2017-1224

United States Court of Appeals for the Federal Circuit

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, an Illinois Non-Profit Mutual Insurance Corporation,

Plaintiff – Appellant,

v.

UNITED STATES,

Defendant – Appellee.

Appeal from the United States Court of Federal Claims in Case No. 1:16-Cv-00744-CFL, Judge Charles F. Lettow

BRIEF OF AMICUS CURIAE NATIONAL ALLIANCE OF STATE HEALTH CO-OPS IN SUPPORT OF APPELLANT LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY FOR THE REVERSAL OF THE COURT OF FEDERAL CLAIMS

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UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, an Illinois Non-Profit Mutual Insurance Corporation **v.** UNITED STATES

Case No. 2017-1224

CERTIFICATE OF INTEREST

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

NATIONAL ALLIANCE OF STATE HEALTH CO-OPs

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

1. Full Name of Party Represented by me	2. Name of Real Party in interest (Please only include any real party in interest NOT identified in Question 3) represented by me is:	3. Parent corporations and publicly held Companies that own 10 % or more of stock in the party
NATIONAL ALLIANCE OF STATE HEALTH CO-OPs	NATIONAL ALLIANCE OF STATE HEALTH CO-OPs	None

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (**and who have not or will not enter an appearance in this case**) are:

Barak A. Bassman and Marc D. Machlin
PEPPER HAMILTON LLP

February 7, 2017
Date

/s/ Barak A. Bassman
Signature of counsel

Please Note: All questions must be answered

Barak A. Bassman
Printed name of counsel

cc:

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STATEMENT OF RELATED CASES

No prior appeal related to the same civil proceeding has been filed.

A series of actions relating to risk corridors payments under the Affordable Care Act are pending in the Court of Federal Claims and in certain district courts that may be affected by the Court's decision in this appeal:

Name of the Case	Docket No.	Judge
Health Republic Insurance Company v. U.S. (Filed February 2016)	16 CV 00259	Judge Sweeney
First Priority Life Insurance Co, Inc., Highmark Health Ins., et al. v. U.S. (Filed May 2016)	16 CV 00587	Judge Wolski
Moda Health Plan, Inc. v. U.S. (Filed June 2016)	16 CV 00649	Judge Wheeler
BCBS of NC v. U.S. (Filed June 2016)	16 CV 00651	Judge Griggsby
Maine Community Health Options v. U.S. (Filed August 2016)	16 CV 00967	Judge Merow
New Mexico Health Connections v. U.S. (Filed September 2016)	16 CV 01199	Judge Bruggink
BCBS of Idaho v. U.S. (Filed October 2016)	16 CV 01384	Judge Lettow
Minuteman Health v. U.S. (Filed October 2016)	16 CV 01418	Judge Griggsby
BCBSM v. U.S. (Filed October 2016)	16 CV 01253	Judge Williams
Montana Health Co-Op v. U.S. (Filed October 2016)	16 CV 01427	Judge Wolski
Alliant Health Plans, Inc. v. U.S. (Filed November 2016)	16 CV 01491	Judge Braden
Blue Cross and Blue Shield of South Carolina and Blue Choice Health Plan of South Carolina, Inc. v. U.S. (Filed November 2016)	16 CV 01501	Judge Griggsby
Health Net, Inc. v. U.S. (Filed December 2016)	16 CV 01722	Judge Wolski
Gerhart v. U.S. (Filed May 2016)	16 CV 151 (S.D. Iowa)	Judge Ebinger
Neighborhood Health Plan Incorporated v. U.S. (Filed December 2016)	16-cv-01659	Judge Bruggink

Name of the Case	Docket No.	Judge
Blue Cross and Blue Shield of Kansas City v. U.S. (Filed January 2017)	17-cv-00095	Judge Braden
HPHC Insurance Company, Inc. v. U.S. (Filed January 2017)	17-cv-00087	Judge Griggsby
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Molina Healthcare of California, Inc., et al. v. U.S. (Filed January 2017)	17-cv-00097	Judge Wheeler

I. STATEMENT OF IDENTITY AND INTEREST OF AMICUS CURIAE NATIONAL ALLIANCE OF STATE HEALTH CO-OPs

Amicus Curiae National Alliance of State Health CO-OPs ("NASHCO")[1] is a non-profit trade association. Its membership consists of non-profit health insurance Consumer Operated and Oriented Plans that were established pursuant to section 1322 of the Patient Protection and Affordable Care Act ("Affordable Care Act," "ACA," or "Act"). *See* 42 U.S.C. § 18042.

