No. 2017-1994

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

Appeal from the United States Court of Federal Claims
in Case No. 1:16-cv-00649, Judge Thomas C. Wheeler.

BRIEF OF BLUE CROSS BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLEE AND IN SUPPORT OF AFFIRMANCE OF THE COURT OF FEDERAL CLAIMS

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August 28, 2017

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

MODA HEALTH PLAN, INC. **v.** UNITED STATES

Case No. 17-1994

CERTIFICATE OF INTEREST

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

BLUE CROSS BLUE SHIELD ASSOCIATION

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
BLUE CROSS BLUE SHIELD ASSOCIATION	BLUE CROSS BLUE SHIELD ASSOCIATION	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:

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

8/28/2017
Date

/s/Ursula Taylor
Signature of counsel

Please Note: All questions must be answered

Ursula Taylor
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STATEMENT OF IDENTITY AND INTEREST OF AMICUS CURIAE[1]

Blue Cross Blue Shield Association ("BCBSA") is the non-profit trade association that promotes the national interests of the independent, locally operated Blue Cross Blue Shield health insurance companies ("Blue Plans"). Together, these thirty-six community-based 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 offer insurance products and services to a wide range of customers, from large private and public employer groups to small businesses and individuals. The Blue Plans have been working to make healthcare more affordable for patients since 1929, making the Blue Plans the oldest, most experienced health insurers in the country, and the backbone of the individual insurance market. More than eighty years later, the Blue Plans remain committed to making quality healthcare accessible and affordable to all Americans.

The Blue Plans are directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010),

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(4)(E), counsel for amicus curiae certifies that no counsel for a party authored this brief in whole or in part, no party or counsel for a party contributed money that was intended to fund preparing or submitting this brief, and no person other than the amicus curiae or its counsel contributed money that was intended to fund preparing or submitting the brief. Pursuant to Federal Rule of Appellate Procedure 29, all parties have consented to the BCBSA filing this amicus curiae brief.

amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA"), as issuers of Qualified Health Plans ("QHP issuers") on the ACA Exchanges. The Blue Plans have been the leading providers of health insurance coverage through the ACA Exchanges, and in some states, a Blues Plan is the largest, if not the only, insurance provider in the program. This appeal concerns the ACA's risk corridors program, one of several risk stabilizing mechanisms built into the ACA to enable insurers to participate in the new health insurance marketplaces in the early years of the ACA's implementation. In their role as highly-regulated entities and significant participants in the Exchanges, the Blue Plans have a substantial interest in the administration of the risk corridors program.

BCBSA files this brief to assist the Court in understanding the structure and function of the risk stabilization programs under the ACA, how the risk corridors program was designed to advance the purpose of the ACA, and why full and certain risk corridors payments are necessary in order for the risk corridors program to achieve its intended purpose. BCBSA also seeks to aid the Court in its understanding of the nature and timing of the obligations and undertakings by QHP issuers within the health insurance markets in relationship to risk corridors payments. BCBSA's perspective will, thus, provide the Court with a deeper understanding of the ACA risk corridors program within the health insurance

markets and why QHP issuers are entitled to full risk corridors payments under the statutory formula.

SUMMARY OF ARGUMENT

The trial court correctly held that Section 1342 of the ACA obligates the government to make full risk corridors payments to QHP issuers. This result is compelled by the plain language of the risk corridors statute, a comparison to the other two risk-stabilization provisions of the ACA, and the purposes of the risk corridors provision and the larger goals of the ACA.

The objective of the ACA is to provide affordable health insurance coverage to all Americans, regardless of health or condition. The ACA Exchanges provide the vehicle through which this is achieved with the assistance of private health insurers, offering health insurance plans to individuals and small groups. Private health insurers play a critical role in realizing the goals of the ACA by providing consumer choice and the ability to price health insurance products at competitive rates. In order to induce the participation of private health insurers, encourage affordable pricing, and bring stability to the new markets, Congress included mechanisms in the ACA to reduce the uncertainty faced by participating QHP issuers in providing coverage to the previously uninsured. Reduction of uncertainty was particularly important during the early years of the ACA when insurers lacked data regarding the health or size of the newly insured populations.

The risk corridors program was intended to reduce the risk faced by participating QHP issuers and create stability by requiring the government to share in any profits or losses above specified thresholds. The risk corridors program could not contribute to stabilizing the new ACA markets as intended, however, unless the required risk corridors payments were certain. QHP issuers could not have accounted for unknown and indeterminate receipts in pricing their plans.

The government incorrectly argues that it had no obligation to pay any risk corridors amounts unless and until contingent future events came to pass, namely the enactment of annual budget legislation three years after QHP issuers' began providing health insurance coverage via QHPs sold on the ACA Exchanges. At that point, the government argues that its obligation was limited to the amounts paid into the program. Not only does the government's interpretation negate the meaning of the mandatory "shall pay" language of the risk corridors statute and run contrary to established jurisprudence, but the government's interpretation would do nothing to serve the program's purpose of bringing stability to the new ACA Exchange markets through certain and knowable payments.

