No. 2017-1994

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

On Appeal from the United States Court of Federal Claims
Case No. 1:16-cv-00649
Before the Honorable Thomas C. Wheeler.

BRIEF OF BLUE CROSS BLUE SHIELD ASSOCIATION AS *AMICUS CURIAE* IN SUPPORT OF PETITIONS FOR REHEARING EN BANC

Ursula A. Taylor
Sandra J. Durkin
Butler Rubin Saltarelli & Boyd LLP
321 North Clark Street
Suite 400
Chicago, Illinois 60654
(312) 444-9660

Counsel for Amicus Curiae
Blue Cross Blue Shield Association

August 13, 2018

CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, Counsel for *Amicus Curiae* Blue Cross Blue Shield Association certifies the following:

1. The full name of every party or amicus represented by undersigned counsel is:

   Blue Cross Blue Shield Association.

2. The names of the real party in interest (if the party in the caption is not the real party in interest) represented by undersigned counsel is:

   Not applicable.

3. All parent corporations and any publicly held companies that own 10 percent or more of the stock of the amicus represented by undersigned counsel are:

   None.

4. The names of all law firms and the partners or associates that appeared for the amicus now represented by undersigned counsel in the trial court or agency or are expected to appear in this court are:

   Ursula A. Taylor and Sandra J. Durkin, Butler Rubin Saltarelli & Boyd LLP.

5. The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal:

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Land of Lincoln Mutual Health Insurance Co. v. United States, No. 16-1224

Maine Community Health Options v. United States, No. 17-2395

Blue Cross Blue Shield of North Carolina. v. United States, No. 17-2154

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Maine Community Health Options v. United States, No. 17-1387C (Horn, J.)

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Vullo v. United States, No. 17-1185C (Wolski, J.)

Dated: August 13, 2018

/s/Ursula A. Taylor

Ursula A. Taylor
Sandra J. Durkin
Butler Rubin Saltarelli & Boyd LLP
321 North Clark Street
Suite 400
Chicago, Illinois 60654
(312) 444-9660

Counsel for Amicus Curiae
Blue Cross Blue Shield Association

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STATEMENT OF INTEREST OF AMICUS CURIAE[1]

Blue Cross Blue Shield Association ("BCBSA") is the non-profit association that promotes the national interests of thirty-six independent, community-based and locally-operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, the Blue Plans provide healthcare coverage to more than 106 million people-nearly one-third of all Americans-in every zip code in all fifty states, Washington D.C., and Puerto Rico. The Blue Plans are regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) ("ACA") and have been the leading providers of health insurance coverage in the ACA markets ("Exchanges").

The panel's decision in this appeal concerns the government's ability to alter statutory obligations under the ACA risk corridors program that were intended to stabilize the new ACA Exchange markets. Dkt. No. 87-1 ("Op.") at 4-5. The Blue Plans have a substantial interest in the panel's decision as highly-regulated entities and significant partners of the government in providing health insurance coverage. Pursuant to Federal Rule of Appellate Procedure 29(b), BCBSA files a motion for leave concurrently with this proposed brief.

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), counsel for *amicus* certifies that it authored this brief in its entirety and that no person or entity other than *amicus* or its counsel authored any part of this brief or made a monetary contribution intended to fund the preparation or submission.

SUMMARY OF ARGUMENT

The panel found that Congress indefinitely halted $12.3 billion in risk-stabilizing payments to health insurers through riders to annual budget legislation ("Appropriations Riders") passed nearly a year *after* insurers incurred significant losses partnering with the government to provide health insurance coverage to uncertain new populations. The panel did not find that Congress effectuated this intention expressly or by the words of the legislation. Rather, the panel found that an intention to retroactively suspend billions of dollars is *implied* from circumstances that occurred months after insurers trusted and relied upon the government's commitments. Op. at 31. The retroactive application of the Appropriations Riders based upon an implication of congressional intent found nowhere in the statutory language is misplaced. The equitable and jurisprudential implications of the panel's decision warrant *en banc* review.

Health insurers participating in the new ACA markets undertook significant risk and financial obligations with the expectation and assurance that the government would serve as a risk-bearing partner and honor its commitments. The purpose of the risk corridors program to stabilize the new ACA markets could not be realized without (i) trust from participating insurers that the government would fully satisfy its payment obligations and (ii) insurers' reliance upon those commitments in setting affordable healthcare rates. Retroactively relieving the

government of its obligations after insurers performed undermines the objective of the risk corridors program and the ACA in a manner that inflicts gross inequity upon participating insurers.

