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 and Appendix of THE STATE OF OREGON AND THE STATES OF ALASKA, CALIFORNIA, CONNECTICUT, HAWAII, ILLINOIS, IOWA, MARYLAND, MASSACHUSETTS, MINNESOTA, NEW MEXICO, NORTH CAROLINA, PENNSYLVANIA, RHODE ISLAND, VERMONT, VIRGINIA, WASHINGTON, WYOMING, and THE DISTRICT OF COLUMBIA, as Amici Curiae in Support of Appellee

---

ELLEN F. ROSENBLUM
Attorney General

BENJAMIN GUTMAN
Solicitor General
State of Oregon
Department of Justice
1162 Court St. NE
Salem, Oregon 97301-4096
Telephone: (503) 378-4402
benjamin.gutman@doj.state.or.us

Attorneys for Amici Curiae

UNITED STATES COURT OF APPEALS FOR THE FEDERAL CIRCUIT

Moda Health Plan, Inc. **v.** United States

Case No. 2017-1994

CERTIFICATE OF INTEREST

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

State of Oregon

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
Oregon and other states	None	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:

None

August 28, 2017
Date

/s/ Benjamin Gutman
Signature of counsel

Please Note: All questions must be answered

Benjamin Gutman
Printed name of counsel

cc:

Reset Fields

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

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 ask this court to affirm the Court of Federal Claims judgment directing the government to 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.

In adopting the ACA, Congress mandated annual "risk corridor" payments to insurance companies under certain circumstances; it did so to mitigate risk and entice those companies into a marketplace that was untested in crucial respects. Predictably, many state regulators relied on that mandate when reviewing proposed rates, and when attempting to ensure—despite the uncertainties in the new health-insurance marketplace that the ACA fostered—that their citizens would receive access to affordable health insurance from financially stable companies. The result in this case will have a practical impact not just in states in which Moda insures citizens, but may affect 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 Moda has insured over 200,000 Oregon citizens. 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 the amici states' strong interest in the outcome of this case, they submit this brief under Federal Rule of Appellate Procedure 29(a)(2).

SUMMARY OF ARGUMENT

Even before the ACA's adoption, many states, including Oregon, subjected health insurance rates to prior review and approval. Further, the ACA itself requires the federal government to work with the states to review proposed rates. But to conduct meaningful rate review, and to perform their regulatory duties adequately, states need to assess whether a proposed rate will jeopardize an insurer's financial health. Congress understood this when it enacted the ACA; it knew that the ACA—which was intended to ensure that millions of previously uninsured citizens would receive coverage—introduced a host of unknowns into the health insurance marketplace. To mitigate those uncertainties, Congress created three risk-mitigation programs. One of those

was the risk-corridor program, which mandated payments to insurance companies under certain circumstances, in the event that insurers had set their rates too low.

Congress necessarily anticipated (and intended) that insurers would rely on the mandatory nature of the risk-corridor payments when proposing rates, and that many state regulators would rely on the payments' mandatory nature when reviewing those rates. That supports the inference that Congress intended the mandated payments to constitute an enforceable obligation, an obligation that could be satisfied from the Judgment Fund in the event that Congress did not expressly identify some other source.

If the government's proposed statutory construction were correct, and if it were *not* required to make the payments at issue, the ability of Moda and other companies to continue providing health insurance coverage would be compromised, costs would be transferred to consumers, and states would bear additional regulatory burdens. Ultimately, such a construction would undermine Congress's stated goal in adopting the ACA—providing health insurance coverage for millions of Americans who previously were uninsured.

ARGUMENT

A. Congress must have expected, and intended, that state regulators and insurance companies—in making rate-setting decisions—would assume that risk-corridor payments would be made as mandated by the ACA.

When adopting the ACA, Congress would have expected that state regulators and insurance companies—in making rate-setting decisions in the new health-insurance marketplace that the ACA created—would assume that risk-corridor payments would be made as mandated by the ACA. In turn, that supports the inference that Congress intended that payments would be made even if it did not separately appropriate funds to do so.

1. Many states reviewed proposed health-insurance rates prior to the ACA, and the ACA itself calls for such review.

"Historically, many states subjected health insurance rates to prior approval." (Appx. 4, "State Insurance Regulation," National Association of Insurance Commissioners & The Center for Insurance Policy and Research 2011, at p. 3).[1] In Oregon, for example, state statutes—even before the ACA was adopted—required the state to review proposed rates to assess whether they

[1] That paper can be found at: http://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf

were "[a]ctuarially sound," reasonable, and "[b]ased upon reasonable administrative expenses." Or. Rev. Stat. § 743.018(4) (2009); Or. Laws 2009, ch. 595, § 31.[2] The state was entitled to consider, among other things, the insurer's "financial position," its "projected loss ratio between the amounts spent on medical services and earned premiums," and whether the proposed rate is "necessary to maintain the insurer's solvency." Or. Rev. Stat. § 743.018(5)(a), (c), (g) (2009); Or. Laws 2009, ch. 595, § 31.[3]

The ACA requires the federal government to act "in conjunction with" the states to conduct annual rate reviews. *See* 42 U.S.C. § 300gg-94(a)(1) (requiring federal government, "in conjunction with States," to "establish a process for the annual review, beginning with the 2010 plan year * * * , of unreasonable increases in premiums for health insurance coverage"); 42 U.S.C. § 300gg-94(b)(2)(A) (requiring government, beginning with 2014 plan years, to act "in conjunction with the States" to "monitor premium increases of health insurance coverage"). Congress thus wanted, and intended, the states to bear

---

[2] That version can be found online at:

https://www.oregonlegislature.gov/bills_laws (under "Oregon laws: 1999-2016 Sessions")

[3] That version can be found at:

https://www.oregonlegislature.gov/bills_laws (under "Oregon laws: 1999-2016 Sessions")

most of the regulatory load in reviewing rates, and it created a grant program to help states do so. *See* 42 U.S.C. § 300gg-94(c)(1) (requiring "a program to award grants to States during the 5-year period beginning with fiscal year 2010 to assist such States in carrying out subsection (a), including * * * reviewing and, if appropriate under State law, approving premium increases for health insurance coverage").[4]

2. Congress anticipated (and intended) that many state regulators would rely on the statutorily mandated "risk corridor" payments when making rate-review decisions.

If states are to conduct meaningful rate review, they need to assess whether a proposed rate will jeopardize an insurer's financial health. Doing so enables them to fulfill their twin regulatory objectives: (1) assuring that affordable health insurance is available to their citizens while (2) ensuring that insurers are financially strong enough to be able to provide such insurance into the foreseeable future. (Appx. 3, "State Insurance Regulation," National

---

[4] 45 CFR § 154.301 established a "rate review program" and identifies criteria for concluding that a state has an "Effective Rate Review" program, such that the federal government will adopt that state's determination whether rate increases in its market are unreasonable. As of March 2017, 47 states and the District of Columbia had "Effective Rate Review" programs. (Appx 8: Centers for Medicare and Medicaid Services: The Center for Consumer Information & Insurance Oversight: "State Effective Rate Review Programs"; accessible at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/rate_review_fact_sheet.html)

Association of Insurance Commissioners & The Center for Insurance Policy and Research 2011, at p. 2, noting that "[t]he fundamental reason for government regulation of insurance is to protect American consumers," and that "[t]he public wants two things from insurance regulators": "solvent insurers who are financially able to make good on the promises they have made and * * * insurers [who] treat policyholders and claimants fairly").

Making those assessments following the ACA's passage was no easy task. As the government acknowledges (Appellant's Brief 4), the ACA essentially 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). The ACA created a new federally regulated marketplace, in which federally shaped products would be offered to millions of citizens whose health histories or risks were largely undocumented, and whose purchasing behavior under the new marketplace rules was difficult to predict. Further, the ACA required policies to be "guaranteed issue"—*i.e.*, policies 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); Or. Laws 2003, ch.