The incredulity of the government's positions becomes even more apparent when one considers and understands the nature and timing of the QHP issuers' obligations and undertakings. QHP issuers were required to undertake significant obligations in committing to the design and prices for QHPs and entering into

agreements with state and federal authorities years prior to the point at which the government argues it became necessary to even decide whether, or to what extent, to pay any risk corridors amounts. The government's interpretation cannot be reconciled with the practical realities of the health insurance markets, including the limitations and obligations imposed upon QHP issuers with respect to setting premiums, plan certification and coverage.

For all of these reasons and those advanced by the appellee and other amici curiae, BCBSA urges affirmance of the trial court's decision requiring full risk corridors payments.

ARGUMENT

I. THE ACA REQUIRES FULL RISK CORRIDORS PAYMENTS ACCORDING TO THE STATUTORY FORMULA.

The plain language of ACA Section 1342 requires that the government make full risk corridors payments to eligible QHP issuers. This Court should reject the government's claim that it may avoid this unambiguous statutory mandate and render the risk corridors provision ineffectual in advancing the ACA's stated goal of offering insurance market stability during the early years of its implementation. Contrary to appellant's argument, the risk corridors provision of the ACA was not designed to be budget neutral – risk corridors payments to eligible QHP issuers are wholly independent from payments into the system. Nor did the requirement of full risk corridors payment expose the government to uncapped liability. When

compared to related risk-sharing provisions of the ACA, it is clear that Congress intended eligible QHP issuers to receive risk corridors payments regardless of the revenue generated from more profitable participants and the amounts paid into the program.[2]

A. The Requirement of Full Risk Corridors Payments is Compelled by the Statutory Language of the ACA.

Section 1342 of the ACA, in pertinent part, sets out the payment methodology of the risk corridors program as follows:

> (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.

ACA § 1342 (codified at 42 U.S.C. § 18062 (2012)) (emphasis added). The highlighted statutory language above unambiguously requires that the HHS

[2] BCBSA wholly concurs with the reasoning and analysis of the trial court and the appellee that this result is further bolstered by HHS' rulemaking, guidance and repeated announcements assuring full risk corridors payments from the federal government to QHP issuers. (Appx26; Appellant Brief ("Br.") at 6-8.)

Secretary "shall pay" specific amounts to QHP issuers based upon each plan's ratio of costs to premiums collected. And, as the trial court correctly concluded, "the Section gives the Secretary ***no discretion*** to increase or reduce this amount":

> It is true that Section 1342(a) gives the Secretary the authority to "establish and administer" the risk corridor program, but the later directive that the Secretary "shall pay" unprofitable plans these specific amounts of money is unambiguous and overrides any discretion the Secretary otherwise could have in making "payments out" under the program. Finally, there is no language of any kind in Section 1342 that makes "payments out" of the risk corridor program contingent on "payments in" to the program. Instead, Section 1342 simply directs the Secretary of HHS to make full "payments out." Therefore, full payments out he must make.

(Appx23-24.) Just as QHP issuers whose collected premiums exceeded their plans' costs were obligated to make full payment of a specific amount *into* the risk corridors program (*see* ACA § 1342(b)(2) ("the plan shall pay")), so too is the government obligated to make full payments *out*, pursuant to the plain language of the ACA. The statutory language – "shall pay" – means nothing if, as the government contends, payments to QHP issuers are contingent upon highly speculative events such as the payments into the program or future Congressional legislative budget processes.

B. The Purposes of the Risk Corridors Provision and the ACA Are Not Served by Uncertain or Partial Payments.

In interpreting ACA Section 1342, the Court may look not only to the language of the statute, but also its structure and purpose. *Delverde, SrL v. United*

States, 202 F.3d 1360, 1363 (Fed. Cir. 2000); *Crandon v. United States*, 494 U.S. 152, 158 (1990) ("In determining the meaning of the statute, we look not only to the particular statutory language, but to the design of the statute as a whole and to its subject and policy.") The Court must reject those interpretations – such as the government's position here – that disregard the structure and purpose of the ACA.

Congress designed the risk corridors program to induce issuer participation and stabilize the Exchanges during the early years of ACA implementation when information concerning the newly insured populations was unknown. The object was to ameliorate the uncertainty surrounding the new markets and allow issuers to price plans at affordable levels by requiring that the government share in profits and losses suffered by the issuers. HHS Notice of Benefit and Payment Parameters ("NBPP") for 2014, 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013) (to be codified at 45 C.F.R. pts 153, 155, 156, 157 and 158) (the risk corridors program is designed to provide "greater payment stability as insurance market reforms are implemented" and "protect against uncertainty in rate setting" for QHP issuers by "limiting the extent of issuers' financial losses and gains."); *id.* at 15,413 ("The risk corridors program will protect QHP issuers in the individual and small group market against inaccurate rate setting and will permit issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets.). This purpose aligns with the broader goal of the ACA to help

ensure that every American has access to high-quality and affordable healthcare. *Id.* at 15,411. Without stabilizing mechanisms such as the risk corridors program, the uncertainty of the new markets would have been reflected in higher premium rates, higher prices would have discouraged participation by healthy enrollees, and the consequent risk pool (comprised of disproportionately unhealthy members) would have created further price pressure, threatening affordability and participation.

