No. 2017-1994

IN THE 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,
in case no. 1:16-cv-00649, Judge Thomas C. Wheeler

Brief of THE STATE OF OREGON AND THE STATES OF ALASKA, CALIFORNIA, CONNECTICUT, DELAWARE, HAWAII, KENTUCKY, MARYLAND, MASSACHUSETTS, MINNESOTA, NEW MEXICO, NORTH CAROLINA, PENNSYLVANIA, RHODE ISLAND, VERMONT, WASHINGTON, WYOMING, and THE DISTRICT OF COLUMBIA, as Amici Curiae in Support of Petition for Rehearing En banc

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases Cited

Constitutional and Statutory Provisions

Other Authorities

STATEMENT OF INTEREST OF AMICI

This case implicates the interests that Oregon and other states have as the primary regulators of the health insurance industry. *See* 15 U.S.C. § 1012(a) ("[t]he business of insurance * * * shall be subject to the laws of the several States"); 15 U.S.C. § 1011 ("the continued regulation and taxation by the several States of the business of insurance is in the public interest"). Amici support rehearing on the question whether the government must make the "risk corridor" payments to Moda Health Plan, Inc. ("Moda") that the Affordable Care Act ("ACA") mandates, and that the government has refused to make.

Congress mandated risk-corridor payments to insurance companies to mitigate risk and entice those companies into a marketplace that was untested in crucial respects. Many state regulators relied on that mandate when reviewing proposed rates to ensure that their citizens would receive access to affordable health insurance from financially stable companies. The ruling in this case will have a practical impact in future cases in which Congress mandates risk-mitigating payments to attract participation in a state-regulated industry.

Oregon, moreover, is particularly interested in this case because the federal government's refusal to make the statutorily mandated payments placed Moda in financial jeopardy, placed thousands of Oregon citizens at risk of

losing health-insurance coverage, and required the state to assume supervision of Moda.

Because of their strong interest in the outcome of this case, 18 states and the District of Columbia participated as amici in support of Moda before the panel, and the amici states now submit this brief in support of en banc rehearing under Federal Rule of Appellate Procedure 29(b)(2).

SUMMARY OF ARGUMENT

The majority opinion in this case held that, when enacting risk-corridor payments, Congress intended to create an enforceable obligation to pay insurance companies the full amount due under a statutory formula. But the majority then relied on post-enactment appropriations riders to infer that Congress repealed that obligation, even though Congress at the same time failed to pass a substantive amendment that would have done so expressly.

If the majority opinion is allowed to stand, the federal government will be allowed to avoid making the promised payments that it used to entice Moda and other companies into offering insurance under the ACA. That result compromises those companies' ability to continue providing health insurance coverage, transfers costs to consumers, places additional regulatory burdens on the states, and undermines Congress's stated goal in adopting the ACA—providing health insurance coverage for millions of Americans who previously

were uninsured. This court should revisit whether Congress intended to achieve such a substantive and far-reaching result by means of appropriations riders after expressly rejecting stand-alone legislation to the same effect.

ARGUMENT

The majority opinion in this case held that, in the statute creating the risk-corridors program, Congress "created an obligation of the government to pay" insurers "the full amount indicated by the statutory formula for payments out under the risk corridors program." (Maj. Op. at 19). The amici states agree with that holding.

But the majority also held that "riders in the appropriations bills for FY 2015 and FY 2016 repealed or suspended" that obligation to the extent that the relevant statutory formula called for outgoing payments in an amount exceeding incoming payments under the risk-corridors program. (Maj. Op. at 20). The majority viewed those riders as supplying an "*implication* of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question." (Maj. Op. at 20–21 (emphasis added)). As explained below, the effect of that "new payment methodology" is too significant for Congress to have implemented it implicitly in an appropriations rider. And because the ruling will have far-reaching effects on the market for health insurance, it warrants en banc review.

A. Because eliminating risk-corridor payments would significantly impair the ACA, that result cannot be inferred from appropriations riders.

The majority opinion held that Congress intended, through appropriations riders, to excuse the government from making payments that would be due under the risk-corridor program as it was originally enacted. But Congress would have understood that eliminating those payments would have undermined the goals of the larger bill creating the risk-corridors program. In the absence of a clear statement from Congress, this court should not infer an intent to cause such far-reaching effects from appropriations riders.