748, § 7[5] (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); Or. Laws 2011, ch. 500, § 24[6] (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 many uncertainties, many health insurance companies were reluctant to enter it. The same uncertainties bedeviled many 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

---

[5] That version can be found at:

https://www.oregonlegislature.gov/bills_laws (under "Oregon laws: 1999-2016 Sessions")

[6] That version can be found at;

https://www.oregonlegislature.gov/bills_laws (under "Oregon laws: 1999-2016 Sessions")

on an enrollee's health." (Appellant's Brief 4). "In an effort to mitigate" those risks and uncertainties, "the ACA established three premium-stabilization programs" that commenced in 2014—the "reinsurance, risk adjustment, and risk corridor" programs. (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 market place, and to diminish the risks of entering that market place. Congress would have known 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 would be deterred from allowing carriers to shoulder those risks.

Before the federal government announced in October 2015 that it would not be making the majority of the mandated 2014 risk-corridor payments,

Oregon (like many states) had allowed Moda and other insurers to list anticipated risk-corridor payments as assets for statutory accounting purposes. Only after the federal government's announcement did Oregon (following guidance published by the National Association of Insurance Commissioners—*see* Appx. 13)[7] begin treating the risk-corridor payments as "not reasonably collectible," and begin disallowing them as assets for statutory accounting purposes.

Those factors support the inference that Congress intended state regulators and insurance companies to be able to rely on the expectation that the mandated payments would be made, even if Congress did not separately appropriate funds for that purpose. Put slightly differently, Congress intended the statutorily mandated payments to create an enforceable obligation.

In short, if a statute mandates payments to insurance companies under certain circumstances in order to entice them into an untested marketplace and to diminish their risks, the mandate creates an enforceable obligation (at least in the Court of Federal Claims) even if Congress has not separately appropriated funds for the mandated payments. As Moda points out, the ACA

---

[7] That NAIC document also can be found at: http://www.naic.org/documents/committees_e_app_eaiwg_related_int_1501_risk_corridors.pdf

unambiguously requires that the government "shall pay" the risk-corridor obligations at issue, "with no hint that such payments are limited to receipts from profitable insurers." (Appellee's Brief 10). When, as in this case, a private party seeks money damages from the government, the Tucker Act provides a remedy and, as Moda puts it, the "only necessary appropriation is the permanent, indefinite Judgment Fund" that Congress created prior to the ACA's adoption. (Appellee's Brief 11).

B. Moda is not asking the government to rescue it from its own business decisions.

Through the ACA, Congress essentially invited insurance companies and states to enter an uncertain economic arena. Congress enticed them do so, in part by mandating the payments at issue as a way to reduce the financial exposure participating companies would face. Although the government then failed to make the mandated payments to those whose exposure was greater than they anticipated, the government is now trying to fault the companies (and, by implication, states such as Oregon) for relying on the statutory mandate, and for accepting Congress's invitation.

The government suggests that Moda, and others who are entitled to the mandated payments, believe that the risk-corridor payments were designed to "eliminate" their risks and to insulate insurers from lapses in "business judgment." (Appellant's Brief 32, 27). It writes that "[t]he indemnity that

insurers now seek * * * would have exacerbated insurers' incentives to compete for market share * * * by selling policies below cost." (Appellant's Brief 32). Yet neither Moda nor any other insurer held any such belief; the risk-corridor provisions in the ACA unmistakably provided that risk-corridor payments would cover only a *portion* of an insurance company's losses when approved rates turned out to be too low. *See* 42 U.S.C. § 18062((b)(1) (if insurer's "allowable costs" exceed target amount by more than three percent, government shall pay a specified percentage of the difference). Moda would have understood that even if the government were to make all mandated risk-corridor payments, the ACA's text nonetheless requires companies to bear a significant portion of their own losses if they "aimed too low" in their proposed rates.

Even under Moda's proposed construction of the ACA, insurers retained significant incentives to avoid proposing artificially low rates, given that risk-corridor payments would not cover all of their losses if those rates were based on assumptions that later proved to be faulty. Moda's proposed construction does not reward insurers for errors in assessing the risks associated with particular insurance rates, and it does not suggest that states would have felt free to "rubber stamp" proposed rates reflecting such errors.

C. The government's proposed statutory construction will undermine the ACA's goal of expanding health insurance coverage, will transfer costs to consumers, and will impose additional regulatory burdens on states.

The government's refusal to make the mandated payments has jeopardized the ability of citizens to maintain health-insurance coverage and has increased the regulatory burden on states such as Oregon. If the judgment directing the government to make the mandated payments is reversed, health-care consumers will suffer the consequences.

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. (Appx. 19, January 28, 2016 statement from Oregon Department of Consumer and Business Services).[8] With respect to Moda's Oregon business, the government failed to provide it with $93,362,051 in risk-corridor payments. (Appellant's Brief, Appx. 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

---

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

representative on site and controlled all financial decisions. (Appx. 19, 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 amount that Moda had failed to collect from the federal government with respect to the coverage it provided in Oregon, Washington, and Alaska. (Appx. 20-25, Consent Order, Case No. INS 16-13-002).

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. (Appx. 26-29, online article in *Alaska Dispatch News*, published 1/28/2016[9]). To stabilize its Oregon operation, Moda also had pulled out of the Washington market, thus weakening the health insurance market in that state. (*See* Appx. 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

[9] 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/

participate in the Washington Health Benefit Exchange * * * for 2016 coverage").[10]

Similarly, 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. (Appx. 31, Order Extending Supervision; Appx. 33, online article in *The Oregonian*, October 16, 2015[11]). 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*

---

[10] In Pennsylvania, the failure to make full risk-corridor payments has undermined the ACA's goal of promoting stability in the market. After the federal government announced that it would not be making full payments for 2015, several insurance carriers 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).

[11] The article can also be found at:

http://www.oregonlive.com/health/index.ssf/2015/10/oregon_insurer_health_republic.html

forma financial statements that included substantial risk-corridor payments in 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 ACA's overall goals.

If the government is correct, and if it need not make the payments mandated by the ACA, the following will occur: 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* Appx. 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")[12]. Like many states, Oregon has struggled to maintain statewide coverage in the face of federal headwinds.

---

[12] That statement can be found at:

Footnote continued…

If the government were correct, and if it were not required to make the mandated payments, insurance companies would be less able, and less willing, to insure those that the ACA hoped to insure. The government's proposed statutory construction is at odds with Congress's express intent in adopting the ACA—its intent to ensure that millions of previously uninsured citizens receive health-insurance coverage.

CONCLUSION

This court should affirm the Court of Federal Claims' judgment directing the government to make the mandated payments at issue.

Respectfully submitted,

ELLEN F. ROSENBLUM
Attorney General

/s/ Benjamin Gutman

BENJAMIN GUTMAN
Solicitor General
State of Oregon
Department of Justice
1162 Court St. NE
Salem, Oregon 97301-4096
Telephone: (503) 378-4402
benjamin.gutman@doj.state.or.us

Attorneys for Amici Curiae

(…continued)
http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1211

JAHNA LINDEMUTH
Attorney General
State of Alaska
PO Box 110300
Juneau, AK 99811-0300

XAVIER BECERRA
Attorney General
State of California
1300 I Street
Sacramento, CA 95814

GEORGE JEPSEN
Attorney General
55 Elm Street
Hartford, CT 06106

DOUGLAS S. CHIN
Attorney General
Department of the Attorney General
of the State of Hawaii
425 Queen Street
Honolulu, HI 96813

LISA MADIGAN
Attorney General
State of Illinois
100 West Randolph Street, 12th Floor
Chicago, IL 60601

THOMAS J. MILLER
Attorney General of Iowa
1305 E. Walnut Street
Des Moines, IA 50319

BRIAN E. FROSH
Attorney General of Maryland
200 Saint Paul Place
Baltimore, MD 21202