Congress intended full and certain payment of risk corridors to eligible QHP issuers to induce and encourage stability, affordability, and continued participation in the new Exchange markets in line with the goals and purposes of the program and the ACA. Interpreting the statute to mean that "[n]o payment obligation could arise without further action of Congress," as the government now argues (Appellant Br. at 20), would mean that it was not intended for the payments to be knowable, certain or in any way guaranteed. Without certainty as to the payments and payment amounts, however, QHP issuers could never have relied on risk corridors when pricing their policies and, accordingly, risk corridors would have had no effect in lowering premiums and stabilizing the markets – a result that runs contrary to achieving the fundamental purpose of the program. *King v. Burwell*, 135 S. Ct. 2480, 2484 (2015) (rejecting an interpretation of the ACA that would "destabilize the individual insurance market" and "create the very 'death spirals'

that Congress designed the Act to avoid."); S&P Global Market Intelligence, The Unfunded ACA Risk Corridor May Make the U.S. Insurance Market Less Stable, Not More (May 1, 2015)[3] ("Uncertainty of payment due to underfunding [of risk corridors] can cause volatility in the market for all participants.").

Congress intended the risk corridors program to require full and certain payments according to the statutory formula because otherwise the program would have served no rational purpose in stabilizing the early ACA markets. The government advances no logical reason as to why Congress would have devised a risk-stabilizing program premised on government payments yet "reserved its power" to decide years later whether or to what extent the obligations would actually ever be paid. (Appellant Br. at 31.) The Court should reject the government's interpretation as contrary to the language and purpose of the risk corridors statute.

C. Risk Corridors Is Not Designed for Budget Neutrality.

The risk corridors program is not designed to achieve budget neutrality. As detailed above, the statute requires that the government "shall pay" risk corridors amounts to QHP issuers according to a statutory formula. 42 U.S.C. § 18062(b)(1). Specifically, risk corridors calculations include a comparison

[3] Available at https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1396705&SctArtId=314008&from=CM&nsl_code=LIME&sourceObjectId=9141430&sourceRevId=5&fee_ind=N&exp_date=20250430-20:51:02.

between the QHP issuer's "allowable costs," which are defined as the QHP issuer's expenditures on medical care and quality improvement activities, on the one hand, and a "target amount," which is calculated as the issuer's premiums less administrative costs, on the other hand:

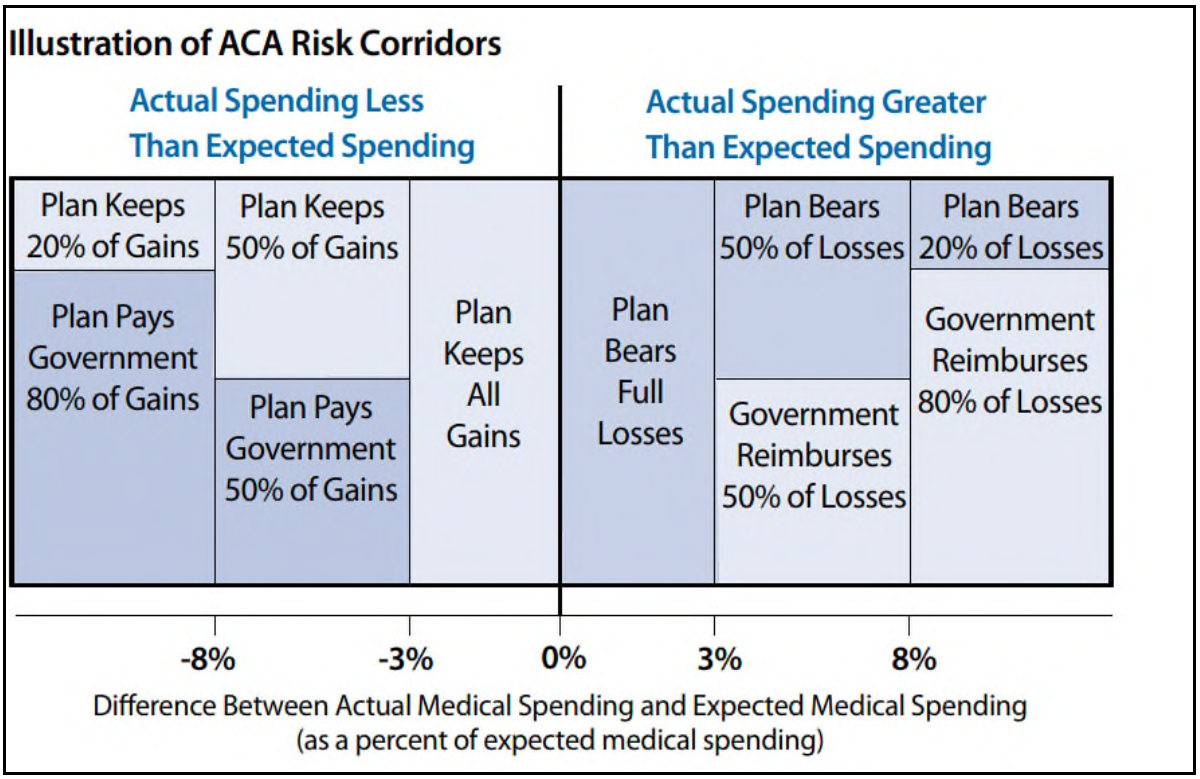
Allowable Costs = QHP Issuer's Medical Claims + Quality Improvement Costs - Net Receipts/Payments from Reinsurance and Risk Adjustment