1. Congress would have understood that eliminating risk-corridor payments would undermine the goals of the ACA.

The ACA created a new insurance marketplace, one full of unknowns. Congress's stated goal was to "add millions of new consumers to the health insurance market * * * and increase the number and share of Americans who are insured." 42 U.S.C. § 18091(2)(C). Under the ACA, insurers would be offering federally shaped products to millions of citizens whose health histories or risks were largely unknown, and whose purchasing behavior under the new marketplace rules was difficult to predict. Further, the ACA required policies to be "guaranteed issue"—i.e., issued without regard to the applicant's health. Before the ACA, Oregon and virtually all other states had permitted individualized medical underwriting. *Compare* Or. Rev. Stat. § 743.766

(2009), *and* Or. Laws 2003, ch. 748, § 7 (pre-ACA version of statute allowing "carriers who offer individual health benefit plans" to "evaluate the health status of individuals for purposes of eligibility"), *with* Or. Rev. Stat. § 743.766 (2013), *and* Or. Laws 2011, ch. 500, § 24[1] (post-ACA version allowing such health status evaluation only for "grandfathered health plans," i.e., health plans in existence prior to enactment of the ACA); *see also* 42 U.S.C. § 18011 (defining "grandfathered health plan" as one in which such individual was enrolled on March 23, 2010). Due to the new marketplace's uncertainties, many health insurance companies were reluctant to enter the market. The same uncertainties initially bedeviled state regulators as they tried to assess the rates that Moda and others proposed for insuring the previously uninsured.

Congress understood all of this when it mandated risk-corridor payments. As the government concedes, Congress recognized the "pricing uncertainty arising from the unknown health status of an expanded risk pool and the fact that insurers could no longer charge higher premiums or deny coverage based on an enrollee's health." (Appellant's Brief 4). "In an effort to mitigate" those risks and uncertainties, "the ACA established" a number of "premium-

[1] The cited Oregon session laws can be found at https://www.oregonlegislature.gov/bills_laws (under "Oregon laws: 1999-2016 Sessions").

stabilization programs" that commenced in 2014—including the "risk corridor" program. (Appellant's Brief 4-5).

It thus is undisputed that Congress intended the statutory "risk corridor" scheme to help stabilize an essentially new and unknown marketplace, and to diminish the risks of entering that marketplace. The majority opinion appears to recognize as much. (*See* Maj. Op. at 3–4 ("The ACA established three programs designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk corridors.")). That congressional intent is consistent with the majority's holding that, as originally conceived, the risk-corridor program created an enforceable obligation.

That intent establishes Congress's knowledge that, unless insurance companies and states believed that the mandated payments would be made, insurers would be less willing to enter that market, and states would find it difficult to perform their regulatory duties—assessing the health and solvency of insurance companies when deciding whether to approve rates proposed by those companies. For the statutory scheme to have the effect intended by Congress (in part, the providing of insurance to millions of previously uninsured citizens), the payment mandate needed to be understood as creating an enforceable obligation. Otherwise, insurance companies would be deterred

by the risks they faced from entering that new market, and state regulators might be deterred from allowing carriers to shoulder those risks.

Those circumstances also demonstrate that Congress would have understood that eliminating that payment obligation could unravel necessary elements of the ACA insurance marketplace. Because Congress knew that a mandatory obligation was necessary to stabilize the new insurance marketplace created by the ACA, Congress also knew that eliminating that obligation would destabilize that marketplace. Without an enforceable claim to payments necessary to mitigate the risk of insuring those that the ACA hoped to insure, insurance companies would be less able, and less willing, to participate in that business.

2. Congress would not have implemented such far-reaching effects implicitly in appropriations riders.

Because Congress understood how significantly the ACA and state insurance marketplaces would be affected by a change to the risk-corridor payment methodology, Congress is unlikely to have implemented such changes implicitly by burying them in appropriations riders. Indeed, Congress expressly considered and rejected stand-alone legislation to implement precisely the same "new payment methodology" that the majority inferred from the appropriations riders. (*See* Dissenting Op. at 10–11 (discussing Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014))). In contrast to that rejected bill,

the appropriations riders at issue did not purport to change the payment methodology or impose a new requirement of budget neutrality; to the contrary, their text did nothing more than prevent certain appropriations or funds from being diverted to pay for the risk-corridor program. (*See* Maj. Op. at 12 (quoting the relevant appropriations rider)).

This court should not interpret an appropriation rider as implicitly enacting an amendment that Congress rejected under the normal legislative process. To do otherwise would undermine the transparency of the legislative process, encouraging legislators to enact important and controversial legislation through the appropriations process rather than through the open debate and proper deliberation required for normal legislation. Such prudential concerns about the legislative process have given rise to the "cardinal rule that repeals by implication are not favored" and that "the intention of the legislature to repeal must be clear and manifest." *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 189 (1978) (quotations omitted; discussing similar prudential concerns about the legislative process). That rule must apply with even greater force here, where the purportedly implicit amendment was rejected as substantive legislation and where that amendment would not just amend, but significantly impair, the ACA.

This case merits en banc review to allow the full court to determine whether and when an appropriations rider can support inferring congressional intent to substantively and significantly amend important legislation.

B. The court's holding here will have a significant adverse impact on the insurance markets in many states.

Consistently with Congress's understanding that risk-corridor payments are necessary to a well-functioning ACA marketplace, the government's failure to make those payments has significantly and adversely affected the insurance markets in multiple states.