The panel's decision also threatens the well-established presumption against retroactive application of statutes and undisputed authority precluding implied repeal of a statutory mandate except where congressional intent is clearly manifest and, specifically, where the subsequent legislation is irreconcilable with the prior statute. The panel's decision is also contrary to established precedent holding that resort to extra-statutory sources of congressional intent is only permitted where a statute is ambiguous. *En banc* review is necessary in order to maintain consistency with these long-standing principles.

The Judiciary is charged with a responsibility to interpret the written law as part of the balance of power between the branches of the federal government. When the Legislature is seemingly at odds with itself, or with the Executive, it is the Judiciary that is empowered and required to bring stability and credibility to the letter of the law regardless of shifting political motivations or contradiction within or among the other branches. The guiding charge of the Court in this process is to interpret the law *as written*.

The panel's ruling that *one-sentence* Appropriations Riders retroactively and impliedly revoked stabilizing government payments relied upon by health insurers

undermines long-standing jurisprudence imposing high standards for changing a statutory mandate and the equitable principles upon which these standards rest. *En banc* review is necessary because of the gross inequity that would befall participating insurance companies and because the panel's decision threatens the credibility of the rule of law and the citizenry's interest in the government as a fair partner.

I. ARGUMENT

A. *En Banc* Review Is Justified by the High Standard for Altering Statutes and the Inequity Sanctioned by the Panel's Decision.

Repeal by implication is a "serious matter" and is "not favored," particularly where—as here—the purported repeal is by budget legislation and has a retroactive effect. *See* Dissenting opinion, Dkt. No. 87-1 ("Dissent") at 7-8, 11, 17-18. The standard that repeal must be "clearly manifest" and made "expressly, or by clear implication," Dissent at 8, 11, is grounded in principles of equity. *See Landgraf v. USI Film Prod.*, 511 U.S. 244, 270 (1994) ("The presumption against statutory retroactivity has consistently been explained by reference to the unfairness of imposing new burdens on persons after the fact."); *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191-92 (2012) ("Contractors need not keep track of agencies' shifting priorities and competing obligations; rather, they may trust that the Government will honor its contractual promises.") The Appropriations Riders fail to meet the standard for an implied and retroactive repeal for all the reasons set

forth by Petitioners (*see* Moda Petition at 6-14), and such a finding is justified by the important implications for health insurance markets.

Health insurers undertook significant risk and cost to offer coverage to the newly insured and made such commitments before Congress passed any of the Appropriations Riders.[2] Health insurance rates were proposed and submitted by insurers to state regulators in the spring before the applicable coverage year.[3] State regulators then reviewed and approved rates months in advance of the applicable coverage year.[4] Similarly, agreements between insurers and the federal government to participate and provide coverage on the ACA Exchanges were entered into in the fall prior to the applicable coverage year.[5]

Once health insurance rates were set, and agreements signed, insurers could not go back on their commitments to cover benefits for every enrollee for the entire