Target Amount = QHP Issuer's Premiums Collected – Allowable Administrative Costs

$$\textbf{Risk Corridor Ratio} = \frac{\text{QHP Issuer's Allowable Costs}}{\text{QHP Issuer's Target}}$$

See 42 U.S.C. § 18062. A QHP issuer with allowable costs less than 97% of its target amount must pay into the risk corridors program, and a QHP issuer with allowable costs greater than 103% of its target amount shares its losses with the government by receiving funds, illustrated as follows[4]:

[4] Chart adapted from: American Academy of Actuaries, Fact Sheet: ACA Risk-Sharing Mechanisms (2013), at http://actuary.org/files/ACA_Risk_Share_Fact_Sheet_FINAL120413.pdf. In addition to the profit and loss sharing depicted in this illustration, an additional 2.5 percent of the target amount is required to be either paid or received by QHP issuers whose allowable costs deviate by more than eight percent from their target amount. 42 U.S.C. § 18062(b)(1)(B), (b)(2)(B).



Importantly, each QHP issuer's profit and loss data is not calibrated or compared to a statewide or market-wide average or other factors that could allow the payments in and out of the program to net to zero across all issuers. *See* 42 U.S.C. § 18062. Rather, the payments owed to QHP issuers under the risk corridors program are calculated according to the profit or losses experienced by each individual issuer and are in no way dependent upon or even compared to the experiences of other QHP issuers or the amounts that other issuers may be obligated to pay into the program. Thus, it would be mere coincidence if the total payments required to be made into the risk corridors program were the same as those required to be made out of the risk corridors program. As discussed above, the lack of certainty concerning the profits of other QHP issuers would have

precluded QHP issuers from relying on the "payments in" to the program when setting premiums – meaning, amounts could have no stabilizing effect on the new markets, as intended.

The government is incorrect in its suggestion that the payments "in" to the risk corridors program by QHP issuers are a "funding source" for the payments "out." (Appellant Br. at 18.) This position is not supported by the statutory language. *See* 42 U.S.C. § 18062(b). Rather, the risk corridors program consists of two entirely separate and independent statutory mechanisms – one requiring the government to share in the profits of QHP issuers, while the other requires the government to share in QHP issuers' losses. *Id*. at (b)(1)-(2).

In addition to the absence of any mechanisms for ensuring budget neutrality by design, there is also no language within the statute requiring budget neutrality, specifying the source of funding, or otherwise limiting the payments out of the program to the payments into the program or to other available funding. As a result, the very structure of the statute reflects Congress' intent not to limit payments to a future-specified source of funding or to require budget neutrality for risk corridors.

D. The ACA's Requirement of Full Risk Corridors Payments Did Not Expose the Government to Uncapped Liability.

Appellant argues against its obligation to make full risk corridors payments under the ACA by suggesting that a contrary interpretation would have created an

"uncapped government obligation to indemnify insurers against losses" and would have encouraged deliberate mispricing by QHP issuers. (See Appellant Br. at 32-33.) Not so. As reflected in the illustration above, QHP issuers remained incentivized to appropriately price their products because the federal government was only obligated to ***share*** a specified amount of losses with QHP issuers. Even with the payment of full risk corridors amounts, the government was only required to absorb 50% of losses between three and eight percent of the target amount and 80% of losses beyond eight percent of the target amount. QHP issuers thus remained incentivized to minimize losses while the government was expected to serve as a trusted partner in navigating the uncertainty of the new markets.