NASHCO and its members have a vital interest in the outcome of this case. All CO-OPs are required by law to participate in the health care exchanges created by the ACA. *See generally* 45 C.F.R. §156.515(c). As a result, all of NASHCO's members participated in the risk corridors program that is the subject of this appeal. NASHCO's current members are owed in excess of $100 million in unpaid risk corridors receivables from HHS. Two of NASHCO's members, Minuteman Health and New Mexico Health Connections, have filed actions in the United States Court of Federal Claims seeking to recover monies owed under the risk corridors program. *Minuteman Health Inc. v. United States*, No. 16-1418C; *New Mexico Health Connections v. United States*, No. 16-1199C. Additional members are part of the class identified in *Health Republic Insurance Company v.*

[1] Pursuant to Federal Rule of Appellate Procedure 29(a), NASHCO has received consent from counsel for Land of Lincoln and the United States to file this *amicus curiae* brief.

United States, No. 1:16-cv-00259. Recovery of these unpaid debts from HHS is crucial to the future growth and success of NASHCO's members. NASHCO's members thus have a compelling interest in the outcome of this action.[2]

II. SUMMARY OF ARGUMENT

This appeal (and the more than dozen additional similar cases pending in the Court of Federal Claims) arises from the government's bait and switch in inducing health insurance carriers to enter the exchange marketplaces created by the ACA by promising to backstop certain insurance underwriting losses through the risk corridors program, but then defaulting on the payments when they came due. This is not the result that Congress intended at the time the ACA was enacted. To the contrary, the plain and unambiguous terms of the ACA mandate full payment of risk corridors funds to carriers pursuant to a detailed payment formula that Congress itself wrote into the text of the statute. 42 U.S.C. § 18062(b). The lower court's refusal to enforce this clear payment obligation should be reversed.

The CO-OPs, which are small new entrants to the health insurance market, have been hit particularly hard by the government's default on its risk

[2] This Brief was not authored, in whole or in part, by counsel for any party. No party, party's counsel, or any person other than NASHCO and its members, contributed money that was intended to fund preparing or submitting this Brief. Land of Lincoln was formerly a member of NASHCO, but its membership has lapsed.

corridors obligations. Congress created the CO-OP program to bolster health insurance competition through member-oriented non-profit carriers which would be required to use their profits either to reduce premiums or to improve product offerings. Congress appropriated billions of dollars of funding for loans to new CO-OPs to get them off the ground in time for the launch of the exchanges on January 1, 2014. But there was a catch: CO-OPs, unlike incumbent carriers, were required to participate on the exchanges every year, offering at least two-thirds of their plans to individuals and small groups, and could not withdraw based upon changing market conditions. And, as new entrants into a new health insurance marketplace intended to insure previously uninsured individuals, they had to make this commitment without having data on the prospective patient population that would help them assess the risk.

Prospective CO-OPs were thus faced with a dilemma: how to deliver on the opportunity to use the government loan program to drive greater innovation and member accountability in health insurance while mitigating the risk that the newly insured population, about whom they had minimal to no underwriting data, would turn out to be sicker than expected, leaving them with huge unanticipated losses but no way to exit from the exchanges. The government offered the answer; it repeatedly assured the CO-OPs that the risk corridors program would be

available for the first three years of the exchanges to mitigate such losses, after which time the CO-OPs would have enough data to set their premiums accurately.

With this assurance, many CO-OPs were formed and entered the market in individual states; close to half the states benefitted on day one of the exchanges from improved price competition and innovative product offerings from the CO-OPs. Unfortunately, claims for the newly insured population turned out to be much greater than expected by almost all carriers in the market, triggering large losses at the CO-OPs in 2014 and 2015. But when it came time for the government to backstop these losses by paying up under the risk corridors program, the government shirked its responsibility, paying only a small fraction of the amount due. Many CO-OPs were thus faced with unsustainable losses and, since they were required by law to focus on offering insurance through the public exchanges and were without sufficient reserves due to their infancy, they often had no viable path forward. The majority of the original twenty-three CO-OPs were forced into liquidation, including Land of Lincoln, and consumers were deprived of competitive, lower cost insurance options in markets around the country. This was not what Congress intended for the CO-OP program.

The surviving CO-OPs are entitled to receive the risk corridors funds they are owed under the unambiguous risk corridors program terms as set forth in the ACA. These are non-profit entities that have been able to survive the

incredible and unfair headwinds created by the government's administration of the exchanges; and they have been able to preserve the enhanced innovation and competition Congress sought to foster in creating the CO-OP program. They represent the last of the limited, and in some counties, the only choice for consumers on the Marketplace. NASHCO thus respectfully submits that the lower court's judgment should be reversed.