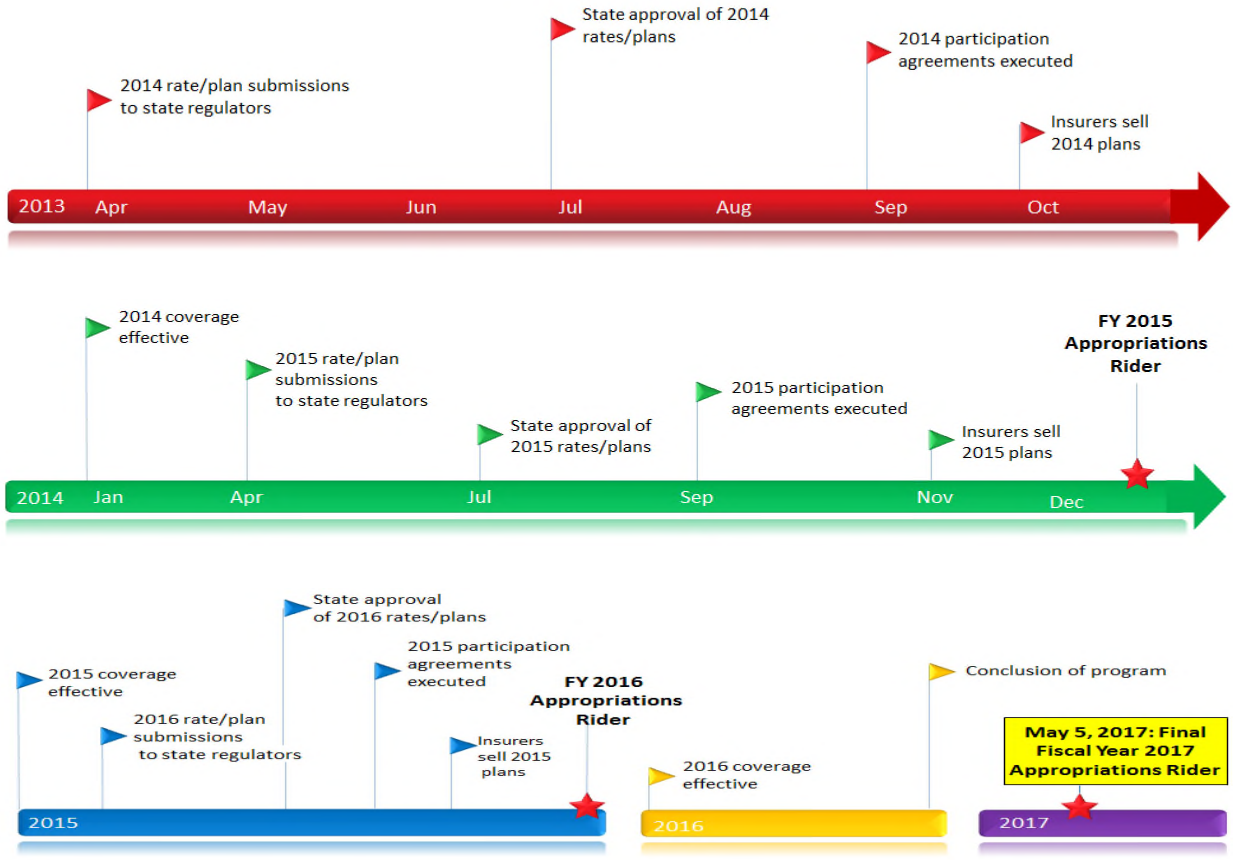
[2] Congress enacted three annual Appropriations Riders for fiscal years 2015-2017. Op. at 12-13.

[3] *See* Colorado Division of Insurance, Filing Approach and Timeline for the 2014 Plan Year at 17 (Mar. 28, 2013) (requiring insurers to submit 2014 rate filings by May 1, 2013), http://connectforhealthco.com/wpfb-file/20130503_board-and-stakeholders_rate-and-form-filing-timeline-for-the-2014-plan-year.pdf.

[4] *See* Oregon Division of Financial Regulation, Understanding Health Insurance Rate Review, at http://dfr.oregon.gov/healthrates/Pages/understanding-rate-review.aspx.

[5] *See* CCIIO, CMS, Affordable Exchanges Guidance at 20 (Apr. 5, 2013), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

coverage year at the approved rates.[6] However, the Appropriations Rider that the government contends cut off insurers' right to full payment was not passed until May of 2017—*after* the three-year risk corridors program had concluded. Dissent at 17 (noting the government's position that no risk corridors payments were due until the end of 2017). The timing of the significant undertakings by insurers relative to the Appropriations Riders is summarized as follows:



Thus, by the time Congress passed the final Appropriations Rider, insurers had designed, priced and sold qualified health plans, sought and obtained regulatory

[6] *See* 42 U.S.C. §§ 300gg-1–300gg-5; 45 C.F.R. § 156.290(a)(2); 45 C.F.R. §147.104(a).

approvals, committed to providing coverage and incurred substantial losses on the ACA Exchanges for all three years of the program.[7] In turn, the government substantially benefited from the lower premium rates that were made possible by insurers' trust that the government would satisfy its risk corridors commitments.

For example, in addition to the benefits of lower-cost health insurance and an increased number of covered enrollees,[8] the government paid less under a separate ACA program whereby the government is required to share premium costs for eligible insureds in the form of tax credits.[9] *See* 42 U.S.C. § 18082. By the panel's decision, the government would retain these benefits while forcing health insurers to bear costs far beyond what they bargained for when they agreed to participate in the ACA Exchanges.