Moreover, Congress designed the risk corridors program to operate only temporarily, for the three earliest years of ACA implementation (2014-16), when participating QHP issuers lacked information as to how to price plans in the new markets populated by previously uninsured individuals. Even with risk corridors as a buffer, an attempt to deliberately underprice plans without adequate information would have exposed QHP issuers to the risk of significant losses. There was no incentive to deliberately underprice during the pendency of the risk corridors program because sufficient data was not available.[5] As a result, not only

[5] A full year of claims data for calendar year 2014 would not have been available until sometime in 2015, and this data would not have reflected any changes in the number or relative cost of insured individuals between the first and second year of

was the government's liability limited by virtue of the temporary, three-year duration of the program, but the uncertainty and lack of information concerning the newly insured populations provided no incentive for QHP issuers to engage in the gamesmanship that the government now alleges.[6]

As a result, contrary to appellant's claim, the government's liability for risk corridors payments was safely limited and cabined by the shared obligations of QHP issuers, the temporary nature of the program, and the disincentives for mispricing within the new markets. To the extent the risk corridors program encouraged more aggressive pricing of plans by QHP issuers during the early years of ACA implementation, however, this result directly aligns with the goals and

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ACA implementation. Meanwhile, QHP issuers were required to submit rates for the third and final year of the risk corridors program by the spring and summer of 2015. Thus, there was no opportunity or incentive to try and deliberately underprice QHPs in reliance on risk corridors payments.

[6] A host of factors unrelated to pricing decisions that could not have been foreseen or controlled by QHP issuers contributed to losses sustained during the early years of ACA implementation, including a belated change in policy that allowed previously-insured individuals to keep their existing policies despite the lack of compliance with the ACA, information technology problems with the healthcare.gov website and the lack of mechanisms and controls surrounding special enrollment periods. *See* Erik Huth & Jason Karcher, A Financial Post-Mortem: Transitional Policies and the Financial Implications for the 2014 ACA Individual Market, Milliman White Paper (July 2016), at http://www.milliman.com/uploadedFiles/insight/2016/2263HDP_20160712(1).pdf; Robert King, Study: Special Enrollment Periods Add Costs to Obamacare, Washington Examiner (Oct. 5, 2016), at http://www.washingtonexaminer.com/study-special-enrollment-periods-add-costs-to-obamacare/article/2603692; Barack Obama, United Health Care Reform Progress to Date & Next Steps, 316 J. Am. Med. Assoc. 525, 530 (Aug. 2, 2016).

purposes of the ACA – and the risk corridors program – to encourage affordable pricing and expand health insurance coverage to all. By contrast, an interpretation of the risk corridors program that subjects payments to unknown future legislative processes would render the program ineffectual in serving the goals and purposes of the ACA and the risk corridors program.

The Court should reject the government's current, purported concern – that full risk corridors payments "would have exacerbated insurers' incentives to compete for market share on the Exchanges" – as a basis for finding that full risk corridors payments are not required by the ACA.

E. Unlike Risk Corridors, the ACA's Other Risk Stabilization Policies Are Designed to Require or Allow for Budget Neutrality.

Congress' intent to require full risk corridors payments becomes even more apparent upon comparing ACA Section 1342 with the other two risk stabilizing policies of the ACA. "[S]tatutory interpretation is 'not guided by a single sentence or member of a sentence, but look[s] to the provisions of the whole law.'" *Hawkins v. United States,* 469 F.3d 993, 1000–01 (Fed.Cir.2006) (quoting *Dole v. United Steelworkers of Am.*, 494 U.S. 26, 35 (1990)); *see also Util. Air Regulatory Grp. v. E.P.A.*, 134 S. Ct. 2427, 2441 (2014) (It is a "fundamental canon of statutory construction that the words of a statute must be read in their context and with a view to their place in the overall statutory scheme.").

Unlike risk corridors, the statutory language setting forth the other two risk stabilization mechanisms under the ACA – the risk adjustment and temporary reinsurance programs – allow for, or specifically require, budget neutrality. The three risk stabilization mechanisms – known as the 3Rs – were collectively designed to "provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers." HHS NBPP for 2014, 78 Fed. Reg. at 15,411. Indeed, the reinsurance and risk adjustment programs are related to and interlock with risk corridors in that reinsurance and risk adjustment payments are included in the calculation of "allowable costs" under the risk corridors statute. 42 U.S.C. § 18062(c)(1)(B). Unlike the risk corridors provision, however, Congress drafted the ACA to require that the reinsurance program be budget neutral and to allow for a budget neutral implementation of the risk adjustment program.

In particular, under the reinsurance program, all health insurance issuers and self-insured plans must make payments to a reinsurance entity and those amounts paid are specifically designated as the funds to be used to make reinsurance payments out to the QHP issuers. 42 U.S.C. § 18061(b)(1)(B) ("[T]he applicable reinsurance entity collects payments under subparagraph (A) ***and uses amounts so collected*** to make reinsurance payments to health insurance issuers described in subparagraph (A)" (emphasis added)). Unlike the reinsurance program, the risk

corridors program is not statutorily limited to a specified source of funding such as the payments into the program.

