2017-1994

In the

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,
Case No. 1:16-cv-00649, Judge Thomas C. Wheeler

BRIEF OF AMICUS CURIAE THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PLAINTIFF-APPELLEE

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CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, counsel for *amicus curiae* the National Association of Insurance Commissioners certifies the following:

1. The full name of every party or *amicus* represented by one or more of the undersigned is:

- The National Association of Insurance Commissioners

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

- None

3. All parent corporations and publicly held companies that own 10% or more of stock in the party:

- 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:

- Douglas J. Schmidt and Kirsten A. Byrd, Husch Blackwell LLP

/s/ Steven A. Neeley
Steven A. Neeley

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I. IDENTITY AND INTEREST OF *AMICUS CURIAE*[1]

Founded in 1871, the National Association of Insurance Commissioners ("NAIC") is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. The NAIC membership reflects a diversity of views, with both appointed and elected state officials serving the public interest. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight. NAIC staff supports these efforts. The NAIC represents the collective views of state regulators domestically and internationally. The NAIC members, together with the centralized resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. This not only allows for consistency in regulating companies that do business in multiple states, but it provides a central point of communication and facilitation for joint initiatives with federal and

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(c)(5), amicus states that no counsel for a party authored this brief in whole or in part, and no person or entity other than amicus or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

international regulators. The NAIC also regularly assists federal regulators, federal agencies, members of Congress and the Government Accountability Office by providing information and data related to state insurance regulation, health insurance issues, terrorism insurance, annuities, insurance fraud and many other topics. Collectively, the state insurance commissioners work to develop model legislation, rules, regulations, handbooks, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers, promote competitive markets, and maintain the financial solvency of insurance companies and the financial stability of the insurance industry as a whole.

As founding members of the International Association of Insurance Supervisors, the NAIC and its members remain extensively engaged with international counterparts in developing the elements of a stronger international insurance regulatory framework.

Hundreds of state and federal laws, including the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 199 (2010), assign duties to the NAIC and incorporate NAIC standards, models and other publications. Insurers are statutorily required to file annual and quarterly financial statements with the NAIC which maintains them in databases on behalf of the states. NAIC model laws, regulations and other standards, as implemented by the

states, are a critical part of the robust regulatory structure in place to monitor the financial solvency of insurers.

The NAIC provided technical guidance and input to Congress as it drafted and debated the ACA. State insurance commissioners generally, and the NAIC specifically, are mentioned over 15 times in the Affordable Care Act. The NAIC was asked to develop standards for or provide expert input to the Secretary of the Department of Health and Human Services ("HHS") on the Medical Loss Ratio, the Summary of Benefits and Coverage, Exchanges, age bands, the temporary reinsurance program, external review standards, and more. The NAIC has also developed model laws and regulations to assist states in the implementation of the ACA and provided comments on federal regulations.

The interest of the NAIC in this case arises out of the adverse effect of unpaid risk corridor amounts on state insurance commissioners' ability to protect consumers. The essential functions through which insurance commissioners promote financial solvency and the fair treatment of policyholders have been impaired. Enormous risk corridor payments have been withheld, throwing rate review and the financial stability of insurers into uncertainty. These unpaid amounts have undermined competition and overburdened the insurers willing to market health plans to a population whose health needs were unknown. Regulators are also challenged in effective solvency oversight, including capital reserving,

with no direction on whether risk corridor payments can be relied upon in an insurance company's balance sheet. Finally, insurance commissioners are forced to navigate outstanding risk corridor amounts in the event of an insurer's insolvency, when the commissioner must advocate for the Government to make the payments for the benefit of policyholders.

II. BACKGROUND

The appellee, Moda Health Plan Inc. ("Moda") offers health insurance plans through American Health Benefit Exchanges ("Exchanges") established in each state for the purchase of insurance in the individual and small group markets. The risk corridor program, along with reinsurance and risk-adjustment programs, constituted "the three R's" of the ACA which were intended to "provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets." *Reinsurance, Risk Corridors and Risk Adjustment Final Rule*, Center for Consumer Information and Insurance Oversight, Center for Medicare & Medicaid Insurance, Department of Health and Human Services (March 2012).[2] Through passage of the ACA, the United States Congress created the risk corridor system with the intent that insurers would pay the Government a percentage of profits above a certain threshold of actual cost from

[2] Available at: https://www.cms.gov/CCIIO/Resources/Files/Downloads/3rs-final-rule.pdf.