Beyond the financial harms imposed on participating health insurers, the panel's decision poses a threat to any industry that deals with the government by

[7] Setting aside the government's position that risk corridors payments were not owed until 2017 (making the operative Appropriations Rider the fiscal year 2017 rider), insurers had participated in the new ACA Exchanges for nearly a year, and had set rates and committed to participation for the second year, by the time that Congress passed the first Appropriations Rider in December of 2014.

[8] *See* Barack Obama, United States Health Care Reform Progress to Date and Next Steps, 316 J. Am. Med. Assoc. 525, 527-28 (Aug. 2, 2016) (noting the early benefits of the ACA in terms of increased insured coverage rates and projected lower federal healthcare spending).

[9] Premium tax credits under ACA Section 1401 are available to eligible insureds according to household income and the cost of coverage available in the enrollee's geographic area. *See* 42 U.S.C. § 18082. Thus, the higher the premium, the more the government pays in the form of tax credits. *See id.*

undermining the credibility of the government as a reliable partner. *See United States v. Winstar Corp.*, 518 U.S. 839, 884 (1996) (noting that expanding opportunities for the government to abrogate its contracts undermines the Government's credibility and increases the cost of its engagements). The principle that the government must honor its commitments safeguards the expectations of those who deal with the government. *See Ramah Navajo*, 567 U.S. at 191.

The retroactive and implied suspension of risk corridors payments after insurers had performed their obligations constitutes a departure from long-standing jurisprudence disfavoring implied or retroactive repeal and yields gross inequity for participating health insurers who unwittingly agreed to provide coverage in the new and uncertain markets in trust and reliance upon the commitments and assurances of the government. The important equitable and jurisprudential implications of the panel's decision warrant *en banc* review.

B. A Purported Expectation of Budget Impact or a Subsequent Change in HHS Policy Do Not Support the Panel's Decision.

In reaching its decision, the panel relies upon a purported expectation by Congress that the risk corridors program would have "minimal, if any, budget impact." Op. at 8-9, 32. From there, the panel concludes that Congress passed the Appropriations Riders in an effort to ameliorate the allegedly unforeseen budget impact of an HHS policy that contributed to insurer losses and, thus, affected the

government's risk corridors payment obligations.[10] *Id.* The panel's reliance upon a purported budgetary expectation in discerning congressional intent is not only contrary to well-settled principles of statutory construction (*see* BCBSNC Petition at 14-16), but is also unjustified given the design and purpose of the risk corridors program.

The risk corridors program was not designed to achieve a particular budgetary outcome because such a design would not serve the purpose of the program to stabilize the new ACA health insurance markets. Insurers required certainty that the government was going to absorb a portion of losses in order to take the risk corridors program into account in setting affordable health insurance rates that would bring stability to the new ACA markets.[11] Thus, Congress designed the program such that specified percentages of profits and losses were to be shared between the government and insurers according to a statutory formula.[12] By contrast, a budget-neutral design—or a design that included a budgetary cap—

[10] The ACA required plans to meet certain requirements effective January 1, 2014. However, in November 2013 HHS announced a policy that allowed insurers to continue to offer non-compliant plans, which dampened enrollment, especially by healthier individuals who elected to maintain their prior coverage instead of buying coverage in the new ACA markets. Op. 8-9.

[11] *See* HHS Notice of Benefit and Payment Parameters ("NBPP") for 2014, 78 Fed. Reg. 15410, 15411 (Mar. 11, 2013) (the risk corridors program is designed to provide "greater payment stability" and "protect against uncertainty in rate setting").

[12] Risk corridor payments paid into and out of the program were to be based on the profits and losses incurred by participating insurers. *See* 42 U.S.C. § 18062.

would undermine the risk-stabilizing purpose of the program because an insurer's share of available funds could not be known, predicted or quantified in advance since they would depend upon the experience of other insurers. Uncertain payments undermine the program's risk-stabilizing objective because insurers cannot reasonably rely upon them in setting rates. The government's payment obligations were contained by virtue of the shared incentives of insurers and by the temporary nature of the program—not by a reasonable expectation that the program would have minimal budget impact.

In fact, the risk corridors program was designed and implemented on the premise that the only certainty with respect to the new ACA markets was *uncertainty*.[13] The losses sustained by insurers under the risk corridors program were not limited to the effects of the HHS policy, but rather resulted from a host of factors, none of which could have been accurately foreseen or quantified in advance, yet all of which were expected and required to be shared by the government.[14] Unforeseen budget impacts arising from the November 2013 HHS

[13] *See* HHS NBPP for 2014, 78 Fed. Reg. at 15410.