Under the risk adjustment program, payments are made into or out of the program based on the "actuarial risk" (the relative health or sickness) of the QHP issuers' enrollees as compared to the "average actuarial risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1), (2). The comparison between each QHP issuers' experience to the "average actuarial risk" in each state allows for a budget neutral interpretation for risk adjustment because, unlike risk corridors, the payments in and out of the risk adjustment program are calibrated around a statewide average.[7] In contrast, Section 1342 indicates that the government "shall pay" risk corridors payments according to a statutory formula and the amount of the statutorily required payments out of the program to QHP issuers is unaffected by the amount of the payments into the program. *See* 42 U.S.C. § 18062.

"Where Congress uses certain language in one part of a statute and different language in another, it is generally presumed that Congress acts intentionally."

[7] Where a state has elected to have HHS implement its risk adjustment methodology (every state except Massachusetts in 2014), HHS has operated the program such that the total risk adjustment charge and payment amounts net to zero across each market and within each state. HHS NBPP for 2014, 78 Fed. Reg. at 15,417; HHS NBPP for 2018, 81 Fed. Reg. 94,058, 94,082 (Dec. 22, 2016) (codified at 45 C.F.R. pts. 144, 146, 147, 148, 153, 154, 155, 156, 157, & 158) (noting that a proposed change to risk adjustment will "maintain the balance of payments and charges within the risk adjustment program").

Nat'l Fed'n of Indep. Bus. v. Sebelius, 132 S. Ct. 2566, 2583 (2012) (citing *Russello v. United States*, 464 U.S. 16, 23 (1983)); *see also Turtle Island Restoration Network v. Evans*, 284 F.3d 1282, 1296 (Fed. Cir. 2002) ("When Congress omits from a statute a provision found in similar statutes, the omission is typically thought deliberate.") (citing *I.N.S. v. Phinpathya*, 464 U.S. 183, 190 (1984)). The government cites no authority in support of its position that a specific appropriation had to exist within the risk corridors provision to trigger the government's payment obligation. (*See* Appellee Br. at 17-21.)

Congress clearly understood how to design a risk stabilization program that is budget neutral or limited to specified funds, as evidenced in the ACA's treatment of both the reinsurance and risk adjustment programs. Congress did not express that same intent when designing the risk corridors program. A review of the three risk stabilization programs together thus compels the conclusion that Congress intended that the risk corridors payments be made in full according to the statutory formula.

II. THE APPROPRIATIONS RIDERS DO NOT DEFINE OR LIMIT QHP ISSUERS' RIGHTS TO FULL RISK CORRIDORS PAYMENTS.

The government erroneously contends that despite the mandatory "shall pay" language of the risk corridors statute, future legislation by way of annual appropriations was required before it had an obligation to pay any portion of its risk corridors obligations under the statutory formula. (Appellant Br. at 10-11.)

Although the Government Accountability Office identified available funding for fiscal year 2014 – the initial year of the risk corridors program – the government seeks to disregard these amounts, arguing instead that the amounts must be specifically appropriated for the following fiscal year in which the risk corridors payments were calculated. (*Id.* at 33-37.)

The government's position is without merit for all of the reasons set forth by the appellee, including long-standing jurisprudence establishing that a contractual or statutory obligation is not negated or limited by a lack of appropriations. (*See* Appellee Br. at 26-29.) In addition, a requirement of full risk corridors payments according to the statutory formula is necessitated by the practical realities of the health insurance markets and the timing and nature of the various commitments and processes that had to be undertaken by QHP issuers in order to offer coverage on the ACA Exchanges – processes that necessarily began well in advance of, and were in no way related to, legislative budgeting processes.

While the government argues that legislation triggering its risk corridors payments had to specifically relate to the fiscal year following the applicable coverage year, the processes for QHP issuers to commit to provide coverage on the ACA Exchanges began many months before the applicable coverage year. QHP issuers are generally required to submit rates to state regulatory authorities for approval in the spring in order use them in connection with plans sold on the ACA

Exchanges in the following calendar year.[8] Rates are typically approved by the state regulators and set well in advance of the year before the applicable coverage year.[9] Once set, there is little or no opportunity to make mid-year adjustments to rates.[10] Even year-to-year requests for rate adjustments are subject to time-consuming approval processes and are far from guaranteed, involving independent actuarial review, public hearings and/or notice periods for insureds.[11] Thus, QHP issuers could not account for contingencies surrounding future legislative actions when setting premium rates years earlier, except to ignore the potential effects of risk corridors altogether as a stabilizing force in the new markets, which, as discussed above, would run counter to the goals and purposes of the risk corridors program.

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

[9] *See e.g.*, *id.* (Department of Insurance rate approval between May 1, 2013 and June 30, 2013 for the 2014 coverage year).

[10] *See e.g.*, CMS, QHP Webinar Series Frequently Asked Questions, at 7 (June 28, 2013) ("In the individual market, one set of rates applies for the entire calendar year."), at http://bewv.wvinsurance.gov/Portals/2/pdf/QHP%20FAQ%2012%20-%20June%202013.pdf.