MAURA HEALEY
Attorney General
Commonwealth of Massachusetts
One Ashburton Place
Boston, MA 02108

LORI SWANSON
Attorney General of Minnesota
102 State Capitol
75 Rev. Dr. Martin Luther King Jr. Blvd.
St. Paul, MN 55155

HECTOR BALDERAS
Attorney General of New Mexico
408 Galisteo St.
Santa Fe, NM 87501

JOSH STEIN
Attorney General of North Carolina
North Carolina Department of Justice
Post Office Box 629
Raleigh, NC 27602

JOSH SHAPIRO
Attorney General of Pennsylvania
Pennsylvania Office of Attorney General
Strawberry Square
Harrisburg, PA 17120

PETER F. KILMARTIN
Attorney General
State of Rhode Island
150 S. Main St.
Providence, RI 02903

THOMAS J. DONOVAN, JR.
Attorney General
Office of the Attorney General
109 State Street
Montpelier, VT 05609-1001

MARK R. HERRING
Attorney General of Virginia
202 North Ninth Street
Richmond, VA 23219

ROBERT W. FERGUSON
Attorney General of Washington
1125 Washington Street SE
PO Box 40100
Olympia, WA 98504-0100

PETER K. MICHAEL
Wyoming Attorney General
Kendrick Building
2320 Capitol Avenue
Cheyenne, WY 82002

KARL A. RACINE
Attorney General for the District of Columbia
One Judiciary Square
414 4th Street, NW
Suite 600 South
Washington, D.C. 20001

APPENDIX

STATE INSURANCE REGULATION

This article provides an overview of state insurance regulation, including a brief history, discussion of state regulatory roles and institutions involved.

NAIC National Association of Insurance Commissioners

The Center for Insurance Policy and Research

A Brief History

Benjamin Franklin helped found the insurance industry in the United States in 1752 with the Philadelphia Contributionship for the Insurance of Houses from Loss by Fire. The current state insurance regulatory framework has its roots in the 19th century with New Hampshire appointing the first insurance commissioner in 1851. In 1869, the Supreme Court held, in the case Paul v. Virginia, that "issuing a policy of insurance is not a transaction of commerce." As a result, states were left with responsible over the taxation and regulation of insurance. The need to discuss issues of common concern led to the formation of the National Insurance Convention in 1871, which later became known as the National Association of Insurance Commissioners (NAIC). Insurance regulators' responsibilities grew in scope and complexity as the industry evolved. Another Supreme Court case (United States v. Southeastern Underwriters) led to the overturning of the Paul v. Virginia decision. In the Southeastern Underwriters case the Supreme Court held that insurance was indeed commerce. This caused turmoil as there was a regulatory void that led Congress to enact the McCarran-Ferguson Act in 1945. The McCarran-Ferguson Act clarified that states should continue to regulate and tax the business of insurance and affirmed that the continued regulation of the insurance industry by the states was in the public's best interest.

The Financial Services Modernization Act of 1999, also known as the Gramm-Leach-Bliley Act, established a comprehensive regulatory framework to permit affiliations among banks, securities firms and insurance companies by repealing the Depression Era Glass-Steagall Act. The Gramm-Leach-Bliley Act once again affirmed that states should regulate the business of insurance by declaring that the McCarran-Ferguson Act remained in effect. However, Congress also called for state reform to allow insurance companies to compete more effectively in the newly integrated financial service marketplace and to respond with innovation and flexibility to evermore demanding consumer needs. It established the concept of functional regulation where each functional regulator is responsible for regulation of its functional area.

The Wall Street Reform and Consumer Protection Act of 2010, better known as the Dodd-Frank Act once again had an impact on state insurance regulation. While primarily banking and securities reform legislation, Dodd-Frank did create the Federal Insurance Office as an information gatherer to inform Congress on insurance matters. It also included some reinsurance reform and changed the basis for regulation and taxation of surplus lines insurers. The Federal Insurance Office was granted limited authority to enter into covered agreements with other nations on insurance regulatory matters. However; the primary state insurance regulatory functions remain as they have been since the enactment of McCarran-Ferguson. This allows to states to perform solvency oversight of the U.S. insurance industry and to regulate insurer behavior in the marketplace.

The Role of the State Legislatures

State legislatures are the public policymakers that establish set broad policy for the regulation of insurance by enacting legislation providing the regulatory framework under which insurance regulators operate. They establish laws which grant regulatory authority to regulators and oversee state insurance departments and approve regulatory budgets. State insurance departments employ 11,600 regulatory personnel (2010 figures). Increases in staff and enhanced automation have allowed regulators to substantially boost the quality and effectiveness of their financial oversight of insurers and expand consumer protection activities.

State regulation of insurance provides a major source of state revenue. In 2010, states collected roughly $18.6 billion in revenues from insurance sources. Of this amount, $1.24 billion—roughly 6.7 percent—went to regulate the business of insurance while the remaining revenues went to state general funds for other purposes.

National Association of Insurance Commissioners (NAIC)

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. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate their regulatory oversight. NAIC staff supports these efforts and represents the collective views of state regulators domestically and internationally. NAIC members, together with the central resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The Purpose and Structure of Insurance Regulation

The fundamental reason for government regulation of insurance is to protect American consumers. Insurance is more heavily regulated than other types of business because of the complexity of the insurance contracts, the lack of sufficient information for insurance consumers to adequately shop for prices and adequacy of coverage and because insurance contracts are generally contracts of adhesion. Conceptually insurance regulation is very simple. The public wants two things from insurance regulators. They want solvent insurers who are financially able to make good on the promises they have made and they want insurers to treat policyholders and claimants fairly. All regulatory functions will fall under either solvency regulation or market regulation to meet these two objectives. State insurance regulatory systems are accessible and accountable to the public and sensitive to local social and economic conditions. State regulation has proven that it effectively protects consumers and ensures that promises made by insurers are kept. Insurance regulation is structured around several key functions, including insurer licensing, producer licensing, product regulation, market conduct, financial regulation and consumer services.

Insurer Licensing: State laws require insurers and insurance-related businesses to be licensed before selling their products or services. Currently, there are approximately 7,800 insurers in the United States. All U.S. insurers are subject to regulation in their state of domicile and in the other states where they are licensed to sell insurance. Insurers who fail to comply with regulatory requirements are subject to license suspension or revocation, and states may exact fines for regulatory violations. In 2010, there were 342 companies that had their licenses suspended or revoked. The NAIC's Uniform Certificate of Authority Application (UCAA), an insurer licensing facilitation system, helps states expedite the review process of a new company license. In addition, an NAIC database has been developed to facilitate information sharing on acquisition and merger filings. These databases assist insurance regulators by creating a streamlined and more cost efficient regulatory process.

Producer Licensing: Insurance agents and brokers, also known as producers, must be licensed to sell insurance and must comply with various state laws and regulations governing their activities. Currently, more than two million individuals are licensed to provide insurance services in the United States. State insurance departments oversee producer activities in order to protect insurance consumer interests in insurance transactions.

The states administer continuing education programs to ensure that agents meet high professional standards. Producers who fail to comply with regulatory requirements are subject to fines and license suspension or revocation. In 2010, roughly 5,000 insurance producers had their licenses suspended or revoked. Fines exceeded $25 million and over $50 million was returned to rightful owners.

When insurance producers operate in multiple jurisdictions, states must coordinate their efforts to track producers and prevent violations. Special databases are maintained by the NAIC to assist the states in this effort. The National Insurance Producer Registry (NIPR)—a non-profit affiliate of the NAIC—was established to develop and operate a national repository for producer licensing information.

Product Regulation: State regulators protect consumers by ensuring that insurance policy provisions comply with state law, are reasonable and fair, and do not contain major gaps in coverage that might be misunderstood by consumers and leave them unprotected. The nature of the regulatory reviews of rates, rating rules and policy forms varies somewhat among the states depending on their laws and regulations.

