behalf of enrollees. *See* Eyles Decl. ¶ 9. The Administration also announced that it would not complete reconciliation of 2016 cost-sharing reductions for some issuers, thus failing to make whole those issuers who were underpaid for 2016. *See id.* ¶ 11.

These immediate losses will hurt many health plans currently participating in the market. *See, e.g.*, White Decl. ¶ 20 (stating that Molina was due to receive payments of approximately $51 million in October 2017); Ko Decl. ¶ 3 (Premera and LifeWise (Washington state plans) will each suffer financial losses of $1.5 million if cost-sharing reduction reimbursements for 2017 are not received).

Regarding the Court's question in the October 19, 2017 briefing order, the termination of cost-sharing reduction payments will also have a significant impact on 2018 premium rates. The scope and nature of this impact varies widely across the country, depending upon the issuer and the state in which the Exchange operates. The map attached as an exhibit to this brief depicts the patchwork of rating assumptions across the 50 states and the District of Columbia. AHIP worked with its member health plans and attempted to document the different approaches taken by state regulators in anticipation of or following the October 12, 2017 announcement regarding cost-sharing reduction payments. The map reflects seven different categories of state regulatory

approaches, as well as the considerable ongoing uncertainty as a result of the Administration's announcement. For example, in some states, regulators provided clear written guidance to advise issuers as to how they should address and incorporate the potential for lack of cost-sharing reduction payments in their premium rates. In other states, no guidance has been given or regulators encouraged issuers to consider different approaches. The result is a graphic description of the patchwork of approaches the Administration's eleventh-hour decision has injected into the market.

The declarations submitted to this Court similarly illustrate the problem. One issuer, Blue Cross Blue Shield of Vermont, has estimated that it will suffer significant financial losses "likely exceeding $9,000,000, straining financial resources to pay for claims and significantly draining surplus *** meant to protect members and providers in the case of unexpected risk" if it is not authorized to increase its 2018 rates on plans in the individual market. Greene Decl. ¶ 5. It also appears that three jurisdictions (North Dakota, Vermont, and the District of Columbia) are not permitting plans to update premium rates. *See* Eyles Decl. ¶ 12; AHIP Map, *supra*. And in another six states, the state regulator did not specify how issuers should address the cost-sharing reduction issue. *See* AHIP Map, *supra*. Still further, in four states, the extra costs associated with uncompensated cost-sharing reductions is spread across all metal level of products, rather than limited to the silver plans. *See id.*; Eyles Decl. ¶ 15. In those states, the Administration's actions thus will lead to higher prices for *all purchasers* of Exchange products, not just those who are eligible for cost-sharing reductions or purchase silver plans. As referenced above, according to the Congressional Budget Office and Congress's Joint Committee on Taxation's projections, for single policyholders, gross premiums for silver plans offered through the

Exchanges would, on average, rise by about 20% in 2018 relative to the amount in the Congressional Budget Office's March 2016 baseline. *See* Eyles Dec. ¶ 13.

Even issuers in those states that allowed issuers to file two sets of rates—one assuming the availability of cost-sharing reductions and one not—will face considerable disruption to business continuity and operations. The Administration's eleventh-hour decision will force issuers on two weeks' notice to implement the new premium rates and prepare for open enrollment. That truncated timeline creates increased administrative difficulties and expenses, such as delaying renewal notices and/or having to send renewal notice corrections, updating multiple internal and external rating systems, and updating materials with revised rates. It also leaves issuers with no time for an orderly transition and no chance to educate consumers about how the Administration's decision not to make cost-sharing reduction payments will affect the products offered on the Exchanges. That will inevitably result in increased administrative costs as issuers seek to address challenges presented by confused and anxious consumers shopping on the Exchanges during open enrollment, such as problems with the online shopping platform and high call volumes on consumer help lines.

B. The Termination Of Cost-Sharing Reductions Will Significantly Impact Enrollment And Issuer Participation On The Exchanges, To The Detriment Of Issuers And Consumers

All of this customer confusion and frustration at the increase in premium rates is also likely to reduce enrollment. *See* Eyles Decl. ¶ 18. According to a recent Hart Research study, consumers who think that affordable plans are available are more likely to purchase health insurance (77% will purchase) than are those who do not believe there are affordable plans available (41% will purchase) or are not sure (48% will purchase). *See* Hart Research Associates, New Polling Among ACA Marketplace Insured and Eligible Uninsured 2 (Oct. 16, 2017).

The effect on enrollment is not limited to those silver plan customers who have policies with the cost-sharing reduction benefit. Because the premium rate increases impact all silver plans—and, as noted above, plans across all metal tiers in some states—the premium "sticker shock" will affect a broad swath of consumers, inevitably causing some consumers to forgo purchasing insurance until they become sick due to a lack of plan options or affordability, or neglect to enroll in non-ACA coverage options that fail to meet their health care needs. *See* Eyles Decl. ¶ 18. Such decisions will have a negative impact on the risk pool with sicker, older, and higher-risk consumers enrolling in coverage without the necessary younger and healthier population to balance costs.