[11] *See e.g.*, Oregon Division of Financial Regulation, Understanding Health Insurance Rate Review, at http://dfr.oregon.gov/healthrates/Pages/understanding-rate-review.aspx; *see also* The Center for Consumer Information & Insurance Oversight, State Effective Rate Review Programs, at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html.

The process of QHP certification under federal regulations similarly includes deadlines and commitments well in advance of the applicable coverage year. Initial QHP applications are due in the spring of the year before the coverage year and QHP certification agreements are executed in the fall prior to the corresponding coverage year.[12] Importantly, once plans were certified, QHP issuers could not go back on their commitments, including commitments to offer health insurance coverage subject to ACA reforms such as the prohibition against pricing or denying coverage according to individuals' medical history. 42 U.S.C. §§ 300gg-1 – 300gg-5; 45 C.F.R. § 156-290(a)(2); 45 C.F.R. §147.104. QHP issuers were, thus, undertaking substantial risk and obligations months in advance of the calendar year in which they agreed to offer health insurance coverage under the QHPs.

Despite the early and significant undertakings and commitments by QHP issuers, the government argues that its obligation to pay risk corridors obligations has always been contingent upon the passage of budget legislation in subsequent years. (Appellant Br. at 10.) By the government's reasoning, the government's obligation to pay risk corridors amounts was not defined until fiscal year 2017

[12] *See e.g.*, Center for Consumer Information and Insurance Oversight, Affordable Exchanges Guidance, at 20 (April 5, 2013), at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2014_letter_to_issuers_04052013.pdf.

according to the "three year framework" that the government contends applies to the risk corridors program. (*See* Appellant Br. at 51-54.) Notably, the appropriations bill for fiscal year 2017 was not passed until May of this year. *See* Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, div. H, tit. II, § 223 (2017). By this point, however, QHP issuers had designed, priced and sold QHPs, sought and obtained regulatory approvals, committed to providing coverage and incurred substantial losses on the ACA Exchanges for all three years of the risk corridors program.

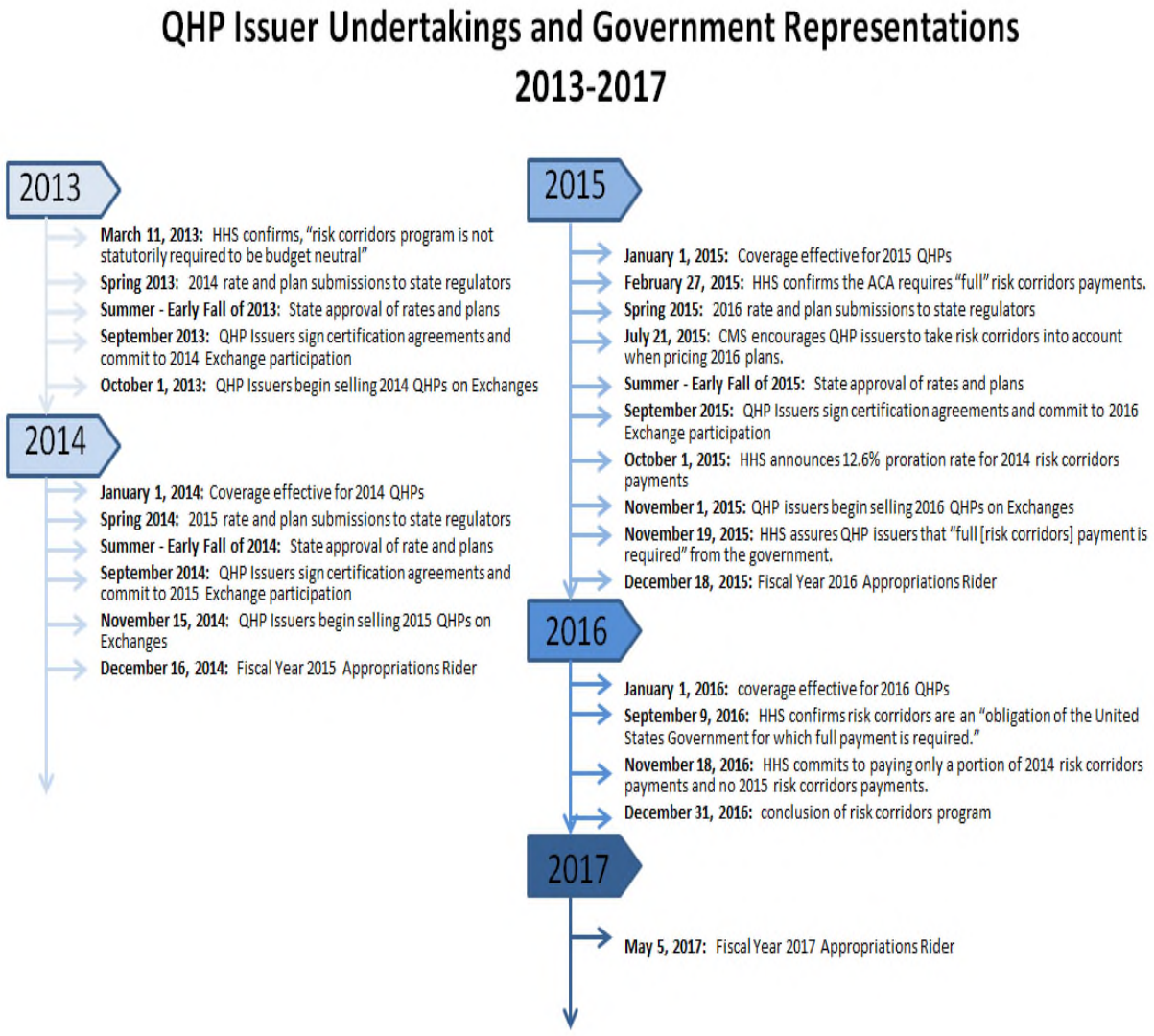
The timing of the Appropriations Riders relative to the timing and nature of the commitments QHP issuers undertook multiple years earlier underscores precisely why the retroactive application of statutes is disfavored. *Landgraf v. USI Film Prod.*, 511 U.S. 244, 270 (1994) ("The presumption against statutory retroactivity has consistently been explained by reference to the unfairness of imposing new burdens on persons after the fact.") For similar reasons, statutory impacts on existing contractual rights are deemed a breach, entitling damaged parties to recourse. *See e.g.*, *Mobil Oil v. United States*, 530 U.S. 604, 620 (2000).

