[ORAL ARGUMENT NOT YET SCHEDULED]
No. 16-5202

IN THE UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

UNITED STATES HOUSE OF REPRESENTATIVES,

Appellee,

v.

SYLVIA MATHEWS BURWELL, IN HER OFFICIAL CAPACITY AS SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ET AL.,

Appellants.

On Appeal from the U.S. District Court for the District of Columbia

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AND BLUE CROSS BLUE SHIELD ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF NEITHER PARTY

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and D.C. Circuit Rule 26.1, counsel for *amici curiae* states that America's Health Insurance Plans and Blue Cross Blue Shield Association are unincorporated trade associations whose members have no ownership interests.

/s/Pratik A. Shah
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GLOSSARY

ACA	Affordable Care Act
AHIP	America's Health Insurance Plans
BCBSA	Blue Cross Blue Shield Association

CERTIFICATIONS UNDER FEDERAL RULE OF APPELLATE PROCEDURE 29 AND D.C. CIRCUIT RULE 29

Pursuant to Federal Rule of Appellate Procedure 29 and D.C. Circuit Rule 29, counsel for *amici curiae* certifies:

- that no party's counsel authored this brief in whole or in part;
- that no party or party's counsel contributed money that was intended to fund preparing or submitting this brief;
- that no person, other than *amici curiae*, their members, and their counsel, contributed money that was intended to fund preparing or submitting this brief;
- that all parties have consented or do not object to the filing of this brief; and
- that a separate brief was necessary because *amici curiae*, based on their unique health insurance issuer perspective and experience, provide practical insight beyond points addressed by other known *amici* and file this brief in support of neither party.

/s/Pratik A. Shah
Pratik A. Shah

STATEMENT OF INTEREST OF *AMICI 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.

The Blue Cross Blue Shield Association (BCBSA) is the trade association that coordinates the national interests of the independent, locally operated Blue Cross and Blue Shield Plans ("Blue Plans"). Together, the 36 independent, community-based, and locally operated Blue Plans provide health insurance benefits to nearly 107 million people—almost one-third of all Americans—in all

50 states, the District of Columbia, and Puerto Rico. The Blue Plans offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses, and individuals.

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 and BCBSA have participated as *amici curiae* in other cases to explain the practical operation of ACA. *See, e.g.*, *King v. Burwell*, No. 14-114 (U.S.); *Halbig v. Burwell*, No. 14-5018 (D.C. Cir.). Likewise here, AHIP and BCBSA seek to provide the Court with their unique expertise and experience regarding the operation of health insurance markets, the changes made by ACA, the objectives those changes advance, and the foreseeable consequences to consumers as well as to issuers that would follow from holding that Congress required issuers to reduce cost-sharing for qualifying beneficiaries but made no permanent appropriation to reimburse issuers for those cost-sharing reductions. AHIP's and BCBSA's perspectives will provide the Court with a deeper and more comprehensive understanding of the practical consequences of the parties' dispute.

INTRODUCTION & SUMMARY OF ARGUMENT

The Affordable Care Act (ACA) fundamentally changed our Nation's system of health insurance in the individual market from one based on individualized assessments of risk to one in which coverage is available regardless of health status through an interrelated collection of incentives and reforms intended to create a balanced risk pool. In order to make quality, affordable health insurance available to more Americans, ACA employed a now-familiar "three-legged stool" of interdependent reforms: insurance market reform, an individual mandate, and a schedule of subsidies. *See King v. Burwell*, 135 S. Ct. 2480, 2485-2486 (2015). This case concerns one important component of ACA's reforms related to the schedule of subsidies: cost-sharing reductions.