III. ARGUMENT

A. Congress Created the CO-OP Program to Bolster Competition and Consumer Choice in Health Insurance.

Congress enacted the Affordable Care Act to "increase the number of Americans covered by health insurance and decrease the cost of health care." *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2580 (2012); *see also* 42 U.S.C. § 18091(2)(C) (stating that the Act will have the effect of "add[ing] millions of new customers to the health insurance market" and "increas[ing] the number and share of Americans who are insured"). The ACA mandated, for the first time, that every American be permitted the opportunity to purchase a health insurance policy ("guaranteed issue") and that carriers could not underwrite policies, charging differing rates based upon each individual's differing medical history, such as preexisting conditions ("community rating"). ACA, Pub. L. No. 111-148, § 1201(2)(A); 42 U.S.C. §§ 300gg-1 - 300gg-5.

The goals of increased access to health insurance and lowered costs could not be achieved, however, without robust competition among health insurance carriers to generate attractive options for consumers and to drive down premiums. This was a real hurdle, as health insurance markets around the country have been plagued for decades by lack of competition. Over time, the number of competitors has declined, and the level of concentration has increased. *See e.g.,* Nancy Lopez, *The Consumer Operated and Oriented Plan (CO-OP) Program*, HEALTH REFORM GPS, at 1 (June 22, 2011) ("in most states 3 or fewer for-profit insurance companies account for over 65% of the market"); Leemore S. Dafny, *Evaluating the Impact of Health Insurance Industry Consolidation: Learning from Experience,* The Commonwealth Fund (Nov. 20, 2015), at 2, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2015/nov/1845_dafny_impact_hlt_ins_industry_consolidation_ib.pdf ("Between 2006 and 2014, the four-firm concentration ratio for the sale of private insurance increased significantly, from 74 percent to 83 percent"); *Focus on Health Reform: How Competitive are State Insurance Markets*, The Henry J. Kaiser Foundation (Oct. 2011), at 6, https://kaiserfamilyfoundation.files.wordpress.com/2013/01/8242.pdf (finding that "the current insurance markets in many states are highly concentrated with only modest competition"); *see also United States v. Aetna Inc.*, C.A. No. 16-1494,

2017 U.S. Dist. LEXIS 8490 (D.D.C. Jan. 23, 2017) (granting an injunction prohibiting the proposed merger of Aetna Inc. and Humana Inc. because further contraction would weaken what little competition exists).

Congress recognized the market reality that individuals and small businesses lacked sufficient affordable alternatives within the existing private insurance market, and that such alternatives were necessary to achieve the goal of near-universal health care coverage for all Americans. *See* Nancy Lopez, *The Consumer Operated and Oriented Plan (CO-OP) Program*, HEALTH REFORM GPS (June 22, 2011). After the failure of certain Congress members' attempts to create a government-funded "public option" to provide an insurance alternative on the new ACA health insurance exchanges[3], Congress created the CO-OP program to enhance competition and consumer choice.

An ACA CO-OP is a non-profit corporation organized under state law. *See generally* 42 U.S.C. § 18042(c). A CO-OP is obligated to use any profits it earns "to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members." *Id.* § 18042(c)(4). Substantially all of the activities of the CO-OP must consist of issuing CO-OP qualified health plans in the individual and small employer group markets;

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[3] *Id.*

substantially all of the CO-OP policies or contracts for health insurance likewise must be plans offered in those markets. *Id.* § 18042(c)(1)(B); 45 C.F.R.§ 156.515(c)(1).

Congress appropriated billions of dollars to HHS to fund start-up and solvency loans to finance the launch and growth of CO-OPs across the United States. 42 U.S.C. § 18042(g). The regulations promulgated by the Secretary of HHS provide that in order to receive these loans, the CO-OP must offer insurance plans on State "Exchange[s]." 45 C.F.R. §156.515(c). Thus, from the start, every CO-OP was obligated to participate in the Exchange marketplaces created by the ACA and had no ability to withdraw from them without breaching their loan agreements with HHS.

B. The CO-OPs Secure Loans and Commit to the Exchanges Based Upon HHS's Assurances of Risk Corridors Payments.

On January 5, 2012, CMS publicly issued Funding Opportunity No. OO-COO-11-001 to solicit loan applications from prospective CO-OPs. *See* HHS, et al., *Loan Funding Opportunity Number: OO-COO-11-001* (Dec. 9, 2011), https://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf. Between February 2012 and December 2012, HHS provided loans to 24 CO-OPs. *See* CCIIO, *Loan Program Helps Support Customer-Driven Non-Profit Health Insurers,* https://www.cms.gov/CCIIO/Resources/Grants/new-loan-program.html (last updated Dec. 16, 2014). In

order to secure a loan through the CO-OP program, an applicant was required to submit a detailed business plan for HHS's review. HHS, et al., *Loan Funding Opportunity Number: OO-COO-11-001*, at 13-14. These business plans were in turn expressly incorporated into and made part of the final executed loan agreements. Annie L. Mach & Grant A. Driessen, Cong. Research Serv., R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions* (2016), at 4 n.23, https://fas.org/sgp/crs/misc/R44414.pdf.