2014 through 2016. 42 U.S.C. § 18062. The system also required the Government to cover insurers' losses during those years beyond a corresponding threshold. *Id.*

The Government Accountability Office, in its analysis of the risk corridor system and its intent, noted it would be difficult to predict the proportion of high-cost enrollees and price the plans appropriately: "In order to minimize the possible negative effects of this uncertainty during the initial years of operation of the Exchanges, section 1342 of PPACA directs the Secretary of HHS to operate a temporary risk corridors program. This program is intended to protect against uncertainty in rates for qualified health plans by limiting the extent of issuer losses and gains for calendar years 2014, 2015, and 2016." Letter from Susan A. Poling, *General Counsel, U.S. Gov't Accountability Office, to Sen. Jeff Sessions and Rep. Fred Upton* (Sept. 30, 2014)[3] (citing Pub. L. No. 111-148, § 1342(a) and 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012)).

This calculation was intended to reduce risk to insurers operating on the Exchanges and "serves as a financial buffer for health plans that might otherwise be reluctant to participate on the Exchanges." Nicholas Bagley, *Legal Limits and the Implementation of the Affordable Care Act*, 164 U. Pa. L. Rev. 1715, 1735 (2016).

[3] Available at: http://www.gao.gov/assets/670/666299.pdf.

Drafters of the ACA predicted that any losses would be balanced out by profits from insurers who performed well financially on the Exchanges, "temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government." Doug Norris, Mary Van Der Heijde, and Hans Leida, *Risk Corridors Under the Affordable Care Act – A Bridge Over Troubled Waters, but the Devil's in the Details*, Health Watch, Soc'y of Actuaries, at 5 (Issue 73, Oct. 2013). This prediction did not come to pass. Many insurers sustained heavy losses in 2014 and 2015, and the few companies that did well on the Exchanges still did not profit excessively.

Insurers planning to operate on the Exchanges were assured of full risk corridor payments. On March 11, 2013, the Center for Medicare and Medicaid Services ("CMS") released its rule governing the schedule of the risk corridor program and stated that "the risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the [ACA]." *See Moda Health Plan, Inc., v. United States,* 130 Fed. Cl. 436, 444 (2017). Moda began selling qualified health plans as defined by federal law ("QHPs") to consumers on the Exchanges on October 1, 2013. *See id.*

It was not until 2014, when coverage under these QHPs was effective, that insurers operating on the Exchanges began receiving conflicting guidance from the

Government on the amount of funds available. In April of 2014, a memorandum issued by HHS announced possible pro rata payments depending on available funds. The memorandum indicated the goal of the program was budget neutrality. *See id.* at 445. HHS acknowledged the possibility that there may not be sufficient funds coming in to the program to offset amounts owed to insurers. However, HHS indicated only that future guidance would be issued by rulemaking in that event. *See id.* at 446.

By December of 2014, Congress had specifically prohibited the CMS Program Management appropriation from specifically funding risk corridor payments in 2015 and 2016. *See id.* at 447. As a result, the available offset funds to make insurers whole under the program represented only 12.6% of the amounts owed. *See id.* at 448.

III. ARGUMENT

The unpaid risk corridor funding impacts not only the insurance companies, but the insurance regulators and, most importantly, the consumers those regulators are charged with protecting. The weakening of overall capital adequacy is felt at all stages of the regulatory relationship between commissioners and insurers from licensing to solvency oversight, to rate review and to the provision of healthy, competitive markets. These are core functions of the NAIC's members with a common goal of consumer protection. Insurance commissioners continue to

maximize the interests of consumers wherever possible, but their ability is limited in a defunded Exchange marketplace. This is most evident in the rate review process.