For personal property-casualty lines, about half of the states require insurers to file rates and to receive prior approval before rate or policy form filings go into effect. With the exception of workers' compensation and medical malpractice, commercial property-casualty lines in many states are subject to a competitive rating approach. Under such a system, regulators typically retain authority to disapprove rates if they find that competition is not working.

Rates for life insurance and annuity products generally are not subject to regulatory approval, although regulators may seek to ensure that policy benefits are commensurate with the premiums charged. Historically, many states subjected health insurance rates to prior approval—with some states using a

"file and use" system or no provisions for review. The recently adopted Affordable Care Act has changed the landscape for health insurance. All states now must review health insurance rates before they go into effect. Health insurance rates are also subject to review by the Department of Health and Human Services if the rate change is deemed to be "unreasonable." Improvements are also included addressing the way in which consumers shop for health insurance. Health insurance exchanges are being developed and there is much focus of transparency of consumer information.

State insurance regulators, in the early 1990s, developed SERFF (System for Electronic Rate and Form Filings). The intent was to provide a cost-effective method for handling insurance policy rate and form filings between regulators and insurance companies. The SERFF system is designed to enable companies to send and states to receive, comment on, and approve or reject insurance industry rate and form filings. It has added incredible operational efficiencies that enhanced speed to market for rate and policy form filings. In 2010, over 565,000 filings were processed through SERFF.

Insurance regulators have also been innovative in addressing speed to market concerns of insurers desiring the ability to make a single filing that applies in multiple jurisdictions. The Interstate Insurance product Regulation Compact (Compact) is an important modernization initiative that benefits state insurance regulators, consumers and the insurance industry. The Compact enhances the efficiency and effectiveness of the way insurance products are filed, reviewed and approved allowing consumers to have faster access to competitive insurance products in an ever-changing marketplace. The Compact promotes uniformity through application of national product standards embedded with strong consumer protections.

The Compact established a multi-state public entity, the Interstate Insurance Product Regulation Commission (IIPRC) which serves as an instrumentality of the Member States. The IIPRC serves as a central point of electronic filing for certain insurance products, including life insurance, annuities, disability income and long-term care insurance to develop uniform product standards, affording a high level of protection to purchasers of asset protection insurance products. The IIPRC uses the SERFF filing network for its communications between the 41 participating jurisdictions, representing approximately two-thirds of the premium volume nationwide, and the insurers using the system for flings.

Financial Regulation: Financial regulation provides crucial safeguards for America's insurance consumers. The states maintain at the NAIC the world's largest insurance financial database, which provides a 15- year history of annual and quarterly filings on 5,200 insurance companies. Periodic financial examinations occur on a scheduled basis. State financial examiners investigate an insurer's accounting methods, procedures and financial statement presentation. These exams verify and validate what is presented in the insurer's annual statement to ascertain whether the insurer is in sound financial standing. When an examination of financial records shows the company to be financially impaired, the state insurance department takes control of the insurer. Aggressively working with financially troubled companies is a critical part of the regulator's role. In the event the insurer must be liquidated or becomes insolvent, the states maintain a system of financial guaranty funds that cover most of consumers' losses.

State financial regulators are subject to a peer review through an accreditation process. To achieve accreditation, an insurance department is required to undergo a comprehensive review by an independent review team every five years to ensure the department continues to meet baseline financial solvency oversight standards. The accreditation standards require state insurance departments to have adequate statutory and administrative authority to regulate an insurer's corporate and financial affairs, as well as the necessary talent and resources to carry out that authority.

Market Regulation: Market regulation attempts to ensure consumers are charged fair and reasonable insurance prices, have access to beneficial and compliant insurance products and insurers operate in ways that are legal and fair to consumers. With improved cooperation among states and uniform market conduct examinations where uniformity is needed, regulators hope to ensure continued quality consumer protection at the state level. Traditional market conduct examinations occur on a routine basis, but also can be triggered by complaints against an insurer. These exams review producer licensing issues, complaints, types of products sold by insurers and producers, producer sales practices, compliance with filed rating plans, claims handling and other market-related aspects of an insurer's operation. When violations are found, the insurance department makes recommendations to improve the insurer's operations and to bring the company into compliance with state law. In addition, an insurer or insurance producer may be subject to civil penalties or license suspension or revocation.

Insurance regulators, through the NAIC, began the Market Conduct Annual Statement (MCAS) in 2002 with the goal of collecting uniform market conduct related data. The MCAS provides market regulators with information not otherwise available for their market analysis initiatives. It promotes uniform analysis by applying consistent measurements and comparisons between insurers. MCAS has always been a collaboration of regulators, industry and consumers who recognize the benefits of monitoring, benchmarking, analyzing, and regulating the market conduct of insurance companies. Through this teamwork, MCAS has grown from eight states collecting only Life and Annuity information to nearly all states collecting Property and Casualty data, as well as Life and Annuity information.

Consumer Services: The single most significant challenge for state insurance regulators is to be vigilant in the protection of consumers, especially in light of the changes taking place in the financial services marketplace. State insurance regulators have established toll- free hotlines, Internet Web sites and special consumer services units to receive and handle complaints against insurers and insurance producers. The state insurance regulators also have launched an interactive tool to allow consumers to research company complaint and financial data using the NAIC Web site. Called the Consumer Information Source, this web-based tool allows consumers to file a complaint, report suspected fraud and access key financial and market regulatory information about insurers

During 2010, state insurance departments handled over 2.1 million consumer inquiries and over 300,000 formal consumer complaints. As needed, state insurance departments worked together with claimants, policyholders and insurers to resolve disputes. In addition, many states sponsor consumer education

CMS.gov
Centers for Medicare & Medicaid Services

The Center for Consumer Information & Insurance Oversight

State Effective Rate Review Programs

For more than a decade, health insurance premiums have risen rapidly, straining the pocketbooks of American families and businesses. Since 1999, the cost of coverage for a family of four has climbed 131 percent.[i] These increases have forced families and employers to spend more money, often for less coverage. Many times, insurance companies have been able to raise rates without explaining their actions. In most cases, consumers receive little or no information about proposed premium increases, and aren't told why health insurance companies want to raise rates.

The Affordable Care Act is bringing an unprecedented level of scrutiny and transparency to health insurance rate increases. The Act ensures that, in any State, any proposed rate increase by individual or small group market insurers at or above 10 percent will be scrutinized by independent experts to make sure it is justified. This analysis will help moderate premium hikes and lower costs for individuals, families, and businesses that buy insurance in these markets. Additionally, insurance companies must provide easy to understand information to their customers about their reasons for unreasonable rate increases, as well as publicly justify and post on their website any unreasonable rate increases. These steps allow consumers to know why they are paying higher rates.

The Affordable Care Act makes $250 million available to States to take action against insurers seeking unreasonable rate hikes. To date, 43 States and the District of Columbia are using $250 million in grants provided by HHS to help them improve their oversight of proposed health insurance rate increases.

State rate review activities are paying off for consumers:

- Improved rate review has reduced total premiums in the individual and small group markets by approximately $1 billion in 2013 and $1.2 billion in 2012 [ii]
- Rhode Island's Insurance Commissioner used his rate review authority to reduce a proposed increase by a major insurer in that State from 7.9 percent to 1.9 percent.
- Californians were saved from rate increases totaling as high as 87 percent after a California insurer withdrew its proposed increase after scrutiny by the State Insurance Commissioner.
- Nearly 30,000 North Dakotans saw a proposed increase of 23.7 percent cut to 14 percent following a public outcry.
- Connecticut's Insurance Department rejected a proposed 20 percent rate hike by one of the State's major insurers.

New Tools Will Help States, Consumers

Starting September 1, 2011, insurers seeking rate increases of 10 percent or more for non-grandfathered plans in the individual and small group markets are required to publicly disclose the proposed increases and the justification for them. Such increases will be reviewed by State or Federal independent experts to determine whether they are unreasonable. The proposed increases will also be made publicly available through HHS, State and/or insurer websites.