Prospective CO-OPs faced a significant challenge in crafting persuasive and viable business plans: while expected to come forward with a plan to bring new affordable insurance products into the exchanges, CO-OPs had virtually no underwriting data on the populations that they were going to cover. This was because the previously uninsured – the target population for the business plans – were, by definition, not captured in existing insurance data sets. Even for the previously insured, CO-OPs faced a disadvantage because, as new start-ups, they lacked historical claims data.

Congress had anticipated this problem. Thus, for the first three benefit years of the ACA exchanges (2014-2016), it created a "risk corridors" program to backstop carriers' losses if actual medical costs significantly outstripped premium revenues. *See* 42 U.S.C. § 18062(b). This provided a safeguard for carriers, especially new entrants focused on the exchanges, such as

the CO-OPs. Not only did it provide a safeguard for carriers, but also for the government's multi-billion dollar loan investment in the CO-OPs (which might otherwise have suffered unpredictable losses within the first three years). Specifically, if carriers overshot in aggressively lowering premiums to expand access to insurance at affordable prices – the very goals of the ACA – there would be a safety net to protect them until they had sufficient data to price their products more accurately. Conversely, if a carrier set prices too high in these first three years and reaped windfall profits, it owed money back to HHS, thus penalizing price-gouging behavior that could turn consumers away from the new exchange marketplaces.

Congress, through Sections 1342(b)(1) and (2) of the ACA, expressly established the payment methodology and formula for the risk corridors program:

> (b) Payment methodology
>
> (1) Payments out
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the

> sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
>
> (2) Payments in
>
> The Secretary shall provide under the program established under subsection (a) that if—
>
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
>
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

ACA, Pub. L. No. 111-148, § 1342(b) (codified at 42 U.S.C. § 18062(b)).

To determine whether a carrier pays into, or receives payments from, the risk corridors program, HHS compares allowable costs (essentially, medical claims costs subject to adjustments for health care quality, health IT, risk adjustment payments and charges and reinsurance payments) and the target amount (the difference between earned premiums and allowable administrative costs). Through this risk corridors payment methodology, carriers keep all gains and bear all losses that they experience within three percent of their target amount for a calendar year. For example, a carrier that has a target amount of $10 million in a given calendar year will not pay a risk corridors charge or receive a risk corridors

payment if its allowable charges range between $9.7 million and $10.3 million for that calendar year. Losses above the three percent threshold are partially reimbursed by HHS; gains above the three percent threshold are heavily forfeited back to HHS.

At the time that the CO-OPs were developing their business plans and weighing whether to commit their businesses irrevocably to the new exchanges before their launch in January 2014, HHS was aggressively reassuring them (and the rest of the industry) that risk corridors program payments would be made in full according to the statute's formula. For example:

- On July 11, 2011, HHS issued a fact sheet on HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment," stating that under the risk corridors program, "qualified health plan issuers with costs greater than three percent of cost projections ***will receive payments*** from HHS to offset a percentage of those losses." *Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment*, Healthcare.gov (July 11, 2011), https://web.archive.org/web/20110720093202/http:/www.healthcare.gov/news/factsheets/exchanges07112011e.html (emphasis added).

- On March 23, 2012, HHS implemented a final rule regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment. *See* Standards Related to Reinsurance, Risk Corridors, and Risk Adjustment, 77 Fed. Reg. 17,219 (Mar. 23, 2012). Although HHS did not expressly propose deadlines for making risk corridors payments, HHS stated that "QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." *Id.* at 17,238. The payment deadline for QHP issuers

to pay HHS under the risk corridors program is, for each applicable year, "within 30 days after notification of such charges" by the Government. *See* 45 C.F.R. § 153.510(d). There was no suggestion of anything less than full payment.

- On March 11, 2013, HHS publicly affirmed that the risk corridors program is not statutorily required to be budget neutral, *i.e.*, payments into the program do not have to equal payments out of the program. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409 (Mar. 11, 2013). HHS confirmed that, "***Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act***." *Id.* at 15,473 (emphasis added).[4]

C. HHS's Breach of Its Risk Corridors Obligations Cripples the CO-OP Program and Frustrates Congressional Intent to Enhance Competition.