Cost-sharing reductions work in tandem with premium tax credits to make healthcare more affordable to millions of lower- and middle-income Americans. The statute recognizes that subsidizing the purchase of insurance coverage through premium tax credits alone is not sufficient to ensure that many such individuals can afford to access care from doctors, hospitals, and other healthcare providers. As a result, individuals and families with incomes up to 250% percent of the poverty line are eligible for cost-sharing reductions—to help cover, *e.g.*, deductibles, copays, and co-insurance—if they are eligible for a premium tax credit and purchase a silver plan through one of ACA's "Exchanges." These reductions are

provided seamlessly to enrollees by virtue of the fact that health plans pay an increased portion of the cost of care (in the amount of the reduction) directly to providers.

ACA requires all health insurance issuers participating in Exchanges to offer silver plans—where the issuer pays approximately 70% of healthcare costs—that include cost-sharing reductions to qualified individuals. At the same time, ACA provides that issuers are to be reimbursed by the federal government for assuming those costs (and no more). The district court has taken the view that these interconnected obligations are independent of each other: that issuers are required to provide cost-sharing reductions, but are not required to be reimbursed for these reductions if there is no annual appropriation. In the district court's view, the continued disbursement of those payments to issuers would be unlawful—not because ACA fails to provide for them, but because they are not funded annually by Congress.

Amici file this brief to lay out the consequences of the district court's summary judgment ruling for health insurance issuers, whose interests have not previously been represented in this litigation, and for the Americans who rely upon individual coverage. In particular, *amici* seek to assist the Court's understanding of how cost-sharing reductions are central to issuers' provision of, and consumers' access to, affordable healthcare. *Amici* also explain how the district court's

decision, if upheld without relieving health plans of the requirement to provide cost-sharing reductions, would lead to higher premiums for all enrollees (regardless of whether they were eligible for cost-sharing reductions), create untenable business uncertainty that threatens health plans' ability to participate in ACA's Exchanges, decrease plan options overall (by virtue of the fact that an issuer must offer a silver plan or forgo Exchange participation altogether), and consequently harm consumers.

Issuers must navigate a myriad of state and federal requirements when they agree to participate in the individual market (whether through Exchanges or otherwise), design healthcare coverage, and determine premium rates. It would not be feasible for those decisions to be made in the face of year-to-year doubt over whether Congress will fund substantial reimbursement for cost-sharing reductions. Among other realities, the deadlines for electing to participate in Exchanges and proposing rates for regulatory approval for the coming year would almost certainly pass *before* annual federal appropriations bills are enacted. To guard against the uncertain possibility of bearing those costs notwithstanding ACA's explicit reimbursement directive, issuers would face a choice with consequences that nobody desires: raise relevant premiums for silver-plan enrollees more than a thousand dollars on average to offset those unreimbursed costs, or decline to participate in Exchanges in the first instance. Both paths lead to fewer health

insurance options and higher costs across not only the Exchanges but the individual market as a whole, and therefore undermine ACA's affordability and coverage goals.

In the event the district court's judgment is upheld, *amici* also seek to alert the Court to significant potential consequences of an unanticipated mid-year disruption in cost-sharing reduction reimbursements. Despite being saddled with tens of millions of dollars in unreimbursed cost-sharing reductions at the government's behest, an issuer in some states may be prohibited from raising premiums or withdrawing from the Exchanges in the midst of a plan year. To the extent permitted by law, issuers elsewhere may take prompt steps mid-year to raise premiums to adjust for the unreimbursed costs or to cease offering coverage through the Exchanges altogether—a result that will create considerable uncertainty for consumers. Consistent with this Court's remedial authority, those realities should be taken into account before the Court permits an injunction that would immediately halt the very reimbursements that facilitated issuers' participation in Exchanges.