Even for states that have permitted usage of an alternate rate that is "loaded" onto on-Exchange silver plans only, there is likely to be considerable confusion on the part of individuals who are enrolled in on-Exchange silver plans during open enrollment, especially among those consumers who are not receiving cost-sharing subsidies or premium tax credits. These consumers will be receiving renewal notices this week with 2018 premiums that are on average 20% higher than they would have been without uncertainty regarding cost-sharing reductions reflected in the pricing of silver plans. In some states (*e.g.*, Colorado), this issue extends to all metal levels, which now reflect increased costs due to uncertain cost-sharing reduction funding. Under existing rules issued by the Centers for Medicare & Medicaid Services ("CMS"), these consumers are auto-enrolled and renewed in these same plans unless they take some affirmative action during open enrollment to switch plans. Alternatively, these consumers can non-renew their coverage by not paying January 2018 premiums or by going to the Exchange to end their coverage. Because of inertia or confusion, these consumers may not go and shop for new coverage in other metal tiers or off-Exchange, and instead may decide to let their plans lapse

because the premium is too high. Overall, the changes to premiums may have the effect of hurting consumers who stay in a more costly on-Exchange silver plan and pay higher premiums than they need to, and/or cause them to drop out of the market and lose their coverage all together. This is likely to lead to decreased enrollment and overall less robust risk pools going forward. Purchasing insurance is a complex decision with a challenging process for many consumers and this now unprecedented injection of uncertainty into the market only makes the issue worse.

The natural consequence will likely be to hasten the exit of issuers from the Exchanges. Several issuers had already announced that they would exit or substantially reduce their Exchange presence in 2018 as a result of the Administration's prior announcement that it was evaluating cost-sharing reductions on a month-by-month basis. *See, e.g.*, Amy Goldstein, *Aetna Exiting All ACA Insurance Marketplaces in 2018*, WASH. POST (May 10, 2017).[7] In light of the Administration's most recent announcement, several additional issuers have made clear that they will reassess their participation in Exchanges, as the availability of cost-sharing reductions is a crucial part of all issuers' decisions to participate in Exchanges. *See, e.g.*, Burrell Decl. ¶ 9 (CareFirst).[8] A decline in enrollment and a higher-risk insurance pool will necessarily increase

[7] https://www.washingtonpost.com/national/health-science/aetna-exiting-all-aca-insurance-marketplaces-in-2018/2017/05/10/9dedbeea-35d4-11e7-b373-418f6849a004_story.html?utm_term=.eec5704628f8.

[8] The agreement between CMS and issuers contemplated termination if cost-sharing reductions become unavailable. Indeed, the first page of the agreement between CMS and the issuers indicates that "[i]t is anticipated that periodic APTCs, advance payment of CSRs, and payments of FFE user fees will be due between CMS and QHPI." Eyles Decl. ¶ 8. The individual QHP agreements similarly provide: "CMS acknowledges that QHPI has developed its products for the [Exchange] based on the assumption that APTCs and CSRs will be available to qualifying Enrollees. In the event this assumption ceases to be valid during the term of this Agreement, CMS acknowledges that Issuer could have cause to terminate this Agreement subject to applicable state and federal law."

costs for those issuers who remain in the Exchanges—costs for which they did not account when setting premiums for 2018.

Furthermore, any assertion that paying cost-sharing reductions to issuers that have built the absence of such payments into their rates for 2018 will result in a windfall for most issuers, *see, e.g.*, Wu Decl. ¶ 19, is untrue. AHIP supports the goal of ensuring that consumers receive the benefit of continuous funding for cost-sharing reduction assistance, which makes it more affordable for low- and middle-income Americans to see their doctor or fill their prescriptions. If relief is granted, plans stand ready to work with states to operationalize any changes required to meet this goal.

C. After-The-Fact Recovery Of Cost-Sharing Reduction Payments Cannot Negate The Harms

As the Court observed in its October 19, 2017 Order regarding briefing, there are strong arguments to be made that issuers could recover cost-sharing reduction payments in a Tucker Act suit. But even putting aside the uncertainty inherent in any litigation, the balance of harms would remain unchanged. The reality is that the prospect of later recovery would not avert the immediate and destabilizing impacts (as just described) on individuals entering the open enrollment period, issuers' decisions to participate in Exchanges, premiums that have already been filed or will be adjusted, and the individual insurance market more broadly.