Here, the federal government not only designed and implemented a statutory program to require payment according to a defined formula, but it also consistently and repeatedly assured payment as an obligation of the United States government prior to and throughout the duration of the program. Most notably, before QHP

issuers priced plans for the initial year of ACA implementation, HHS assured that "[t]he risk corridors program is not statutorily required to be budget neutral… [r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." *See* HHS NBPP for 2014, 78 Fed. Reg. at 15,473 (Mar. 11, 2013). *See also*, Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,942-943 (July 15, 2011) (codified at 45 C.F.R. pt. 153) (the risk corridors program provides a mechanism for "sharing risk . . . between the Federal government and QHP issuers"); HHS NBPP for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) (codified at 45 C.F.R. 144, 147, 153, 154, 156, & 158) (again noting that the ACA requires "full" risk corridors payments and indicating that to the extent collections are insufficient, "HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations."); Letter from Kevin J. Counihan, Director, CCIIO, a division of CMS, to State Insurance Commissioners (July 21, 2015) (encouraging states to take the risk corridors program into account when making final decisions on the rate filings that health plans submitted for the third and final year of the program while noting that "HHS recognizes that the Affordable Care Act requires the Secretary to make full [risk corridors] payments to issuers"), at https://www.cms.gov/CCIIO/Resources/Letters/Downloads/DOI-Commissioner-Letter-7-20-15.pdf; CMS, "Risk Corridors Payments for the 2014

Benefit Year" (Nov. 19, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and the HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required."), at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf; CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) (confirming that the risk corridors obligations are an "obligation of the United States Government for which full payment is required"), at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF.

The relevant chronology is summarized as follows:



An ability by the government to reserve whether, and to what extent, it will follow through on its risk corridors payment obligations, despite the statutory language and repeated assurances of payment, runs counter to the very purposes of the risk corridors program and the ACA and threatens the public-private relationship of trust upon which the stability of the ACA markets depend. The government may not induce, compel and require the commitments of QHP issuers

– to the tune of $8.3 billion in risk corridors payment amounts for the first two years alone – while withholding its own promised and confirmed commitments.

CONCLUSION

For the reasons stated above, in the Appellee's brief, and in the brief of other amici curiae, the Blue Cross Blue Shield Association supports the affirmation of the trial court's decision below, granting the Appellee's cross-motion for partial summary judgment and denying Appellant's Motion to Dismiss.

Dated: August 28, 2017

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief of amicus curiae complies with the type-volume limitation of Federal Rule of Appellate Procedure 29 and Federal Rule of Appellate Procedure 32(a)(7)(B)(i) and contains 5959 words, excluding the portions of the brief exempted by Federal Rule of Appellate Procedure 32(f) and Federal Circuit Rule 32(b).

I also certify 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) and has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14 point Times New Roman Font.

Dated: August 28, 2017

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CERTIFICATE OF SERVICE

I hereby certify that, on August 28, 2017, I filed the foregoing **BRIEF OF BLUE CROSS BLUE SHIELD ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF PLAINTIFF-APPELLEE AND IN SUPPORT OF AFFIRMANCE OF THE COURT OF FEDERAL CLAIMS** with the Clerk of Court using the CM/ECF System, which will serve via e-mail notice of such filing to all counsel registered as CM/ECF users.

Dated: August 28, 2017

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