ARGUMENT

I. COST-SHARING REDUCTIONS PROVIDED BY ISSUERS, MADE POSSIBLE BY FEDERAL REIMBURSEMENT, ARE CRITICAL TO LOW-INCOME CONSUMERS' ACCESS TO AFFORDABLE HEALTHCARE

A. Many Low-Income Consumers Could Not Access Or Afford To Seek Care Without Cost-Sharing Reductions

Congress in ACA "adopt[ed] a series of interlocking reforms designed to expand coverage in the individual health insurance market." *King*, 135 S. Ct. at 2485. ACA integrates insurance market reforms, personal responsibility, and premium tax credits into a legislative package directed to making individual market coverage affordable and available regardless of health status. *See id.* at 2485-2486 (citing Br. for America's Health Insurance Plans as *Amicus Curiae* 10-11). Cost-sharing reductions—*i.e.*, reductions in the amount of consumers' financial responsibility when they seek care from doctors, hospitals, and other healthcare providers—are a critical part of this design and, in tandem with premium tax credits, allow consumers both to afford and to use their healthcare coverage.

The subsidies that ACA provides for premiums and cost-sharing reductions, the latter of which is directly at issue here, are inextricably linked elements of the same program. Eligibility for the premium tax credit is a precondition for cost-sharing reductions. 42 U.S.C. § 18071(f)(2). And both the premium tax credit and

the cost-sharing reductions are designed around the silver plan (*i.e.*, one of four "metal level" plans available on Exchanges aside from bronze, gold, and platinum). The amount of the premium subsidy is determined based on a benchmark silver plan in the applicable state, 26 U.S.C. § 36B(b)(2), and cost-sharing reductions are available only to those qualified individuals who enroll in silver plans.

While premium tax credits provide advance payments that reduce the purchase price of coverage, cost-sharing reductions make it possible for low-income consumers to use and access their coverage by reducing their cost-sharing. Without cost-sharing reductions, low-income consumers would be much less likely to visit the doctor when sick, fill prescriptions for critical drugs, or seek needed treatment for chronic conditions.

Here is how cost-sharing reductions work: Individuals and families with incomes up to 250% of the federal poverty level ($60,750 for a family of four in 2016) are eligible for cost-sharing reductions if they are eligible for a premium tax credit and purchase a silver plan through the Exchange in their state. The standard silver plan on an Exchange provides an "actuarial value" of 70%. 42 U.S.C. § 18022(d)(1)(B). That means the plan is structured so that the issuer pays 70% of the average enrollee's healthcare costs, leaving the enrollee responsible for the other 30% through cost-sharing (such as deductibles or copays). *See id.*

For individuals who are eligible for cost-sharing reductions and who enroll in silver plans, ACA requires issuers to reduce cost-sharing payments by the enrollee, thereby increasing the percentage (above 70% actuarial value) of the enrollee's healthcare costs the plan covers. 42 U.S.C. § 18071(c)(2). Each silver-plan variation—reflecting a specific level of cost-sharing reduction—will charge the same premium, cover the same benefits, and include the same healthcare providers in its network as the standard silver plan on which it is based. But the amount of cost-sharing assistance built into each variation, set in order to provide a certain actuarial value level specified by statute, depends on the enrollee's household income. *See id.*

These variations account for differences in low-income consumers' ability to pay deductibles and copays, and individuals are automatically enrolled in the plan variation that corresponds to their income level. For example, an individual with an annual income of $17,000 can access a silver plan cost-sharing variation with a deductible of $0.

Below is a chart setting out sample cost-sharing variations based on income for the 2016 plan year (actual figures or variations may vary by issuer and year):

How Does the Cost-Sharing Reduction Level Affect Cost-Sharing Charges?				
	Standard Silver—No CSR	CSR Plan for 201-250% FPL ($22,981-$28,725)	CSR Plan for 151-200% FPL ($17,236-$22,980)	CSR Plan for up to 150% FPL (up to $17,235)
Actuarial Value	70% AV	73% AV	87% AV	94% AV
Deductible (Individual)	$2,000	$1,750	$250	$0
Maximum OOP Limit (Individual)	$5,500	$4,000	$2,000	$1,000
Inpatient hospital (After deductible)	$1,500/ admission	$1,500/ admission	$250/ admission	$100/ admission
Physician visit (After deductible)	$30	$30	$15	$10