The rate review regulations work in conjunction with other parts of the Affordable Care Act that will also hold premiums down. The law requires insurers to spend at least 80 percent of premium dollars on direct medical care or to improve the quality of care instead of on overhead, advertising, and executive salaries and bonuses. If an insurer fails to meet that test, they must pay a rebate to their enrollees. This "medical loss ratio" regulation, released on November 22, 2010, makes the health insurance marketplace more transparent and increases the value consumers receive for their money.

States with Effective Rate Review Programs

HHS encourages States to conduct rate review and has worked with States to strengthen their programs. As detailed in the rate review regulation finalized on May 19, 2011, and amended in 2011, 2012 and 2013, 2015, and 2016, States with effective rate review systems must conduct reviews of proposed rates above the applicable threshold (currently at or above10%), but if a State lacks the resources or authority to conduct the required rate reviews, HHS will conduct them.

An effective rate review system:

- Must receive sufficient data and documentation concerning rate increases to conduct an examination of the reasonableness of the proposed increases.
- Must consider the factors below as they apply to the review:

- Medical cost trend changes by major service categories
- Changes in utilization of services (i.e., hospital care, pharmaceuticals, doctors' office visits) by major service categories
- Cost-sharing changes by major service categories
- Changes in benefits
- Changes in enrollee risk profile
- Impact of over- or under-estimate of medical trend in previous years on the current rate
- Reserve needs
- Administrative costs related to programs that improve health care quality
- Other administrative costs
- Applicable taxes and licensing or regulatory fees
- Medical loss ratio
- The issuer's capital and surplus
- The impacts of geographic factors and variations
- The impact of changes within a single risk pool to all products or plans within the risk pool; and
- The impact of reinsurance and risk adjustment payments and charges under sections 1341 and 1343 of the Affordable Care Act.

- Must make a determination of the reasonableness of the rate increase under a standard set forth in State statute or regulation.
- Must post either rate filings under review or rate filing justifications on the State website or post a link to the rate filing justification information that appears on the CMS website.
- Must provide a mechanism for receiving public comments on proposed rate increases.
- Must report results of rate reviews to CMS for rate increases subject to review.

To determine whether a State met these standards, HHS reviewed all available documentation, and met with State regulators and their staff to verify the information and obtain any updates. CMS will continue to accept information from States and monitor States in order to ensure correct classification. CMS can reevaluate the status of this list as changes are made in each State.

HHS also issued an amendment to the rate review final rule making clear that coverage sold to individuals or small groups through an association is subject to rate review, on or after November 1, 2011. The list below indicates whether Federal or State process will be used to review proposed insurance rate increases in each market.

As of March 17, 2017:

- Forty-seven States and the District of Columbia have effective rate review in both insurance markets;
- In three States, the Federal government will conduct reviews in both markets, until those areas are able to strengthen their review processes and authorities.

List of Effective Rate Review Programs

The list below indicates whether Federal or State process will be used to review proposed insurance rate increases.

Updated March 17, 2017.

State	Individual Market	Small Group Market	Individual & Small Group Effective Rate Review Program
Alabama	State	State	Yes
Alaska‡	State	State	Yes
Arizona‡	State	State	Yes

Arkansas	State	State	Yes
California	State	State	Yes
Colorado	State	State	Yes
Connecticut	State	State	Yes
Delaware	State	State	Yes
District of Columbia	State	State	Yes
Florida	State	State	Yes
Georgia	State	State	Yes
Hawaii‡	State	State	Yes
Idaho‡	State	State	Yes
Illinois	State	State	Yes
Indiana	State	State	Yes
Iowa‡	State	State	Yes
Kansas	State	State	Yes
Kentucky	State	State	Yes
Louisiana	State	State	Yes
Maine	State	State	Yes
Maryland	State	State	Yes
Massachusetts	State	State	Yes
Michigan	State	State	Yes
Minnesota	State	State	Yes
Mississippi	State	State	Yes
Missouri	State	State	Yes
Montana	State	State	Yes
Nebraska	State	State	Yes
Nevada	State	State	Yes
New Hampshire	State	State	Yes
New Jersey	State	State	Yes
New Mexico	State	State	Yes

New York	State	State	Yes
North Carolina	State	State	Yes
North Dakota	State	State	Yes
Ohio	State	State	Yes
Oklahoma	Federal	Federal	No
Oregon*	State	State	Yes
Pennsylvania**	State	State	Yes
Rhode Island	State	State	Yes
South Carolina	State	State	Yes
South Dakota	State	State	Yes
Tennessee	State	State	Yes
Texas	Federal	Federal	No
Utah	State	State	Yes
Vermont***	State	State	Yes
Virginia	State	State	Yes
Washington	State	State	Yes
West Virginia	State	State	Yes
Wisconsin‡	State	State	Yes
Wyoming	Federal	Federal	No

* Oregon State law exempts from rate review association plans that retain 95% or greater of their employer groups (ORS 73.734)

** Pennsylvania will have effective rate review authority for the non-association commercial small group market effective March 21, 2012 per newly enacted legislation (Act 134 (renumbered) of 2011). Until that date, CMS will review Pennsylvania non-association commercial small group products while the State will continue to review rates for all other non-association products. As for the association rates, effective March 21, 2012, Pennsylvania will begin reviewing rates for small group associations situsd in Pennsylvania along with the rates for individual associations situsd in the State that it is already reviewing. CMS will continue to review the rates for individual and small group associations that are not situsd in Pennsylvania.

*** In Vermont, non-situsd plans are exempt from filing with the State under the following circumstances (8 V.S.A. § 3368):

A. the master policy was lawfully issued and delivered in a State in which the insurer was authorized to do insurance business (and thus regulated by the State of issue)

B. (i) no more than 25 of the certificate holders are Vermont residents; or (ii) the master policy covers one or more certificate holders who reside in Vermont, are employed at a workplace located outside Vermont and have obtained insurance coverage through the workplace;

C. The person or entity holding the master policy exists primarily for purposes other than to procure insurance, is not a Vermont corporation or resident, and does not have its principal office in Vermont; and

D. The policy is not offered for sale by an agent or broker licensed in Vermont, offered by mail to a Vermont resident, or marketed in Vermont in a similar manner.

Note: In this chart, the term "sitused" refers to the State where the policy (not the individual certificate) is issued; the Situs State is the State that has the primary jurisdiction and whose laws, rules, and regulations govern the policy. Additionally, for the purposes of this chart, an "exempt" plan is one that is exempt under State law from State rate review requirements.

‡ Status Updates:

- Following the release of August 15, 2011 Bulletin 11-06 from the Iowa Insurance Division, Iowa now has effective rate review in both the individual and small group market.
- Following August 22, 2011 correspondence from the Idaho Department of Insurance confirming its intent to comply with the rate review regulation (45 CFR Part 145), Idaho now has effective rate review in both the individual and small group market.
- As of November 2011, Hawaii is reviewing all rates for association plans sitused in Hawaii.
- As of January 1, 2012, Alaska has rate review authority in all markets per State statute.
- Effective August 1, 2012, the Idaho Department of Insurance will exercise their authority to review rates for Association Products in the Small Group Market.
- Effective January 1, 2013, subsequent to new regulations authorizing the AZ Department of Insurance to collect and conduct Individual Market, including Association Product rate reviews, supported by a bulletin and other information provided by AZ, the Department of Insurance will be reviewing all Individual Market rate increase requests above the review threshold.
- Effective April 1, 2013, the Wisconsin Office of the Insurance Commissioner will exercise its authority to review rates for Association Products in the Individual Market.
- Effective April 1, 2013, HHS will conduct the Effective Rate Review Program in Oklahoma.
- Effective April 1, 2013, HHS will conduct the Effective Rate Review Program in Texas.
- As of April 30, 2013, Montana has effective rate review in all markets per State statute and will review all rate submissions made on or after April 1, 2013.
- As of April 30, 2013, Virginia has effective rate review in all markets per State statute and will review all rate submissions made on or after April 1, 2013.
- Effective January 1, 2014, subsequent to new regulations authorizing the AZ Department of Insurance to collect and conduct Small Group Market rate reviews, supported by a bulletin and other information provided by AZ, the Department of Insurance will be reviewing all Small Group Market rate increase requests above the review threshold.
- Effective January 1, 2014, subsequent to a bulletin issued by the LA Department of Insurance, the LA Department of Insurance will exercise its authority to collect, review and make rate determinations for all single risk pool and transitional plan rate submissions.
- Effective January 1, 2014, Association Plans within each issuer's single risk pool are treated by every effective rate review State as either individual or small group market filings and reviewed by every effective rate review jurisdiction as part of the risk pool and are no longer segregated and treated as separate from the individual or small group market, in accordance with the requirements of the federal market and rating rules.
- Effective July 16, 2014, CMS issued letters to the territories clarifying that the new provisions of the PHS Act enacted in title I of the Affordable Care Act are appropriately governed by the definition of "State" set forth in that title, and therefore the rate review requirements do not apply to group and individual health insurance issuers in the territories. The definition of "State" is defined at 45 C.F.R. § 154.102.
- Effective April 8, 2016, correspondence from the Alabama Department of Insurance confirmed its intent to comply with the rate review regulation (45 CFR Part 154), Alabama now has effective rate review in both the individual and small group market.
- Effective March 17, 2017, CMS issued a letter to the Missouri Department of Insurance designating Missouri as a State with an Effective Rate Review Program.

---

[i] http://ehbs.kff.org/pdf/2010/8085.pdf

[i] "U.S. Department of Health and Human Services Rate Review Annual Report," U.S. Department of Health and Human Services, September 2014
http://aspe.hhs.gov/health/reports/2014/RateReview/rpt_RateReview.pdf

[ii] "U.S. Department of Health and Human Services: Rate Review Annual Report," U.S. Department of Health and

Human Services, September 2013
http://aspe.hhs.gov/health/reports/2013/acaannualreport/ratereview_rpt.cfm

Interpretation of the Emerging Accounting Issues (E) Working Group

INT 15-01: ACA Risk Corridors Collectibility

INT 15-01 Dates Discussed

October 19, 2015; November 5, 2015

INT 15-01 References

Current:
SSAP No. 4—Assets and Nonadmitted Assets
SSAP No. 5R—Revised Liabilities, Contingencies and Impairments of Assets
SSAP No. 9—Subsequent Events
SSAP No. 66—Retrospectively Rated Contracts
SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act

INT 15-01 Issue

1. The federal Affordable Care Act (ACA) includes three types of risk sharing programs known as risk adjustment, reinsurance and risk corridors. The risk corridors program is a temporary program that is effective for benefit years beginning in 2014 through 2016 and applies to Qualified Health Plans (QHPs) in the individual and small group markets whether sold on or outside of an exchange.

2. The risk corridors program creates a mechanism for sharing risk for allowable costs between the federal government and QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. The risk corridors program is intended to protect against inaccurate rate setting by limiting the extent of QHP issuer losses and gains. In the event that risk corridors program collections are not sufficient to cover all the required distributions, the ACA allows the use of other sources of federal funding for the required distributions, subject to the availability of appropriations.

3. On April 11, 2014, the U.S. Department of Health and Human Services (HHS) issued a bulletin titled "Risk Corridors and Budget Neutrality," which described how it intended to administer risk corridors over the three-year life of the program. HHS stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall. The HHS noted that lacking other appropriations or sources of funding, subsequent year program collections would first be applied to the unpaid program balances of preceding years. In December 2014, federal funds were not appropriated for the federal costs of the risk-sharing program.

4. On October 1, 2015, HHS announced proration results for 2014 risk corridors payments. Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. As of October 1, 2015, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent. HHS will begin collection of risk corridors charges in

November 2015, and will begin remitting risk corridors payments to issuers starting December 2015. The announcement noted that the risk corridor payment and charge amounts reflected in the October 1, 2015, bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015, or the effect of subsequent appeals.

5. There was diversity in practice regarding the accrual of 2014 risk corridors receivables for the first two quarters of 2015. Some entities did not accrue material amounts for the risk corridors receivables or did not accrue any amount due to the lack of federal government appropriations, and pursuant to the requirement in *SSAP No. 107—Risk-Sharing Provisions of the Affordable Care Act* (SSAP No. 107), which requires that preparers be conservative and diligent in developing their estimates. Other entities appear to have accrued the full amount of funds estimated to be received under the risk corridors program. For some entities the accrued receivables represent a material amount of surplus and uncollectibility or delayed collectibility represents a solvency concern.

6. At a minimum, impairment analysis and/or updated estimates are required under SSAP No. 107 for the 2014 risk corridors receivables. In determining the amount to be impaired, one issue identified is that 2015 and 2016 collections may not be sufficient to cover the full 2014 program requests.

7. The accounting issues are:

Issue 1: **Determining the Amount of Impairment** – The 2015 and 2016 program collections may not be sufficient to fund the shortfall of 2014 program requests. Therefore, the accounting issue identified is how to determine the required impairment amount.

Issue 2: **Nonadmittance** –The accounting questions regarding nonadmission have been focused on the amounts in excess of the confirmed proration payment of 12.6%, of which there is a reasonable and probable expectation that the 2015 and 2016 program collections will cover some portion of the 2014 benefit year shortfall.

An accounting issue identified is whether nonadmittance is required or permitted to be applied to the 2014 program benefits in excess of the 12.6% prorated amount for which reporting entities have a reasonable and probable expectation of future collection. Even if an entity has a reasonable and probable expectation of payment of the amount in excess of the confirmed proration of 12.6%, extended delays in payment are expected.

Issue 3: **Timing of Impairment or Nonadmittance Recognition** – The HHS notice of the 12.6% proration amount was provided on October 1, 2015; however, prior to October 1, there were other indicators that the risk corridors program would have 2014 benefit shortfalls (in April and December of 2014 as detailed above and other public reports). Doubts about program collectibility of receivables and problems with estimations are among the reasons many entities did not accrue risk corridors receivables or only accrued immaterial amounts. The accounting issue identified is whether impairment recognition is required to be reflected in the September 30, 2015, financial statements.

Issue 4: **Accrual of 2015 and 2016 Receivables** – Shall the accrual of receivables for the benefit years 2015 and 2016 continue to be estimated?

INT 15-01 Discussion

8. For Issue 1, impairment analysis and/or updated estimates for the 2014 risk corridors receivables are required under SSAP No. 107.

9. The Working Group determined that impairment is indicated if an entity accrued as of the reporting date under the 2014 Risk Corridors program more than they have a reasonable expectation of receiving. SSAP No. 107, paragraph 56.e. (quoted below), requires evaluation of the collectibility of all amounts receivable from the risk corridors program for each reporting period, and if in accordance with SSAP No. 5R it is probable that risk corridors receivables are uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made.