In reliance upon, *inter alia*, these assurances of risk corridors funds, twenty-four CO-OPs entered into loan agreements, and twenty-two CO-OPs offered policies on the exchanges when the ACA marketplaces initially launched on January 1, 2014. Mach & Driessen, Cong. Research Serv., R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions* (2016), at 4. The increased competition from the new CO-OPs delivered

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[4] Even after the exchanges launched, HHS continued to represent that risk corridors payments would be made in full. For example, on July 21, 2015, HHS sent a "Dear Commissioner" letter to state insurance regulators reiterating that "We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Thus HHS urged that "these payments should be taken into account before decisions are made on final rates." Letter from Kevin J. Counihan, CEO of Health Insurance Marketplace & Dir. of CCIIO, to Commissioners (July 21, 2015).

immediate benefits to the public and to HHS. In 2014, in the twenty-two States that had CO-OPs, overall health insurance premiums were approximately eight to nine percent lower than in States without them.[5] NASHCO's member CO-OPs do even better: in Massachusetts, Minuteman Health has offered premiums up to *40%* lower than the three largest issuers in the state. Similarly, New Mexico Health Connections has continuously been the low cost leader for small group plans, offering the lowest cost or second lowest cost plan in each of New Mexico's five rating regions.

Lower premiums not only benefitted consumers, but also the coffers of the federal government. HHS provides subsidies to consumers to pay for many of the health insurance policies sold on the exchanges. *See* ACA, Pub. L. No. 111-148, §§ 1401-02 (codified at 26 U.S.C. § 36B, 42 U.S.C. § 18071). The lower the premiums charged, the lower the amount of the subsidies that HHS had to pay.

The CO-OPs thus kept up their end of the bargain with HHS, enhancing competition, expanding access to health insurance, and lowering premiums. The CO-OPs' lack of underwriting data to guide their rate-setting, though, led to underwriting losses at many CO-OPs as medical claims turned out to

[5] Health Insurance CO-OPs: Examining Obamacare's $2 Billion Loan Gamble: J. Hearing Before the Subcomm. on Energy Policy, Health Care and Entitlements of the H. Comm. on Oversight and Government Reform, 113th Cong. 36–37 (2014) (written statement of NASHCO Executive Director Jan VanRiper).

be higher than predicted. The CO-OPs were therefore counting on HHS's promises under the risk corridors program to make them largely whole.

But then came the bait and switch. In Fall 2015, the first risk corridors payments were due. Virtually every CO-OP was entitled to a risk corridors payment under the program for benefit year 2014, amounting to more than $500 million in total. Yet when the time came to pay, HHS defaulted on its obligations. Acting in response to Congressional restrictions on spending appropriations from the CMS Program Management Account, HHS stated that it would only pay *out* risk corridors obligations to the extent of payments made *in* to the program, resulting in the government making payments to the CO-OPs and other insurers of less than thirteen cents on the dollar. CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

The CO-OPs, unlike their competitors, did not have the option to withdraw from the exchanges or to diversify into other lines of business in reaction to the shortfall. Things only got worse the next year: in the fall of 2016, HHS announced that, for benefit year 2015, it would make no payments because any collections in 2015 would be used to fund the gaping deficits remaining for 2014 and there were no other available funds. CMS, *Risk Corridors Payment and*

Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf. Once again, the CO-OPs were owed hundreds of millions of dollars. *Id.*

Without the promised cushion of the risk corridors payments, many CO-OPs could not remain viable. Today, only six of the original twenty-three CO-OPs remain in business. Land of Lincoln itself is a defunct CO-OP. The failure of the government to provide risk corridors payments was a substantial and direct cause of the financial demise of many of these CO-OPs. *See* MAJORITY STAFF OF H. COMM. ON ENERGY & COM., 114TH CONG., IMPLEMENTING OBAMACARE: A REVIEW OF CMS' MANAGEMENT OF THE FAILED CO-OP PROGRAM (Sept. 13, 2016) ("House Report"), at 43-45, https://energycommerce.house.gov/sites/republicans.energycommerce.house.gov/files/documents/114/analysis/20160913Review_of_CMS_Management_of_the_Failed_CO_OP-Program.pdf.

The remaining CO-OPs are owed well in excess of $100 million in unpaid risk corridors funds for 2014 and 2015, and there will no doubt be millions more owed for 2016. The loss of these funds is hobbling the ability of the CO-OPs to compete and grow. This, in turn, is crippling or threatening to cripple competition in numerous insurance markets. For example:

- In New Mexico, while there are technically four competitors on the state's exchanges, two insurers are priced at high levels that render them uncompetitive, meaning that in reality there are only two viable competitors. Without the New Mexico CO-OP, there will be a virtual monopoly in individual health insurance in the state.