Center on Budget and Policy Priorities, *Key Facts: Cost-Sharing Reductions* tbl.1 (Dec. 3. 2015).[1]

Although premiums remain the same across silver-plan variations (subject to any premium tax credits), cost-sharing reductions on average save enrollees between $573 and $2,843 in annual deductible costs, which otherwise average $3,064 for a standard silver plan. *See* Matthew Rae et al., *Cost-Sharing Subsidies*

[1] http://www.healthreformbeyondthebasics.org/cost-sharing-charges-in-marketplace-health-insurance-plans-part-2/. "CSR" refers to cost-sharing reductions; "FPL" refers to federal poverty level; "AV" refers to actuarial value; and "OOP" refers to "out of pocket."

Cost-sharing reductions are also provided to American Indians/Alaska Natives at all qualified-health-plan "metal levels." Enrollees whose household income is not more than 300% of the federal poverty level bear no cost-sharing for healthcare services; enrollees with household incomes above that threshold have limited cost-sharing. *See* 42 U.S.C. § 18071(d).

in Federal Marketplace Plans, 2016, THE HENRY J. KAISER FAMILY FOUNDATION (Nov. 13, 2015)[2]; *see also* SARA R. COLLINS ET AL., THE COMMONWEALTH FUND, REALIZING HEALTH REFORM'S POTENTIAL: HOW WILL THE AFFORDABLE CARE ACT'S COST-SHARING REDUCTIONS AFFECT CONSUMERS' OUT-OF-POCKET COSTS IN 2016?, at 3 (Mar. 2016) ("REALIZING HEALTH REFORM'S POTENTIAL") (providing similar estimates).[3]

B. Issuers Rely On Reimbursement For Cost-Sharing Reductions To Fund Amounts That Otherwise Would Have Been Paid By Consumers

The process of providing cost-sharing reductions and reimbursing health plans for doing so is invisible to consumers. Consumers are determined eligible for one of the cost-sharing reduction variations at the time of enrollment and are entirely removed from the process by which health plans are reimbursed, even though the reimbursements are for healthcare costs that would be the responsibility of those consumers in the absence of cost-sharing reductions. When an individual with an income at or below 250% of the federal poverty level selects a silver plan and incurs claims, the issuer will pay those claims using the applicable adjusted

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[2] http://kff.org/health-costs/issue-brief/cost-sharing-subsidies-in-federal-marketplace-plans-2016/.

[3] http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/mar/1865_collins_aca_cost_sharing_rb_final_v3.pdf.

cost-sharing parameters so that the enrollee, without even realizing cost-sharing has already been reduced, pays the correspondingly reduced cost-sharing amount.

The health plan must then "notify the Secretary of such reductions and the Secretary shall make periodic and timely payments to the issuer equal to the value of the reductions." 42 U.S.C. § 18071(c)(3)(A). Under this program, the federal government pays health plans on a monthly basis for cost-sharing reductions and reconciles the amount of advance cost-sharing reduction payments provided to health plans throughout the year with the actual amount of cost-sharing reductions health plans provided on an annual basis. That scheme—advanced reimbursement followed by annual reconciliation—ensures that plans are able to fund the reductions during the course of the year, but are not over-reimbursed for providing that benefit to enrollees.

II. 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 *amici*'s members, it is imperative from an operational and business-planning perspective to know whether cost-sharing reduction subsidies will be covered by the federal government (as envisioned by ACA) ahead of filing premiums for state approval, committing to participate in the Exchanges, and making off-Exchange individual market decisions. The absence of such

knowledge 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. This is because there is a see-saw relationship 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 minimum essential coverage. As such, to the extent issuers are required to reduce cost-sharing for enrollees, issuers (absent reimbursements) would need to charge higher premiums. That premium increase would result in correspondingly higher premium subsidies for all premium-credit-eligible individuals, not just those eligible for cost-sharing reductions. *See* pp. 16-19, *infra*.