> 56. Risk corridor assessments meet the definition of liabilities as set forth in SSAP No. 5R. Risk corridor receivables due to the reporting entity meet the definition of an asset and are admissible to the extent that they meet all of the criteria in this statement.
>
> a. Assumptions used in estimating retrospective premium adjustments shall be consistent with the assumptions made in recording other assets and liabilities necessary to reflect the underwriting results of the reporting entity such as claim and loss reserves (including IBNR) and contingent commissions. Contingent commissions and other related expenses shall be adjusted in the same period the additional or return retrospective premiums are recorded.
>
> b. The additions or reductions to premium revenue resulting from the risk corridors program are recognized over the contractual period of coverage, to the extent that such additions or reductions are reasonably estimable. Reporting entities shall be aware of the significant uncertainties involved in preparing estimates and be both diligent and conservative in their estimations. Risk corridors payables and receivables shall be estimated based on experience to date. The method used to estimate the payables and receivables shall be reasonable and consistent between reporting periods. In exercising the judgment required to prepare reasonable estimates for the financial reporting of risk corridors program payables and receivables, the statutory accounting concept of conservatism shall be followed. In addition, reporting entities are required to have sufficient information to determine a reasonable estimate. Part of ensuring sufficient information requires that the reporting entity's estimate is based on demonstrated knowledge of the impacts of the other risk-sharing programs on the risk corridors program and the terms of the risk corridors program. In addition, the estimates shall be consistent with other financial statement assertions and the pricing scenarios used by the reporting entity.
>
> c. The risk corridors receivables are from a federal governmental program. Amounts over 90 days due shall not cause the receivable to be treated as a nonadmitted asset based solely on aging.
>
> d. Provided that the risk corridors receivables due the reporting entity are determined in a manner that is consistent with the requirements of this statement, the receivables are admitted assets until determination of impairment or payment denial is received from the governmental entity or government-sponsored entity administering the program. Upon notification that payments to be paid to the reporting entity will be less than the recorded receivables, any amount in excess of the confirmed amount shall be written off and charged to income, except for amounts

that are under appeal. Any receivable for risk adjustment amounts under appeal shall be reflected as a nonadmitted asset.

e. Evaluation of the collectibility of all amounts receivable from the risk corridors program shall be made for each reporting period. If, in accordance with SSAP No. 5R, it is probable that the risk corridors receivables are uncollectible, any uncollectible receivable shall be written off and charged to income in the period the determination is made. If it is reasonably possible, that a portion of the balance determined in accordance with this paragraph is not anticipated to be collected and is therefore not written off, the disclosure requirements outlined in SSAP No. 5R shall be followed.

f. Reporting shall be consistent with *SSAP No. 66—Retrospectively Rated Contracts* (SSAP No. 66), paragraph 9 guidance on reporting for retrospective premium.

10. Current facts and circumstances must be taken into account when determining impairment. In accordance with SSAP No. 107, paragraph 56.e, any uncollectible receivable shall be written off and charged to income in the period the determination is made. The Working Group noted that the following are some, but not an all-inclusive list of the relevant factors to consider in determining the amount of impairment to include:

a. Amounts in excess of the proration amount of 12.6% must be evaluated for impairment.

b. Judgment is involved in the determination of the impairment amount.

c. Information used in determination of impairment shall be based on the most current and reliable information available.

d. Other known or probable changes in program collections or funding must also be evaluated, including the possibility of fewer contributors or lesser collections due to insolvencies.

e. The intent and ability of the reporting entity to remain in business for a period of time sufficient to allow for recovery of risk corridors receivables.

11. The Working Group noted that the impaired amount would be based on the facts and circumstances and is required to be evaluated at each reporting period by management.

12. For Issue 2, SSAP No. 107 addresses nonadmittance in paragraph 56.c., noting that, "Amounts over 90 days due shall not cause the receivable to be treated as a nonadmitted asset based solely on aging." However, SSAP No. 107 does not preclude nonadmittance for other reasons. In addition, SSAP No. 4 provides that:

> "The ability to meet policyholder obligations is predicated on the existence of readily marketable assets available when both current and future obligations are due. Assets having economic value other than those which can be used to fulfill policyholder obligations, or those assets which are unavailable due to encumbrances or other third party interests should not be recognized on the balance sheet, and are, therefore, considered nonadmitted."

13. The lack of appropriations, documented program shortfalls and known extended payment delays are indicative that some of the program receivables are not available to meet policyholder obligations when due, and therefore, evaluation for possible nonadmittance under SSAP No. 4 in addition to impairment evaluation is appropriate.

14. The Working Group discussed that nonadmission was appropriate for amounts that have a reasonable and probable expectation of recovery which are not currently available to pay claims. In this case, 2014 amounts in excess of the 12.6% proration amount which have not been written off for impairment, and have a reasonable expectation of delayed recovery shall be nonadmitted. The Working Group discussed that amounts in excess of the proration amount which are nonadmitted, shall remain nonadmitted until additional proration amounts are confirmed by HHS or other information of a sufficient nature supports that collectibility is probable and reasonable. Consistent with SSAP No. 107, paragraph 56, the statutory accounting concept of conservatism shall be followed when estimating amounts; reporting entities are required to have sufficient information to determine a reasonable estimate. Part of ensuring sufficient information requires that the reporting entity's estimate is based on demonstrated knowledge of the impacts of the other risk-sharing programs on the risk corridors program and the terms of the risk corridors program. Consistent with Issue 4, below, estimates shall not assume the availability of federal funds unless such federal funds are appropriated by Congress for the federal costs of the risk sharing program.

15. Such admitted amounts should also have a reasonably short time horizon to ensure that amounts will be available to pay policyholder claims. Some regulators and reporting entities may also take the position that it is probable that risk corridors receivables accrued during the 2014 plan year are uncollectible in excess of 12.6% proration, and therefore, any amounts in excess of proration would be fully written off. If this were the case, the 12.6% prorated balance would be admitted unless extended payment delays or other information cause a reevaluation of admissibility.

16. For Issue 3, the October 1 notification from HHS provided evidence of the estimated amount of proration for the underfunded program. The underfunded program was a condition that existed at the date of the September 30, 2015, balance sheet. Therefore, in accordance with *SSAP No. 9—Subsequent Events*, paragraph 11 (quoted below) this would be a Type I subsequent event that would be reflected in the financial statements for the third quarter. Type I events include estimates inherent in the process of preparing financial statements.

> 11. The following are examples of Type I recognized subsequent events:
>
> a. If the events that gave rise to litigation had taken place before the balance sheet date and that litigation is settled, after the balance sheet date but before the financial statements are issued or are available to be issued, for an amount different from the liability recorded in the accounts, then the settlement amount should be considered in estimating the amount of liability recognized in the financial statements at the balance sheet date.
>
> b. Subsequent events affecting the realization of assets, such as receivables and inventories or the settlement of estimated liabilities, should be recognized in the financial statements when those events represent the culmination of conditions that existed over a relatively long period of time. For example, a loss on an uncollectible trade account receivable as a result of a customer's deteriorating financial condition leading to bankruptcy after the balance sheet date but before the financial statements are issued or are available to be issued ordinarily will be indicative of conditions existing at the balance sheet date. Thus, the effects of the customer's bankruptcy filing shall be considered in determining the amount of uncollectible trade accounts receivable recognized in the financial statements at the balance sheet date.

17. For Issue 4, the Working Group determined that risk corridors receivables for the 2015 and 2016 benefit years estimated in accordance with SSAP No. 107, paragraphs 56.b and 56e are nonadmitted 1) until such time that the prior benefit year is paid in full and 2) until additional proration amounts are confirmed by HHS or other information of a sufficient nature supports that collectibility is probable and reasonable. Consistent with SSAP No. 107, paragraph 56, the statutory accounting concept of conservatism shall be followed when estimating amounts; reporting entities are required to have sufficient information to determine a reasonable estimate. Part of ensuring sufficient information requires that the reporting entity's estimate is based on demonstrated knowledge of the impacts of the other risk-sharing programs on the risk corridors program and the terms of the risk corridors program. Estimates shall not assume the availability of federal funds unless such federal funds are appropriated by Congress for the federal costs of the risk corridors program.

INT 15-01 Status

18. No further discussion planned.

State places Oregon health insurer under supervision

January 28, 2016

Salem, OR—The Oregon Department of Consumer and Business Services, Division of Financial Regulation announced today that it has issued an order of supervision to Moda Health Plan, Inc., because of concerns over its financial condition. At the same time, the department will begin working with Moda to transfer its individual market plans to another carrier.