- In New Hampshire, where two CO-OPs competed in 2016, the Maine CO-OP has been forced to withdraw from the marketplace, leaving the Massachusetts CO-OP as one of only three principal commercial competitors left on New Hampshire's individual market exchange.

- In Wisconsin, Common Ground Healthcare Cooperative has enrolled thousands of members from other insurers who are no longer selling on the marketplace. In addition, it is the only marketplace carrier offering a Preferred Provider Organization (PPO) product in all 19 of the counties it services.

- In Maryland, the Evergreen Health CO-OP was the first new entrant into the marketplace in over 20 years, bringing competition to a market where the largest insurer has well over a 70% market share.

D. The Opinion Below Should Be Reversed Because The ACA Clearly and Unambiguously Mandates Payment of Risk Corridors Funds.

The opinion below wrongly denied Land of Lincoln's request to be paid the risk corridors funds it is owed and should be reversed. The ACA is clear on its face: applying the detailed formula that Congress itself wrote into the statutory text, the Secretary of HHS "***shall pay***" issuers amounts due under the program. *See* 42 U.S.C. § 18062(b) (emphasis added). Both the statute and the sole regulation issued by HHS, are plain and unambiguous in stating that HHS "**shall pay**" issuers and issuers "**will receive**" payments under the Risk Corridors

program. *See* 42 U.S.C. 18062(b); 45 C.F.R. 153.510 (emphasis added). That should be the end of the matter, because the agency is required to follow the plain and unambiguous statutory text. *See Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984); *White v. United States*, 543 F.3d 1330, 1333 (Fed. Cir. 2008).

But the lower court disagreed, finding two alleged ambiguities in the language of the ACA that supposedly grant HHS discretion to construe the statute so as to absolve the agency of its payment obligations. First, the lower court found that the statute is ambiguous as to *when* payment shall be made, and deferred to the agency's decision to make final payments only after the conclusion of the program's three-year timespan instead of through full annual payments. *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 104-08 (Fed. Cl. 2016). As it is now February 2017, the shelf life on this dispute is just about expired: the initial three year period of 2014-2016 is over and final risk corridors program calculations will be made this summer. The timing argument, regardless of its dubious merits,[6] is largely academic at this point.

It is thus the second supposed ambiguity found by the lower court that is truly dispositive. The lower court took the position that the statute is ambiguous

[6] *See generally*, *Health Republic Ins. Co. v. United States*, No. 16-259C, 2017 U.S. Claims LEXIS 8, at *39-*48 (Fed. Cl. Jan. 10, 2017) (finding that HHS is required to make *annual* risk corridors payments).

as to the *amount* to be paid, and thus deferred to HHS's position that the amount paid out under the risk corridors program is capped by the amount collected under the program (*i.e.*, that the program is "budget neutral"). *Land of Lincoln Mut. Health*, 129 Fed. Cl. at 106-08. The lower court erred in its reasoning. The lower court opinion nowhere disputes that the statute is clear on how to compute the amount owed; there is in fact a detailed formula in the very text of the ACA. Rather, the lower court found the statute ambiguous because the ACA does not set forth a specific appropriation to pay for any risk corridors payments due over and above the amount of monies collected in under the program. *Id.* at 107. The lower court then deferred to HHS's budget neutral interpretation as "consistent with the CBO's 2010 report, Congress's decision explicitly to authorize funds for other sections of the Act but not Section 1342, and Congress's choice to omit from Section 1342 the critical appropriation language used in the Medicare Program." *Id*.

But the lower court wrongly conflated the amount of the obligation and the means to pay it, which are legally distinct. It is well-established that a payment obligation of the United States is not defeated merely by the lack of a specific appropriation. *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966); *see also United States v. Langston*, 118 U.S. 389 (1886); *Prairie Cty., Mont. v. United States*, 782 F.3d 685, 689-90 (Fed. Cir. 2015); *Greenlee Cty. Ariz.*

v. United States, 487 F.3d 871, 877 (Fed. Cir. 2007); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949).

In the event that HHS does not have an appropriation with which to pay funds, the aggrieved party's recourse is to bring suit in the Court of Federal Claims. *N.Y. Airways*, 369 F.2d at 748. The unpaid amounts can then be paid from the Judgment Fund. *Slattery v. United States*, 635 F.3d 1298, 1316-17 (Fed. Cir. 2011).

The government argued below that this case is not merely an instance of a failure to appropriate funds to pay an obligation, but rather that Congress had always intended the program to be budget neutral. This is incongruous. How can the defendant argue that Congress failed to clearly state it did not intend to fund the payment provided by the law, thus purportedly triggering the need for agency construction of the ambiguous statutory text, while at the same time claim the statute unambiguously provides for budget neutrality?