[14] *See* Obama, 316 J. Am. Med. Assoc. at 530 (noting issues with the healthcare.gov website); Robert King, Study: Special Enrollment Periods Add Costs to Obamacare, Washington Examiner (Oct. 5, 2016) (discussing problems with special enrollment periods), at http://www.washingtonexaminer.com/study-special-enrollment-periods-add-costs-to-obamacare/article/2603692.

policy only reinforce the need for a statutory risk-stabilizing program founded upon trusting reliance from insurers and immune from retroactive change.

By the Appropriations Riders, Congress did not effectuate intent to alter its overriding statutory payment obligations; rather, Congress precluded payment from certain specified funding sources, a congressional practice that is not uncommon. (*See* Moda Petition at 7-11.) This intent is apparent from the lack of any express words repealing or modifying the Section 1342's "shall pay" language in the Appropriations Riders and also by comparison to other provisions of the same budget legislation wherein Congress expressly repealed statutory provisions. *See* Consolidated and Further Continuing Appropriations Act, Pub. L. 113-235, H. R. 83 at Sec. 228(f) (Dec. 16, 2014)("Section 414 of the Social Security Act (42 U.S.C. 614) is repealed.") A congressional intent to leave intact Congress' statutory payment obligations is also evidenced by the failed efforts of Congress to amend the risk corridors program to require budget neutrality—the result now found by the panel. *See* Dissent at 5, 10 (citing Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014)).

Congress designed the risk corridors program to promote stability in the new and uncertain ACA markets, and Congress knew that achieving this purpose required insurers to trust and rely upon the government to share in losses that could

not be calculated in advance. Congress also knew how to effectuate a repeal of these statutory obligations. It did not do so with the Appropriations Riders.

The Court must read and apply Section 1342 and the Appropriations Riders "on the basis of what Congress has written, not what Congress might have written." *See United States v. Great N. Ry. Co.*, 343 U.S. 562, 575 (1952). When the other branches are in conflict with themselves or each other, the court's responsibility to interpret the laws as written becomes critical. *United States v. Cortes*, 697 F. Supp. 1305, 1311 n.9 (S.D.N.Y. 1988) ("The importance of separating the work of the Judiciary from the more political powers delegated to the other branches has been a central tenet of our system of government since its beginning."). *En banc* review is necessary for the Court to fulfill this responsibility and preserve trust in the rule of law and government process.

CONCLUSION

For the reasons stated above and in the briefs of Petitioners and *amici curiae*, the Court should grant rehearing *en banc*.

Dated: August 13, 2018

Respectfully submitted,

/s/ Ursula A. Taylor

Ursula A. Taylor
Sandra J. Durkin
Butler Rubin Saltarelli & Boyd LLP
321 North Clark Street
Suite 400
Chicago, Illinois 60654
(312) 444-9660

Counsel for Amicus Curiae
Blue Cross Blue Shield Association

CERTIFICATE OF COMPLIANCE

The undersigned hereby certifies that this brief complies with the type-volume limitation of Federal Rules of Appellate Procedure 29(b)(4) because it contains 2,590 words, excluding the parts exempted by Federal Rule of Appellate Procedure 32(f) and Federal Circuit Rule 32(b).

The undersigned also certifies that this brief complies with the typeface requirements of Federal Rule of Appellate Procedure 32(a)(5) and the type style requirements of Federal Rule of Appellate Procedure 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word in a 14-point Times New Roman font.

Dated: August 13, 2018

/s/ Ursula A. Taylor
Ursula A. Taylor

CERTIFICATE OF SERVICE

I hereby certify that, on August 13, 2018, I filed the foregoing ***Brief of Blue Cross Blue Shield Association as Amicus Curiae in Support of Petitions for Rehearing En Banc*** with the Clerk of Court using the U.S. Court of Appeals for the Federal Circuit's CM/ECF System, which will send notification of such filing to all counsel of record, which constitutes service pursuant to Federal Rule of Appellate Procedure 25(c)(2), Federal Circuit Rule 25(a), and the Court's Administrative Order regarding Electronic Case Filing 6(A).

Dated: August 13, 2018

/s/ Ursula A. Taylor
Ursula A. Taylor