A. Calculation and approval of prospective insurance rates are skewed by large scale nonpayment of risk corridor amounts.

State laws prohibit approval of proposed policy rates if they are excessive, inadequate or unfairly discriminatory. *See, e.g.*, Colo. Rev. Stat. § 10-16-107; Del. Code Ann. tit. 18, § 2501; Fla. Stat. § 627.062; Haw. Rev. Stat. § 431:14G-104; Mo. Rev. Stat. § 383.206; Or. Rev. Stat. § 743.018. The NAIC's members rely on actuarial justification for proposed rates, and the uncertainty created by partial risk corridor payments undermines both the regulator and the insurer for purposes of setting rates.

The ratemaking process is challenging even in a stable market, as insurers must predict health care costs:

> For the most part, insurance pricing is **prospective**, because it is necessary to determine in advance what insureds must pay to cover losses incurred and benefits that will be paid in the future, in addition to insurers' [administrative] expenses. Because of its prospective nature and the uncertainty associated with predicting future events and losses, insurance pricing is complex. Insurers must use extensive data and various actuarial methods to determine appropriate rates or premiums.

Robert E. Klein, *A Regulator's Introduction to the Insurance Industry*, National Association of Insurance Commissioners, at 19 (2005) (emphasis in original).[4]

An unpaid bill in the hundreds of millions, such as various Exchange insurers have alleged in the Court of Federal Claims, greatly impacts regulators' ability to exercise the appropriate rate review and evaluate whether proposed rates are fair and adequate. As the Pennsylvania Insurance Department noted in support of four domestic insurers in their risk corridor lawsuit, the insurers were locked into market participation before learning of the shortfalls that undermined their ratemaking process:

> Insurers sought approval of rates that accounted for the risk to the extent it could be actuarially predicted. Insurers that chose to sign QHP Agreements did so with the assumption that, should those rates be unexpectedly inadequate, insurers' financial liability would be offset by full payments made under the Risk Corridors provision.

Brief for Penn. Insur. Dep't as Amicus Curiae, *First Priority Life Insurance Co., Inc. et al. v. U.S.,* Case No. 16-587 at 5 (Fed. Cl. filed Oct. 14, 2016).

Furthermore, if this Court determines these massive deficits are indeed not owed by the Government, then state regulators will have to evaluate the fairness of rates in an environment where (1) insurers have tremendous financial exposure through no fault of their own and (2) the market is populated by these disadvantaged insurers, while other financially stronger insurers are dis-

[4] Available at: http://www.naic.org/documents/prod_serv_marketreg_rii_zb.pdf.

incentivized from participating. The sum of this equation is higher rates and a higher burden on consumers. As Maryland Insurance Commissioner Al Redmer testified with respect to risk corridor lawsuits, "[Carriers] would still be legally obligated to provide these more costly plans, but the courts could prohibit Treasury from reimbursing them without an appropriation. . . . Uncertain funding streams lead to higher premiums." *Rising Health Insurance Premiums Under the Patient Protection and Affordable Care Act*: Before the H. Oversight and Gov't Reform Subcomm., 114th Cong. p. 6 (Sept. 14, 2016) (testimony of Comm'r Al Redmer Jr., on behalf of the NAIC ("Redmer Testimony")).

In this respect, the NAIC's members navigate the rate approval process with tied hands. Similarly, their best efforts at licensing insurers and health cooperatives to serve the Exchanges cannot insulate consumers from the effects of risk corridor shortfalls.

B. Incentives created but not fulfilled by the ACA resulted in licensing of new insurers with unique capital challenges.

The very purpose of the ACA, to expand coverage to additional millions of Americans, created an urgent demand for companies willing to offer QHPs to consumers who would otherwise face a financial penalty for declining to purchase health coverage. The state-federal Exchanges, by their nature, were not going to be

comprised of the healthiest and most affluent consumers.[5] Large insurers with the most available capital did not dominate the market, despite the millions of new customers created by the federal individual mandate.