Notably, Congress said nothing in the statutory text about payments out to carriers under the program being limited by payments in. To the contrary, the GAO opined that, before the 2015 spending bill, Congress had appropriated funds that could be used to pay the risk corridors receivables, which would seem to indicate an absence of budget neutrality. *See* GAO, B-325630, *HHS – Risk Corridors Program* (Sept. 30, 2014), http://www.gao.gov/assets/670/666299.pdf.

In fact, the ACA specifically provides that the risk corridors program shall be "based upon" a similar, earlier risk corridors program for Medicare Part D. ACA § 1342(a). That program was not administered by HHS to be budget neutral. *See* 42 U.S.C. § 1395w-115(e)(3)(A). Congress is presumed to be familiar with how agencies have administered and interpreted prior, similar programs when it writes laws. *Goodyear Atomic Corp. v. Miller*, 486 U.S. 174, 184-85 (1988).

The government can only point to two slim reeds to try to support its position, neither of which have merit. First, it leans heavily upon the CBO's budget scoring at the time of the ACA's passage. But that CBO analysis made no mention of risk corridors whatsoever. While the government contends that this was a tacit acknowledgement of legally-mandated budget neutrality, an analysis that completely omitted discussion of the risk corridors program can hardly be said to be probative of HHS's legal obligations under the program. At best, one could infer that the CBO was predicting no appropriations were needed for the program, a conclusion as consistent with a prediction that payments in would be high enough to fund payments out as it is with the government's sweeping legal conclusion. *See generally* Letter from Douglas Elmendorf, Director of CBO, to Nancy Pelosi, Speaker of House of Representatives (Mar. 20, 2010), https://www.cbo.gov/sites/default/files/cbofiles/ftpdocs/113xx/doc11379/amendreconprop.pdf. In fact, the Medicare Part D's risk-corridors program had historically

been revenue-positive for the Government, making it quite plausible for the CBO to predict a similar outcome under the ACA risk corridors program. *See* Obamacare: Why the Need for an Insurance Company Bailout?: Hearing before the H. Comm. on Oversight and Government Reform, 113th Cong. 38-43 (2014) (statement of Timothy Stoltzfus Jost, Professor of Law, Washington and Lee University).

Regardless, Congress does not vote on the CBO report; it votes on the statutory text, which here unambiguously triggered the right to payment. *Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009); *see also Ameritech Corp. v. McCann*, 403 F.3d 908, 913 (7th Cir. 2005). The CBO's views, whatever they may have been, do not have the force of law.

To the extent the CBO's opinion matters, the CBO's actual express discussion of the risk corridors program contradicts the government's litigation position. After passage of the ACA, the CBO affirmed that the program was not intended to be budget neutral. *See* Cong. Budget Office, Pub. No. 4869, *The Budget and Economic Outlook: 2014 to 2024* (2014), at 59, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf ("risk corridor collections . . . will not necessarily equal risk corridor payments, so that program can have net effects on the budget deficit").

Second, the government points to the fact that Congressional appropriations bills beginning in 2015 have forbidden the use of the CMS Program Management account to pay funds owed under the risk corridors program. This is irrelevant to Congress's intent years earlier in passing the ACA. *See e.g.*, *Massachusetts v. EPA*, 549 U.S. 497, 530 n.27 (2007) ("[P]ost-enactment legislative history is not only oxymoronic but inherently entitled to little weight") (quoting *Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005)).

Moreover, the spending bills cannot be considered some sort of repeal of the risk corridors program. There is nothing in their text purporting to alter the risk corridors statute itself. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242. And repeals by implication are strongly disfavored, especially as part of an appropriations rider. *Morton v. Mancari*, 417 U.S. 535, 549 (1974); *TVA v. Hill*, 437 U.S. 153, 190 (1978). All these bills did was to restrict the use of one accounting fund to make payments towards HHS's risk corridors debts.

The government has tried to point to isolated remarks in the legislative history of these spending bills to demonstrate Congress's alleged intent to alter the ACA to make the risk corridors program budget neutral. But grasping at snippets of comments made by a legislator here or there cannot undo the plain

meaning of the text of the actual statute. As explained by the Supreme Court, reliance on such legislative history is frowned upon because it is "often murky, ambiguous, and contradictory. Judicial investigation of legislative history has a tendency to become . . . an exercise in 'looking over a crowd and picking out your friends' . . . judicial reliance on legislative materials like committee reports, which are not themselves subject to the requirements of Article I, may give unrepresentative committee members—or, worse yet, unelected staffers and lobbyists—both the power and the incentive to attempt strategic manipulations of legislative history to secure results they were unable to achieve through the statutory text." *Exxon Mobil Corp. v. Allapattah Servs., Inc.*, 545 U.S. 546, 568 (2005) (quoting Patricia M. Wald, "Some Observations on the Use of Legislative History in the 1981 Supreme Court Term," 68 Iowa L. Rev. 195, 214 (1983)).