It is no accident that cost-sharing reduction payments are "made in advance" and on a "periodic and timely" ongoing basis, and only thereafter reconciled. Centers for Medicare & Medicaid Servs., Manual for Reconciliation of Cost-Sharing Reduction Component of Advance

Payments for Benefit Year 2016, at 6 (Dec. 27, 2016) ("Reconciliation Manual")[9]; *see also* 42 U.S.C. §§ 18071(c)(3)(A), 18082(a)(3). Such a system ensures that issuers are able to fund the reductions during the course of the year, but are not over-reimbursed for providing that benefit to enrollees. As the Department of Health and Human Services explained when it first decided to make monthly period payments:

> We proposed to implement a payment approach under which we would make monthly advance payments to issuers to cover projected cost-sharing reduction amounts, and then reconcile those advance payments at the end of the benefit year to the actual cost-sharing reduction amounts. This approach fulfills the Secretary's obligation to make "periodic and timely payments equal to the value of the reductions" under section 1402(c)(3) of the Affordable Care Act. We expect that this approach would not require issuers to fund the value of any cost-sharing reductions prior to reimbursement.

78 Fed. Reg. 15,410, 15,486 (Mar. 11, 2013) (internal footnote omitted).

A backward-facing litigation remedy would make little sense within that statutory and regulatory construct. Issuers would not only receive their reimbursements well after the period envisioned by Congress, but would find themselves perpetually embroiled in litigation of unknown length as unreimbursed cost-sharing reduction payments continued to accrue. That is no way to run an ongoing program and no basis for a stable and sound business relationship between the federal government and contracted entities.

Even ignoring the impracticality of pursuing such relief—not to mention the associated litigation costs and risk—such after-the-fact reimbursement possibilities are insufficient to advance affordability. Although issuers may seek (or may be required by actuarial soundness requirements) to increase premiums in the future to address any uncertainty regarding the availability of cost-sharing reduction payments, they ordinarily cannot charge additional

[9] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Final-Manual-for-Reconciliation-of-the-Cost-Sharing-Reduction-Component-of-Advance-Payments-for-the-2016-Benefit-Year.pdf.

premiums in future years to recover a past year's losses. *See, e.g.*, American Academy of Actuaries, Actuarial Practices Relating to Preparing, Reviewing, and Commenting on Rate Filings Prepared in Accordance with the Affordable Care Act 19 (Oct. 2012) (suggesting that, in providing written explanation for rate increase, issuers should "includ[e] a statement that the rating is prospective and that the insurer is not recouping past losses").[10]

Moreover, it should not be overlooked that, until now, cost-sharing reduction payments dating back to 2014 have always been made on a monthly basis. Indeed, robust agency instruction does not appear to have contemplated any other payment schedule. *See, e.g.*, 45 C.F.R. § 155.1030(b)(3); 79 Fed. Reg. 13,744, 13,805 (Mar. 11, 2014); Reconciliation Manual 36, 38, *supra*; Centers for Medicare & Medicaid Servs., Standard Companion Guide Transaction Information, Instructions Related to the ASC X12 Benefit Enrollment and Maintenance (834) Transaction 16 (July 2016). And issuer contracts to participate in Exchanges routinely specify that monthly payments are a government obligation. In the face of that considered and longstanding position, the Administration's blanket assertion (backed by no authority) that the "past practice of making monthly [cost-sharing reduction] payments is no more binding on the Government than is any other informal agency procedure," Defs. Br. 27, is wrong. For example, a "preamble" to a final rule—like the one quoted above that established monthly payments—can "bind either [the agency] or regulated parties," even "[a]bsent an express statement to that effect," because a court "may yet infer that the agency intended [a] preamble to be binding if what it requires is sufficiently clear." *Kennecott Utah Copper Corp. v. U.S. Dep't of Interior*, 88 F.3d 1191, 1223 (D.C. Cir. 1996). More broadly, as the Supreme Court has made clear, an agency bears a heightened burden when, as here, it shifts positions and "its prior policy has

[10] http://www.actuary.org/files/RRPN_100512_final.pdf.

engendered serious reliance interests." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009).

At bottom, the Administration's decision to cut off cost-sharing reduction payments has upended "the Government's long-run interest as a reliable contracting partner." *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2190 (2012). Issuers cannot be expected to set rates and make Exchange-participation and other individual market decisions without knowledge of whether and when cost-sharing reductions would be reimbursed. Forcing them to do so makes "willing partners more scarce," *id.*, and defeats core purposes of the program, *see King v. Burwell*, 135 S. Ct. 2480, 2492-2493 (2015) (declining to adopt reading of ACA that would "destabilize the individual insurance market ***, and likely create the very 'death spirals' that Congress designed the Act to avoid" because courts "cannot interpret federal statutes to negate their own stated purposes").

CONCLUSION

This Court should grant Plaintiffs' motion for a temporary restraining order and to show cause why a preliminary injunction should not issue.