State insurance commissioners have worked in good faith to implement the ACA's Consumer Operated and Oriented Plan (CO-OP) program.[6] This provision provides for loans and grants to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans." 42 U.S.C. § 18042. Across the country, new non-profit health cooperatives applied for licenses to transact business on state Exchanges. In states like Maine, Montana and Kentucky, CO-OP plans were more competitive than Blue Cross & Blue Shield and the CO-OPs market share was, in some cases, twice what they had projected. *See* Sabrina Corlette, Sean Miskell, Julia Lerche, and Justin Giovannelli, *Why Are*

[5] "Individuals *See* king coverage through the Exchanges may have potential health risks that are different than those historically handled by an insurer, resulting in a health plan having higher costs than anticipated." Letter from Susan A. Poling, *General Counsel, U.S. Gov't Accountability Office, to Sen. Jeff Sessions and Rep. Fred Upton* (Sept. 30, 2014), *available at* http://www.gao.gov/assets/670/666299.pdf.

[6] Appellee Moda is not a health cooperative, but the appellant in companion case *Land of Lincoln v. United States*, Case No. 17-1224 (Fed. Cir. filed Nov. 15, 2016) did operate as such. *See* http://www.kff.org/health-reform/state-indicator/co-op-loans/?currentTimeframe=0&sortModel=%7B%22colId%22:%22Location%22,%22sort%22:%22asc%22%7D.

so Many CO-Ops Failing? How New Nonprofit Health Plans Have Responded to Market competition, The Commonwealth Fund (Dec. 2015).[7]

However, market dominance was not advantageous to these insurers. The unknown health needs of this population soon became known:

> Many new enrollees had pent-up medical needs, and they and their providers started submitting health care claims early in 2014. . . . Both IA/NE and Kentucky CO-OPs also reported that they quickly realized they had priced their plans to reflect the expected claims costs of a far healthier group of enrollees than they actually acquired. For them, the solvency loans alone would not be sufficient. Their future depended on the ACA's premium stabilization programs.

Id. at 16.

Although initially qualified for licensure, the CO-OPs were largely unable to withstand the capital demands of participating on the Exchanges. By the end of 2016, only six of the 24 CO-OPs operating at peak participation were still in business. "It's not that they couldn't be made into viable businesses: it's that they couldn't last long enough to reach that point. And the reason for that is that they just didn't have those outside investors, those capitalists, that they could call upon to finance them to get there." Tim Worstall, *The Problem with Health Care Coops: No Capitalists to Absorb the Losses, Forbes* (Sep. 26, 2015).[8] This problem is

[7] Available at: http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf.

[8] Available at: https://www.forbes.com/sites/timworstall/2015/09/26/the-problem-with-health-care-coops-no-capitalists-to-absorb-the-losses/#5e9aa7b27155.

exponentially worse when companies must absorb and try to operate without the risk corridor amounts the Government declines to pay. Full payment might have given some of them time to shore up not only capital, but the underwriting experience that strengthens an insurer's financial condition.

While the appellee, Moda, was capitalized well enough to survive to this point, state insurance commissioners are contending with many more companies that are not. The NAIC's members have long supported innovation in the insurance industry and continue to work with new companies with the potential to improve outdated practices and better fulfill customer needs. Regulators want licensing to be a tool for flexibility and consumer protection, but the Government's position on risk corridor payments has been hazardous and punitive for new companies.

For many markets across the country, this inhospitable environment is damaging consumer choice. The organic development of competitive forces in insurance markets is of great benefit to policyholders. The lack of funding for insurers offering QHPs on the Exchanges, however, has operated to stifle competition and leave fewer options at higher cost to consumers.

C. The Government's failure to make full risk corridor payments has suppressed competition in the Exchanges, burdening consumers and regulators.

Promoting competition stands alongside financial solvency and consumer protection as an essential part of the NAIC's mission. Approval of policy rates and

forms, scrutiny of health plans for the inclusion of mandated benefits, and ongoing monitoring of reserves and investments to improve financial solvency are essential regulatory functions and serve the public well. But the infusion of competition is frequently beyond the regulator's control: "[m]arket competition can apply pressure that the Department cannot. Without this pressure, insurers may choose to eliminate certain plan offerings or attributes that consumers have enjoyed in the past." Brief of Penn. Insur. Dep't, *First Priority Life Ins.,* Case No. 16-587 at 10 (2016).