Of the approximately 11.1 million people enrolled through Exchanges in 2016, 9.4 million (~85%) are receiving premium subsidies, and nearly 6.4 million (~57%) are also receiving cost-sharing subsidies. *See* Centers for Medicare & Medicaid Services, *March 31, 2016 Effectuated Enrollment Snapshot* (June 30,

2016).[4] Given the current mix of enrollees in silver plans, the Department of Health and Human Services has 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) ("POTENTIAL FISCAL CONSEQUENCES").[5]

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 9 months in advance (*i.e.*, in April for coverage during the next calendar year) under schedules set by state law. *See* Kristi Wick, AHIP, 2017 QHP RATE FILING—KEY DATES (Apr. 18, 2016) ("KEY DATES").[6] And issuers begin the process of developing and pricing products up to a year before those deadlines.

If cost-sharing reduction reimbursements are paid from annual appropriations, enacted (at best) shortly before the beginning of the plan year that would include the relevant coverage, issuers are unlikely to know whether cost-sharing reductions will be reimbursed until six months or more *after* they have

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

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

[6] https://ahip.org/2017-qhp-rate-filing-key-dates.

filed rates with state authorities. *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").

In addition, initial applications to participate in the federal Exchanges for the next calendar year 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*.

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.[7] The district court's ruling would force issuers to make those decisions in the absence of critical information year after year. Such a system would be unworkable.

B. Issuers' Inability To Rely On Cost-Sharing Reduction Reimbursements Would Significantly Increase Premiums For Everyone In The Individual Market

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 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 to take on the risk of participating in Exchanges in the absence of guaranteed reimbursement for cost-sharing reductions, among other factors. *See* REALIZING HEALTH REFORM'S POTENTIAL 9, *supra* ("Facing substantial revenue shortfalls, many insurers would likely leave the

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[7] The per-capita value of cost-sharing reductions is estimated to be up to $1,070 (depending on the enrollee's income level and thus the level of the cost-sharing reduction). *See* IMPLICATIONS 7 tbl.2, *infra*. According to the Congressional Budget Office, cost-sharing subsidies will 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.

marketplaces[.]"). Such decrease in Exchange participation would reduce competition and the availability not only of silver-plan variations offering cost-sharing reductions but of other plans that may be purchased using premium tax credits across the "metal tiers," thus constricting a key segment of the individual market. *See* LINDA J. BLUMBERG & MATTHEW BUETTGENS, URBAN INSTITUTE, THE IMPLICATIONS OF A FINDING FOR THE PLAINTIFFS IN *HOUSE V. BURWELL* 8 (Jan. 2016) ("IMPLICATIONS") (forecasting that "insurers could begin to pull out of Marketplaces" if they "tire both of the instability and inability to plan and of the costs associated with changing their approaches to predicting appropriate premiums and developing systems to ensure that they are making a sufficient return on their Marketplace business")[8]; *see also* 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) ("More competition tends to put downward pressure on premiums.").[9]

Even for those issuers that continue participating in Exchanges, state law requirements regarding the actuarial soundness of plans would potentially require

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[8] http://www.urban.org/sites/default/files/alfresco/publication-pdfs/2000590-The-Implications-of-a-Finding-for-the-Plaintiffs-in-House-v-Burwell.pdf.

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

setting premiums as if there is no federal cost-sharing reduction reimbursement. *See, e.g.*, ALASKA STAT. § 21.87.190; CAL. INS. CODE § 10181.6; COLO. REV. STAT. § 10-16-107; CONN. GEN. STAT. § 38a-481; IDAHO CODE § 41-5206; MINN. STAT. § 62A.021; *see also* POTENTIAL FISCAL CONSEQUENCES 2 & n.3, *supra* (explaining that absent reimbursement "ACA would still require insurers to provide [cost-sharing reductions] to eligible individuals enrolling in silver plans," and that "[i]n order for insurers to remain solvent (as well as to comply with state insurance market regulations), insurance premiums must be set to cover issuers' expected total costs") (footnote omitted).