Moreover, even if the statutory text were somehow ambiguous (which it is not), the Court should only afford deference to a reasonable agency interpretation that is promulgated through notice and comment rulemaking or similar formal process. *Cathedral Candle Co. v. U.S. Int'l Trade Comm'n*, 400 F.3d 1352 (Fed. Cir. 2005). HHS's implementing risk corridor regulations (promulgated through notice and comment rulemaking) eliminate any alleged ambiguity in the statutory text – but in a way that demonstrates that Land of Lincoln should prevail. The regulations clearly provide that insurers "*will receive*

payment from HHS" without any limiting conditions such as a budget neutral implementation of the program. 45 C.F.R. § 153.510 (emphasis added). These unambiguous regulations are the *only* HHS pronouncements that would be entitled to *Chevron* deference accorded to notice and comment rulemaking.

Rather than looking to the clear text of the regulations issued after notice and comment, the lower court (and the government) look to the agency's post-2013 *ad hoc* subregulatory guidance, which for the first time and in direct contradiction of its prior statements, introduced the concept of budget neutrality. The lower court improperly relied on non-regulatory guidance (and additional preamble remarks) issued by CMS in 2014 and 2015 in which it announced its intention to implement the risk corridors program in a budget neutral way. *Land of Lincoln*, 129 Fed. Cl. at 92, 106. This guidance directly contradicted the agency's earlier 2013 statements publicly affirming that the program was *not* required to be budget neutral. *See supra* at 13.

And HHS had provided no explanation and justification for its abrupt flip-flop, much less the sort of nuanced assessment of statutory text and purpose that one would expect of an expert conducting a careful analysis. When an agency interpretation creates serious reliance interests – as HHS's pre-2014 statements plainly did in encouraging marketplace entrants – a subsequent reversal is facially arbitrary and capricious and unworthy of deference without a reasoned explanation

for that change. *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26 (2016).[7]

In the end, what Congress intended and enacted in the ACA was clear: to prevent premiums from being set artificially high due to the lack of underwriting data when the exchanges launched, Congress mandated that HHS pay out funds to reimburse certain underwriting losses in the early years of the exchanges, thus giving carriers the security they needed to launch on the exchanges with reasonably priced insurance products. This was especially critical to the CO-OP program that the ACA mandated, as new exchange-focused CO-OPs could not take off without some protection for their inability to price accurately before the newly insured population's data was available. When HHS defaulted on its obligations under the program, the ACA's goals of increased competition and lower prices were crippled: three-quarters of CO-OPs failed, and premiums on the exchange have been skyrocketing. *See CO-OP Catastrophe: Total Losses Near $1.9 Billion,* The Energy and Commerce Committee (Jan. 10, 2017), https://energycommerce.house.gov/news-center/blog-posts/co-op-catastrophe-total-losses-near-19-billion; *Obamacare Has Failed: The Affordable Care Act is Harming Individuals and Families,* U.S. House of Reps. Committee on the Budget

[7] For a more detailed explanation of this argument, *see* the opening brief of Land of Lincoln at 49-51.

(Jan. 3, 2017), http://budget.house.gov/uploadedfiles/obamacare_has_failed_-_why_it_needs_to_be_repealed.pdf. And competition on the exchanges is becoming virtually non-existent; nearly 36% of the exchanges will only have one participating insurer in 2017. Maria Castellucci, *One-Third of ACA Exchanges Will Lack Competition in 2017,* MODERN HEALTHCARE (Aug. 23, 2016), http://www.modernhealthcare.com/article/20160823/NEWS/160829982.

Enough is enough. NASHCO respectfully submits that it is time that the government be instructed to follow the terms of the ACA and to honor the terms of the risk corridors program, which should at least mitigate some of the adverse effects on consumers and communities from the government's years of past defaults.

IV. CONCLUSION

For the reasons set forth herein, the judgment of the court below should be reversed.

Dated: February 7, 2017

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for the Federal Circuit

Land of Lincoln Mutual Health Insurance Company v. US, 2017-1224

CERTIFICATE OF SERVICE

I, Elissa Diaz, being duly sworn according to law and being over the age of 18, upon my oath depose and say that:

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February 7, 2017

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