State insurance commissioners have little influence when insurers are repelled by a debilitating market condition. The Government's failure to deliver on the ACA's risk corridor provisions, its shifting position on whether insurers are owed 100%, 12.6%, or nothing at all, has transformed the Exchanges from promising to punitive for the insurance industry.

Regulatory ambiguity can impede markets even outside the complex world of health reform. As the regulatory environment shifts beneath them, companies are forced to limit innovation and growth: "[r]egulatory uncertainty considerably constrains firms and can adversely affect their profitability because the continuous preparation for, and the adjustment to, uncertain regulations absorb firm resources . . . . Correspondingly, anecdotal evidence suggests that regulatory uncertainty can keep firms from more effectively deploying these resources toward both their own

commercial and policymakers' regulatory objectives." Christian Engau and Volker H. Hoffman, *Corporate Response Strategies to Regulatory Uncertainty: Evidence From Uncertainty About Post-Kyoto Regulation*, 44 Pol'y Sci. 53, 55 (2011).

These problems are more pronounced for insurance companies. They began the Exchange venture with a new subpopulation of policyholders whose health needs were virtually unknown. They relied on financial inducement from the Government in deciding to market plans to this new demographic. Insurers' profit margins are under constant scrutiny from state regulators, meaning the companies do not have unfettered ability to raise prices in order to cover losses. They simply could not afford to stay in the Exchanges once the Government, having drastically miscalculated, withheld risk corridor funds.

As of mid-2017, consumers in approximately one third of all U.S. counties had access to only one insurer's plan through the Exchanges. Olga Khazan, *Why so Many Insurers are Leaving Obamacare, how rejecting Medicaid and other Government Decisions Have Hurt Insurance Markets,* The Atlantic (May 11, 2017).[9] The ACA's goal of creating state Exchanges with innovative products and abundant consumer choice has fallen far short in these regions. The broken

[9] Available at: https://www.theatlantic.com/health/archive/2017/05/why-so-many-insurers-are-leaving-obamacare/526137/.

promises of the risk corridor program directly contributed to this ultimate lack of competition.[10]

The risk corridor program was specifically developed to incentivize greater participation by insurers on the Exchanges.[11] When full payments under the program were not forthcoming and guidance was conflicting among HHS and Congress, it was inevitable that insurers were then deterred from participating: "Private companies cannot be expected to participate in a market where the rules and regulations are not made clear in advance and where there is no faith that the

[10] Projections for completely bare counties in 2018 spurred insurance commissioners to collaborate with companies and provide at least one QHP in parts of Nevada, Wisconsin, Iowa, Missouri and Ohio. Reversing this course was described as "a triumph for state regulators around the country, who have fought hard to fill potential bare patches in their coverage maps after insurers announced pullbacks over the past several months amid uncertainty about the law's future." Anna Wilde Mathews, *All U.S. Counties to Have an ACA Plan After Ohio Plugs Last Gap*, Wall St. J. Aug. 24, 2017, https://www.wsj.com/articles/ohio-county-gets-affordable-care-act-coverage-ending-risk-of-marketplace-gap-1503591859.

[11] "By compensating issuers for the risks related to the individuals they enroll, these provisions are designed to lessen the financial risk issuers and state health benefit exchanges will face under the [ACA]. This will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than attracting the healthiest, lower-cost enrollees. Thus, these provisions are critical to the successful implementation of the ACA." *Analysis of HHS Final Rules on Reinsurance, Risk Corridors and Risk Adjustment*, State Health Reform Assistance Network, Wakely Consulting Group (April 2012), http://www.statenetwork.org/wp-content/uploads/2014/11/State-Network-Wakely-Analysis-of-HHS-Final-Rules-On-Reinsurance-Risk-Corridors-And-Risk-Adjustment.pdf.