In either event, premiums would rise across the board and increase costs—including for those individuals who do not qualify for any subsidy, and for the federal government on account of increases in premium subsidies. *See* IMPLICATIONS 7-8, *supra* (projecting $1,040 rise in silver-plan premiums on average for a 40-year-old, and an aggregate increase in federal-government financial assistance of $3.6 billion per year and $47 billion total from 2016 to 2025). In addition, rising premiums used to cover unreimbursed cost-sharing reduction subsidies will cause some of the healthiest individuals to decline 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). That would ultimately lead to a deterioration of the risk pool and actuarially unstable health insurance coverage. *See* IMPLICATIONS 5, *supra* (stating that, because of "increase in silver plan premiums" under district court's decision, "those purchasing silver plan coverage without a tax credit under current implementation of ACA are strongly disincentivized to continue doing so"); REALIZING HEALTH REFORM'S POTENTIAL 9, *supra* (arguing that district court ruling "may lead many people, especially those in good health, to disenroll from their plans, an event that could destabilize marketplaces").

To be sure, issuers may be able to pursue other avenues to recoup cost-sharing reduction payments down the line. For instance, the government acknowledges that ACA requires the government to pay cost-sharing reductions to issuers and suggests that the absence of an appropriation does not necessarily preclude recovery in subsequent litigation. *See* Gov't Br. 53 n.10. But the fact that reimbursement for cost-sharing reductions are "made in advance" and on a "periodic and timely" ongoing basis, CENTERS FOR MEDICARE & MEDICAID SERVICES, DRAFT MANUAL FOR RECONCILIATION OF ADVANCE PAYMENT OF COST-SHARING REDUCTIONS FOR BENEFIT YEARS 2014 AND 2015, at 5 (2016)[10]; *see also* 42 U.S.C. § 18082(a)(3), makes a litigation remedy inapt. Issuers would not only

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[10] https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-Guidance-on-CSR-Reconciliation.pdf.

receive their reimbursements well after the period envisioned by Congress, but would find themselves perpetually embroiled in litigation as unreimbursed cost-sharing reduction payments continue to accrue. That is no way to run an ongoing program.

Moreover, 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 reimbursements, they ordinarily cannot charge additional 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").[11]

At bottom, issuers cannot be expected to set rates and make Exchange-participation and other individual market decisions without knowledge of whether cost-sharing reductions would be reimbursed. Doing so would defeat core

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

purposes of the program. *See King*, 135 S. Ct. at 2492-2493 (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").

III. MID-YEAR CHANGES IN THE COST-SHARING REDUCTION PROGRAM WOULD BE PARTICULARLY DISRUPTIVE TO ISSUERS AND ENROLLEES

In the event this Court affirms the district court judgment and thus must decide how to implement the injunction against cost-sharing reduction reimbursement (currently stayed pending appeal), *amici* urge the Court to avert potentially massive disruption to both issuers and enrollees. As some commentators have observed, the "importance of how such a change in policy is implemented cannot be overstated" because "the timing of such a potential change would be critical." IMPLICATIONS 2, 8 *supra*.

As noted, the government interprets ACA to require that issuers offer cost-sharing reductions even if the government fails to comply with the statutory mandate to make reimbursement payments. Because no party disputes that premise in this litigation, the Court should leave that issue for another day. But assuming *arguendo* the government's interpretation, a mid-year injunction halting payments could unexpectedly saddle issuers with upwards of $7 billion in

unreimbursed cost-sharing obligations for that plan year. *See* n.7, *supra*. That decoupling of the mandate and the reimbursement would represent a seismic shift in not only the foundations of the program, but also in the expectations of issuers currently participating in Exchanges. Health plans made those choices, and determined actuarially sound rates and premiums, based on the shared understanding that reimbursement would make cost-sharing obligations essentially cost-neutral.