Respectfully submitted,

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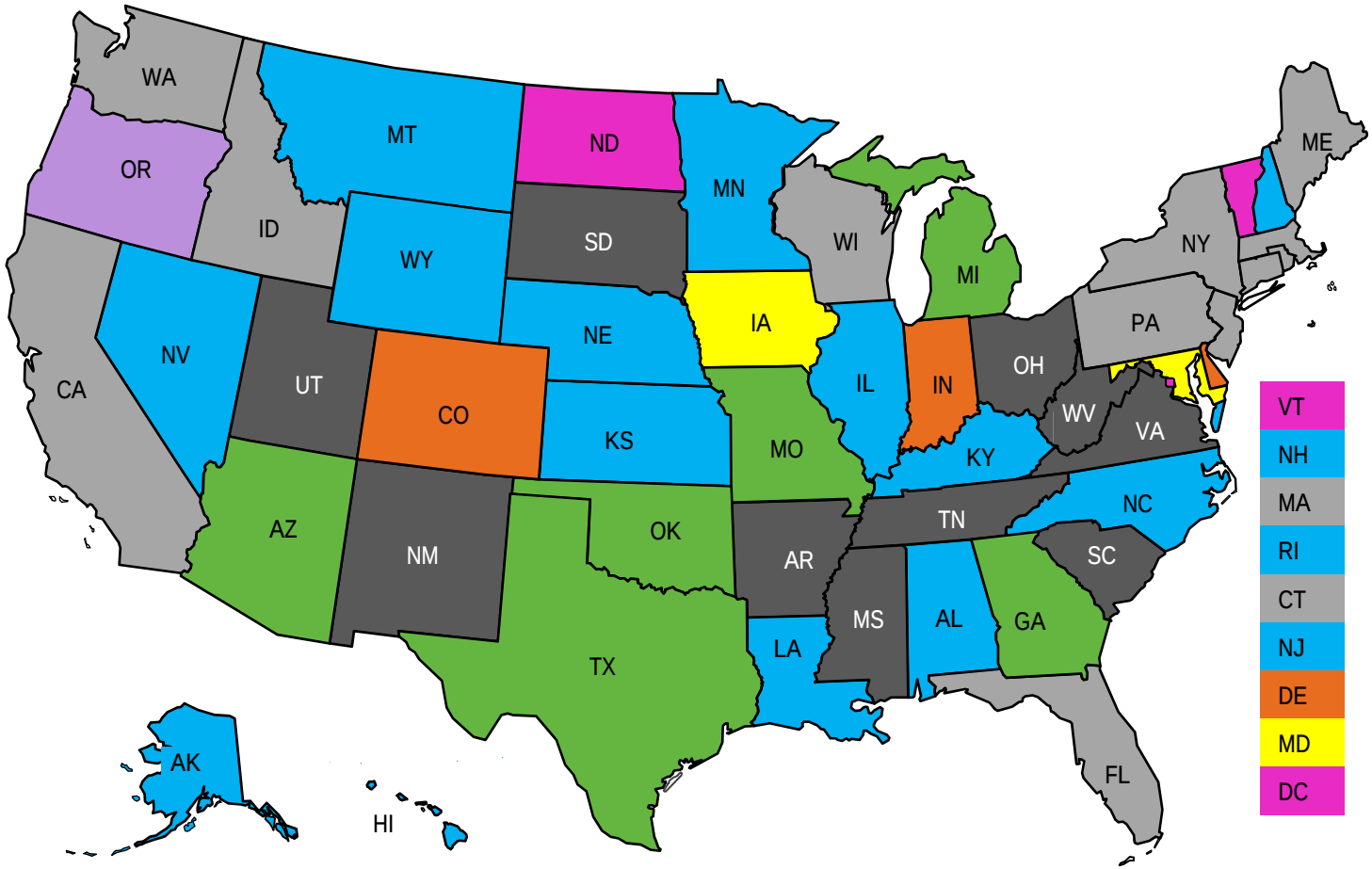
America's Health Insurance Plans

October 21, 2017

EXHIBIT A

2018 State Regulator Approaches to Individual Market Rates

AHIP
America's Health Insurance Plans



Key

Based on information available as of 3:00pm EST, October 20, 2017. Subject to change.

- CSR rate increases loaded into Silver plans; regulator issued guidance requiring 2 sets of rates
- CSR rate increases loaded into Silver plans; regulator issued other guidance on CSR uncertainty
- CSR rate increases loaded into Silver plans; formal guidance from regulator not issued or not available
- Regulator required 1 set of rates that assume CSRs are paid and the State determined CSR load for all carriers
- CSR rate increases loaded into all metal levels
- Regulator did not specify loading approach
- No rate increase allowed for CSRs
- Conflicting or missing information

Note: This represents AHIP's best efforts to describe the approaches used by state regulators to address the uncertain status of CSR payments. Given the fluid nature of events and the various guidance approaches, this map may contain inaccurate or outdated information.