government will uphold its end of the bargain." Erin Trish, Loren Adler, and Paul B. Ginsburg, *To Promote Stability in Health Insurance Exchanges, End the Uncertainty Around Cost-Sharing and Other Rules,* Brookings (April 20, 2017).[12] Once the Exchange marketplace becomes financially unsustainable for insurers, they will remove themselves and a monopoly could result. The states are not likely to *See* intervention from the Government to maintain basic standards of availability and competition. It falls immediately to the state insurance commissioner to conduct outreach and solicit participation by insurers. These efforts come at a cost – commissioners do not retain the same ability to restrain rates once competition is suppressed. Taken together, these conditions will have the greatest impact on states' most vulnerable consumers who rely on the Exchange subsidies in order to comply with the ACA.

D. Regulators are unable to issue definitive guidance for oversight of capital and surplus while risk corridor payments are uncertain.

The dearth of competition puts policyholders at a disadvantage; however, the NAIC's members work vigorously to protect consumers' rights under the insurance contracts they purchase. The payment of valid claims is a promise that must be kept, and regulators keep the pressure on companies to manage that risk

[12] Available at: https://www.brookings.edu/blog/up-front/2017/04/20/to-promote-stability-in-health-insurance-exchanges-end-the-uncertainty-around-cost-sharing-and-other-rules/.

with appropriate reserves. State insurance commissioners are able to mandate sufficient levels of reserving and available capital through their states' adoption of the NAIC's Risk-Based Capital for Insurers Model Act ("RBC Act"). *See* NAIC *Model Laws, Regulations and Guidelines*, 312-1 to 312-14, 20XX WL 8342873 (1993, amended 2011). The RBC Act was adopted in 1993 to require capital levels to correspond with the risk factors of the policy type. "The Act's main purpose is to ensure that insurers' risk-capital levels reflect a rational relationship with the riskiness of the policies that are insured. The Act provides 'trigger points' by which regulatory bodies can gauge the strength of insurers and assess the need for state regulatory intervention." Conrad D. Brooks, *Risk-Based Capital: Provide for the Computation of Risk-Based Capital Levels for Insurers and the Submission of Risk-Based Capital Reports by Insurers; Provide for the Authority of the Commissioner of Insurance to Take Action; Provide Immunity from Civil Action to Receivers*, 13 Ga. St. U. L. Rev. 212, 213 (1996).

Under the RBC Act, every domestic insurer is statutorily required to report its RBC levels on an annual basis in accordance with NAIC-issued RBC instructions. This reporting is required in order for an insurance company to maintain its license in the home state. The instructions contain a formula that was developed (and is regularly updated) as an additional tool to assist regulators in the financial analysis of insurance companies. The purpose of the formula is to

establish a minimum capital requirement based on the types of risks to which a company is exposed. The formula is calibrated to consider the risk of adverse insurance experience and all other relevant business risks.

The RBC system operates as a tripwire that gives regulators clear legal authority to intervene in the business affairs of an insurer upon the occurrence of one of the action levels specified in the RBC law. RBC levels alert regulators to undercapitalized companies while there is still time for the regulators to react quickly and effectively to minimize the overall impact and costs associated with insolvency. RBC provides a baseline of objective standards and regular reporting without diminishing a commissioner's authority to obtain and consider additional information.

The unpaid amounts from the risk corridor program represent significant business risks for insurance companies. If Moda has no choice but to absorb the expense of more than $214 million of risk corridor payments, it reduces their existing surplus and, as a result, impacts their risk-based capital calculation. Companies were incentivized to market plans on the Exchanges with a promise of loss containment, and they still have no clarity on whether or to what extent that promise will be kept.

The NAIC's members must contend with this same uncertainty with respect to their responsibilities maintaining the RBC formula and statutory accounting

guidance. The NAIC's working committees continue to advise insurers to take a conservative approach, providing that "estimates shall not assume the availability of federal funds unless such federal funds are appropriated by Congress for the federal costs of the risk corridor program." 1 *NAIC Accounting Practices and Procedures Manual* 15-01-1, 15-01-5 (2017). While it is important for the NAIC to err on the side of caution in its guidance, it is no less frustrating to regulate around phantom federal policy.