In Oregon, the government's failure to make risk-corridor payments has had a significant adverse impact. As of September 30, 2015, Moda had enrolled roughly 244,000 Oregonians. (App'x 19, January 28, 2016 statement from Oregon Department of Consumer and Business Services).[2] With respect to Moda's Oregon business, the government failed to provide it with $93,362,051 in risk-corridor payments. (Appellant's Brief, App'x 14, Court of Federal Claims Opinion). Those non-payments resulted in Moda descending into hazardous operating conditions, which in turn prompted the State of Oregon to assume supervision of Moda, meaning that it maintained a representative on site and controlled all financial decisions. (App'x 19,

[2] That statement can be found at http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=947.

January 28, 2016 statement from Oregon Department of Consumer and Business Services). The State of Oregon subsequently lifted the supervision order, based on Moda's commitment to raise $179 million in new capital—nearly the $214 million that Moda had failed to collect from the federal government under the risk-corridors program. (App'x 20–25, Consent Order, Case No. INS 16-13-002; Appellant's Brief, App'x 2, Court of Federal Claims Opinion).

Other states also were adversely affected. On the same day that Oregon announced its supervision order, the State of Alaska issued an order requiring Moda, due to inadequate capital, to withdraw from Alaska's individual market. (App'x 26–29, online article in *Alaska Dispatch News*, published 1/28/2016[3]). To stabilize its Oregon operation, Moda also had pulled out of the Washington market, thus weakening the health insurance market in that state. (*See* App'x 30, November 2, 2015 statement by State of Washington, noting that "Moda Health has notified the Office of the Insurance Commissioner that it will not participate in the Washington Health Benefit Exchange * * * for 2016 coverage").

[3] The article also can be found at https://www.adn.com/health/article/alaska-kicks-moda-health-out-individual-insurance-market-leaving-only-premera/2016/01/28/.

The failure to make full risk-corridor payments has similarly undermined the ACA's goal of promoting stability in Pennsylvania's insurance market. After the federal government announced that it would not be making full payments for 2015, several insurance carriers there sought to raise their rates by over 40%. *See* Brief of Pennsylvania Insurance Department as Amicus Curiae Supporting Plaintiffs 13–14, *First Priority Life Ins. Co., et al. v. United States*, No. 16-587C (Ct. Fed. Cl. Oct. 14, 2016).

Finally, the federal government's refusal to make risk-corridor payments of roughly $20 million for 2014–15 to another Oregon company—the Health Republic Insurance Company (HRIC), which insured more than 10,000 members—resulted in that company's failure and in state supervision. (App'x 31, Order Extending Supervision; App'x 33, online article in *The Oregonian*, October 16, 2015[4]). HRIC, which is the lead plaintiff in a class action contesting the governmental non-payments, was a co-op formed with federal start-up loans totaling more than $50 million. (*Id*.; *see also* Court of Federal Claims Opinion, *Health Republic Insurance Company v. the United States*, Case No. 16-259C). In licensing such companies, Oregon had relied on pro forma financial statements that included substantial risk-corridor payments in

[4] The article can also be found at http://www.oregonlive.com/health/index.ssf/2015/10/oregon_insurer_health_republic.html.

addition to loan funds under the ACA. The refusal to make risk-corridor payments frustrates the ACA's goal of diversifying the health insurance marketplace and results in defaults on federal loans. If insurance companies fail, it reduces the availability of potential insurers who are willing to provide insurance in a manner that furthers the ACA's overall goals.

Those effects are likely just the beginning. If the majority opinion stands, regulators and insurers will have to address the permanent loss of the risk-corridor payments on which they had relied. In some instances, unpaid risk-corridor payments will be passed on to ratepayers, thus shifting costs of the federal default to the consumers themselves. In other instances, unpaid risk-corridor obligations, by increasing the costs and risks of doing business in the individual health insurance markets, will reduce the number of carriers willing to cover those markets, particularly in rural areas. (*See* App'x 35, July 8, 2016 statement by Oregon Department of Consumer and Business Services, noting the state's "concern about limited options for consumers, particularly in rural areas of the state," and noting that "several insurers are discontinuing coverage in certain counties for 2017")[5]. Like many states, Oregon has struggled to maintain statewide coverage in the face of federal headwinds. And for the

[5] That statement can be found at http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1211.

reasons set forth above, Congress was not blind to these entirely predictable effects.

In short, the majority's ruling will have an effect beyond just the parties in this case, and in states beyond those in which Moda operates. Moreover, as explained above, the majority's rationale and reasoning will affect future cases where courts must determine whether an appropriations rider has implicitly amended a substantive statute. For all those reasons, this case warrants review by the full court.

CONCLUSION

This court should allow rehearing and consider this case en banc.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 14, 2018, I filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Federal Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the requirements of Federal Rule of Appellate Procedure 32(a)(5) and (6) because it has been prepared in Times New Roman 14 point, a proportionally spaced font. I further certify that this brief complies with the type-volume limitation of Federal Circuit Rule 35(g) because it contains 2,570 words, excluding the parts of the brief exempted by Federal Rule Appellate Procedure 32(a)(7)(B)(iii) and Circuit Rule 32(b).

DATED: August 14, 2018

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