There are two possible consequences that would flow from blowing up that understanding through an injunction cutting off cost-sharing reimbursements mid-stream. Federal regulations prohibit issuers from making mid-year changes to approved premiums. *See* 45 C.F.R. § 156.80(d)(3)(i). As a result, issuers that voluntarily participated in Exchanges for the current plan year—on the shared understanding that they would be facilitators, not funders, of cost-sharing reductions—may be left to foot the bill for a government program. The same would be true even if that federal regulatory prohibition could be waived by the government, because the ability to change premiums mid-year is also governed by state law and therefore may not be permitted in some states.[12] Additionally, contractual or state/federal-law requirements may preclude mid-year termination of

[12] *See, e.g.*, CAL. INS. CODE § 10901.9(c)(2) & CAL. HEALTH & SAFETY CODE § 1399.811(c)(2); OR. REV. STAT. § 743.022(3); WASH. REV. CODE §§ 48.44.021(1)(c)(vi), 48.44.022(1)(f), 48.46.063(1)(c)(vi), 48.46.064(1)(f).

coverage or withdrawal from Exchanges. *See, e.g.*, 42 U.S.C. § 300gg-2(c); 45 C.F.R. § 147.106(c).

In other instances, issuers may (to the extent permissible) take steps during the plan year to raise premiums in order to cover the unreimbursed cost-sharing reductions, or to terminate participation in Exchanges altogether. *See* IMPLICATIONS 8, *supra* (summarizing potentially "significant disruption").

This Court and the Supreme Court have recognized that the type of substantial disruption occasioned by either transitional scenario is to be avoided if possible. *See, e.g.*, *Northern Pipeline Constr. Co. v. Marathon Pipe Line Co.*, 458 U.S. 50, 88 (1982) (plurality opinion) (staying judgment to "afford Congress an opportunity to reconstitute the bankruptcy courts or to adopt other valid means of adjudication, without impairing the interim administration of the bankruptcy laws"); *Chamber of Commerce v. SEC*, 443 F.3d 890, 909 (D.C. Cir. 2006) (vacating rule but withholding mandate for 90 days because the "Commission is in a better position than the court to assess the disruptive effect of vacating the Rule's two conditions").

Prudence counsels in favor of a similar approach here in light of the potential "destabiliz[ation]" of the Exchanges and the ramifications for the broader individual market. REALIZING HEALTH REFORM'S POTENTIAL 9, *supra*. That is particularly true given that affirmance of the district court's ruling, in conjunction

with a lack of annual appropriations, would foist upon issuers an unfunded mandate that amounts to an unconstitutional taking. *See Student Loan Mktg. Ass'n v. Riley*, 104 F.3d 397, 403 (D.C Cir. 1997) (explaining that it "would largely gut the takings clause" if persons "earlier" provided "forms of financial incentives" by the government "were to wake up and discover that the government could subject them to a special tax"); *cf. Ashwander v. Tennessee Valley Auth.*, 297 U.S. 288, 348 (1936) (Brandeis, J., concurring) (interpreting statutes to avoid constitutional difficulties).

Accordingly, if this Court were to affirm the district court's legal conclusions, it should consider (at a minimum) staying the injunction until the cost-sharing reduction reimbursements have been paid for at least the calendar year in which the Court's decision is issued or for some period of time sufficient to allow issuers to pursue relief from state regulators or the Exchanges. Proceeding in that sensible manner would prevent additional harm to millions of consumers.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 4,955 words, and thus complies with the type-volume limitation set forth in Rule 29(d) and 32(a)(5) of the Federal Rules of Appellate Procedure.

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October 31, 2016

CERTIFICATE OF SERVICE

I hereby certify that, on October 31, 2016, I served the foregoing brief upon counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

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