E. Deficits in the company's assets resulting from unpaid risk corridor amounts may burden an insurance commissioner acting in a receivership capacity, compromise state guaranty funds, and leave consumers with unpaid claims

The RBC formula, along with annual reporting requirements and regular financial examination of companies, are all safeguards to promote solvency in the insurance industry and protect the interests of policyholders. Insurance commissioners have additional authority to identify when a company enters a hazardous financial condition and issue orders to prevent further distress, including increasing reserve amounts or limiting new business accepted. *See* Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition, NAIC *Model Laws, Regulations and Guidelines*, 385-1 to 385-5, 20XX WL 8342884 (1985, amended 2008). This kind of early intervention can provide more cushion from the kind of financial distress that would ultimately hurt policyholders.

In situations where an insurer is not able to recover from financial distress, state regulators continue to guide the process through rehabilitation, receivership, or possible liquidation. Insurance commissioners are driven to promote the fair and equitable treatment of consumers in each of these scenarios.

The process of insolvency demonstrates the manner in which insurance commissioners (and ultimately policyholders) could be directly affected by unpaid risk corridor amounts. Under the NAIC's *Insurer Receivership Model Act*, adopted in substantially similar form in each state, the insurance commissioner becomes responsible for rehabilitating or liquidating the company, depending on the severity of financial distress. In the event of total failure, the assets and liabilities of the company will directly impact the NAIC's members:

> An order to liquidate the business of an insurer shall appoint the commissioner and any successor in office as the liquidator and shall direct the liquidator to take possession of the property of the insurer and to administer it subject to this Act. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation.

NAIC *Model Laws, Regulations and Guidelines*, Art. V, Sec. 501, 555-38, 20XX WL 8342898 (1936, amended 2007).

It will be up to the Insurance Commissioner to continue the company's struggle in collecting unpaid risk corridor amounts.[13] The NAIC's members are concerned about the sheer dollar figures representing unpaid risk corridor amounts, particularly in light of policyholder protection. Whether or not the Government is willing to fulfill its promises with respect to the risk corridor program will determine how and to what extent consumers are made whole for their unpaid claims.

The real-life application of these issues has not been encouraging so far. On July 17, 2017, the Iowa Insurance Commissioner (acting in his capacity as receiver for a failed health cooperative, CoOportunity Health, Inc.), filed suit in the U.S. Court of Federal Claims alleging the Government had declined to pay approximately $130 million owed under the risk corridor program. *See Ommen v. U.S.*, Case No. 17-957 (Fed. Cl. filed July 17, 2017), Pl.'s Compl. ¶ 104. Although the Government had identified $16.4 million as owing (12.6% of the $130 million figure), it placed this amount, along with reinsurance and risk adjustment

[13] "The state insurance statutes normally vest the Commissioner, as receiver, with title to all of the assets of the insolvent company and, by statute, the Commissioner becomes the 'successor' to the company with respect to its assets and the enforcement of its contracts and other pre-receivership rights. In addition to a receiver's authority to assert claims on behalf of the insolvent company, the receiver also has authority to assert claims on behalf of policyholders, creditors, and other impacted parties. *See, e.g., Reider v. Arthur Andersen, LLP,* 47 Conn.Supp. 202, 219-224, 784 A.2d 464, 475-478 (2001).

payments, in an administrative hold to set off against debts from the start up loan. *See id.* The complaint alleged:

> [T]he Government would administratively "hold" these payments even though there was, at the time the hold was imposed, no corresponding payment owed by CoOportunity to HHS/CMS. When a payment finally became due (or allegedly due) from CoOportunity to the Government, it would then pay itself by setting off the funds subject to the illegal hold.

Id. at ¶ 106.

If these claims are established, they demonstrate an alarming capacity for the Government to undermine consumers twice: first as a debtor exacerbating an insurer's financial distress by over $100 million, and second as a creditor who seeks to push ahead of policyholders' valid claims.

As the *Ommen* complaint points out, "The ACA did not provide the Government with any unique or preemptive rights with respect to insolvent insurance carriers that are placed into liquidation in their respective domiciles." *Id.* at ¶ 93. The ACA specifically provides that its provisions shall not be construed to preempt a non-conflicting state law. *See* 42 U.S.C. § 18041. Furthermore, state laws regulating the business of insurance, including insurer insolvency proceedings, have the power of reverse federal preemption pursuant to the McCarran-Ferguson Act of 1945, 15 U.S.C. §§ 1011 to 1015; *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508-09 (1993). There is no justification for the Government to prioritize its claims over policyholders' claims.

State insolvency laws are separate and distinct from federal bankruptcy. The protection of policyholders is paramount in state proceedings, and their claims take priority over the Government's. These are not investors who may have rolled the dice in a risky venture. They are consumers who responsibly procured health coverage for themselves in order to comply with the ACA. The NAIC's members strongly urge this Court to consider the possible gap in consumer protection if the Government is permitted, without legal authority, to manipulate the funds earmarked through the 3 "R"s for purposes of insolvency administration.

States where insolvent insurers are domiciled will be additionally burdened by drains on other backstop mechanisms. For example, under many states' insurer liquidation laws, a state guaranty association covers at least a portion of members' claims in the event of insurer insolvency. "The core responsibility of GAs [Guaranty Associations] is to protect consumers whose insurers have failed – not the insurers. GAs were not created to bail out financially troubled insurance companies but rather to ensure that individual consumers receive a base level of financial protection during their insurer's insolvency resolution process." Peter G. Gallanis, *The Life and Health Insurance Guaranty System, GPSolo, at* 34 (March 2011).[14]

[14] Available at: http://apps.americanbar.org/abapubs/design/smart/0411/life.html.

A reduction on risk corridors payments hits the bottom line budget of the states where insurers have gone into insolvency. Every dollar withheld could have compensated a policyholder through the state guaranty fund. Where the resources of guaranty associations are insufficient, it is the health care providers who will bear the burden, ultimately passing it on to consumers through cost of services. Even with the protections of a guaranty association, if risk corridor funds are withheld, the taxpayers of those states will feel the impact.

The effect of the Government's failure to pay risk corridor amounts, and its conduct in the event of insurer insolvency, is uncertainty over where, when, and how the debits and credits will be resolved, with the states and consumers bearing the costs in the meantime. This frustrates the fundamental purpose of the state liquidation process, which is intended to provide a single forum for resolution of these claims and the protection of policyholders and other creditors.

IV. CONCLUSION

The Government's failure to make full risk corridor payments to insurers operating on the Exchanges has interfered with state insurance commissioners' essential mission to protect insurance consumers. It has induced new insurers into the market only to directly compromise these companies' capital levels once they had committed. It has skewed rate review by introducing an additional level of uncertainty. It has forced regulators to continuously revise accounting guidance for insurers who are affected. It has created disproportionate debt that commissioners must pursue from the Government in the event of insolvency. Finally, it has deterred the insurance industry in general from marketing qualified plans on the Exchanges, dampening competition and hurting consumers.

The continuing doubt and lack of clarity caused by the Government is abhorrent to this particular industry. "As any actuary will tell you, insurance hates uncertainty." Redmer Testimony at 4. " As insurance companies increasingly find no advantage to participating in the Exchanges, it is the consumers who suffer from the lack of affordable health coverage.

The NAIC and its members request this Court order payment of full risk corridor amounts in order to protect consumers, stabilize the market, promote competition and boost financial solvency across the health insurance industry.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32 and Federal Circuit Rule 32 because this brief contains 5,776 words excluding the parts exempted Fed. R. App. P. 32(f) and Federal Circuit Rule 32(b).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and (a)(6) because it has been prepared in a proportionally spaced type-face using Microsoft Word in a 14-point Times New Roman font.

/s/ Steven A. Neeley
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CERTIFICATE OF SERVICE

I certify that on August 28, 2017, I filed the foregoing document by the U.S. Court of Appeals for the Federal Circuit's CM/ECF System.

/s/ Steven A. Neeley
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