Categories:
Business
Consumer Information

An order of supervision allows the department to have a representative on site and in control of all financial decisions to ensure that consumers are protected. The order prohibits Moda from issuing new policies or renewing current policies in the individual market, and from adding new groups. The order also requires the company to obtain sufficient capital and present a business plan to DCBS that clearly demonstrates that it can operate in sound financial condition going forward. The supervision order is available at http://www.cbs.state.or.us/external/ins/admin_acti... (http://www.cbs.state.or.us/external/ins/admin_actions/actions_2016/insurer_2016/financial_2016/other_2016/16-13-001.pdf)

The department took this action because of Moda's excessive operating losses and inadequate capital and surplus. Capital and surplus is the amount a company's assets exceed its liabilities. The required minimum increases as the company assumes more insurance risk.

"Our primary goal is to ensure consumers are protected," said Patrick Allen, director of the Department of Consumer and Business Services. "We will continue to work closely with the company to find a sustainable path going forward while minimizing risk to consumers."

The order became effective late yesterday; however, Moda's insurance policies may still appear on HealthCare.gov through the end of open enrollment, Sunday, Jan. 31. DCBS advises consumers still shopping for plans to choose a carrier other than Moda. In the event that Oregonians already enrolled with Moda need to switch plans, there will be a special enrollment period. In the meantime, Moda policyholders can continue to access medical services and get their claims paid.

DCBS, which also runs the Oregon Health Insurance Marketplace, will keep Moda customers apprised of new developments and actions they may need to take.

As of Sept. 30, 2015, Moda enrolled a total of about 244,000 Oregonians in the commercial market, including 95,000 in the individual market, 16,000 in the small group market, and 129,000 in the large group market. Moda also has members in the associations and trusts market.

Eastern Oregon CCO, which serves Oregon Medicaid members and is owned by Moda, serves 48,000 Medicaid members. No one on Medicaid is losing coverage.

The Oregon Health Authority is also working with the Public Employees' Benefit Board and Oregon Educators Benefit Board partners to minimize any potential impacts to their members. There are 1,100 PEBB members and 42,000 OEBB members enrolled in Moda health plans.

Consumers with questions should call the DCBS Division of Financial Regulation's consumer advocates at 1-888-877-4894 (toll-free). Staff will be available to answer calls until 8 p.m. More information can be found on the division's website at http://www.oregon.gov/DCBS/Insurance/insurers/regu... (http://www.oregon.gov/DCBS/Insurance/insurers/regulation/Pages/moda-faqs.aspx)

###

The Division of Financial Regulation is part of the Department of Consumer and Business Services, Oregon's largest business regulatory and consumer protection agency. Visit www.dcbs.oregon.gov (http://www.dcbs.oregon.gov) and www.insurance.oregon.gov. (http://www.insurance.oregon.gov.)

For more information:
Lisa Morawski, 503-947-7873
Lisa.m.morawski@oregon.gov (mailto:Lisa.m.morawski@oregon.gov?subject=RE:%20)

STATE OF OREGON

DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

DIVISION OF FINANCIAL REGULATION

In the Matter of:	)	Case No. INS 16-13-002
	)	
MODA HEALTH PLAN, INC.	)	CONSENT ORDER

On January 27, 2016, the Director, Department of Consumer and Business Services (DCBS), having reasonable cause to believe and having determined that Moda Health Plan, Inc. (MODA), an Oregon health care service contractor, was found to be in such condition that its continuation of business with financial results currently reported was hazardous to the public or to its insureds, entered an Order of Immediate Supervision placing MODA under the immediate supervision of the Director (the "Supervision Order").

In an effort to resolve the hazardous financial condition of MODA, to allow DCBS to release MODA from the Supervision Order, and to restore MODA to compliance with applicable risk based capital standards and trend test requirements, MODA, together with its sole shareholder Moda, Inc. (MODA INC.) and after extensive discussions with DCBS, have filed a Financial Plan of Action of even date with this Order (the RBC Plan). The RBC Plan provides various undertakings and transactions to be completed in the coming weeks and months in order to restore MODA's risk based capital to levels acceptable under Oregon law and is entitled to confidentiality pursuant to ORS 731.752(2) and other applicable law. The Director has authority under ORS 734.043 to enter into this Consent Order.

Transactions and Undertakings

1. MODA is hereby directed and ordered and hereby agrees to undertake and complete the transactions and undertakings set forth in the RBC Plan, subject in each case to the terms thereof.

2. MODA shall, by completion of the transactions and undertakings set forth in the RBC Plan or otherwise with the consent of DCBS, raise a total amount of not less than $179,000,000 of additional capital as scheduled in the RBC Plan. The additional capital amounts set forth in this Paragraph shall be determined on an after tax basis, shall be net of all transaction expenses, and may be satisfied by the receipt of transaction proceeds directly by MODA or by contributions to the capital of MODA by MODA INC.

3. At any time upon DCBS's request, MODA shall prepare and deliver to DCBS its updated projected statements of cash flows setting forth management's reasonable estimate of cash flows of MODA through December 31, 2016 and demonstrating MODA's ongoing solvency and ability to pay and satisfy its obligations as they come due.

4. MODA shall deliver to DCBS, the Washington State Office of Insurance Commissioner (OIC), and the Alaska Division of Insurance (DOI) all such additional financial or other information as may be requested by DCBS, the Washington OIC, or the Alaska DOI, including without limitation detailed plans with respect to managing the operating and other expenses of MODA. MODA shall deliver all such requested information within the timeframe set by DCBS, the Washington OIC, or the Alaska DOI, unless MODA demonstrates good cause for additional time to respond to a request.

5. MODA shall make and maintain a deposit in an amount in cash equal to $15,000,000 for the protection of Alaska policyholders and subject to the requirements of AS 21.24. The funds on deposit pursuant to this Paragraph must be held in a bank and under a form of depository agreement acceptable to the Alaska DOI. The deposit may be made in installments, beginning with an initial installment of $5,000,000 on or prior to February 16, 2016, an additional installment of $5,000,000 on or prior to March 15, 2016, and a final installment of $5,000,000 on or prior to April 15, 2016. Funds held on deposit may not be withdrawn or otherwise removed except by authority of the Alaska DOI. After August 15, 2016, MODA may petition the Alaska DOI for reduction of the required deposit based on updated financial information for MODA.

6. MODA shall comply with the terms, conditions and limitations on the operation of its business as set forth in the RBC Plan, and acknowledges that the RBC Plan is valid and enforceable and remains in full force and effect.

7. MODA shall continue to provide insurance coverage and related services to its individual market policyholders resident in both Oregon and Alaska in accordance with the terms of all outstanding policies, and shall make payment to its providers and other creditors in the ordinary course of business.

Other Provisions

8. Each of MODA and MODA INC. shall, upon request by DCBS, provide all documentation and information determined by DCBS to be necessary to verify compliance with the terms of this Consent Order or the RBC Plan. Except with the prior written consent of DCBS, MODA shall not, and MODA INC. shall cause MODA not to, increase the salaries or benefits of its executives, officers and directors.

9. The rights and remedies available to any party under this Consent Order or the RBC Plan are cumulative and in addition to, and not exclusive of or in substitution for, any rights or remedies otherwise available at law or in equity. By entering into this Consent Order, DCBS does not waive any right that it may have to take other and further regulatory action with respect to MODA or MODA INC. or any regulated affiliates or subsidiaries, including (a) for any matter unrelated to their financial condition, (b) in the event that their financial condition continues to deteriorate, or (c) in the event that DCBS becomes aware of any fact or facts that cause DCBS to materially alter its assessment of their financial condition or operational integrity.

10. The Supervision Order is terminated.

11. This Consent Order and any dispute hereunder shall be governed by the laws of the State of Oregon, without regard to principles of conflicts of laws.

12. This Consent Order, together with the RBC Plan, constitutes the entire agreement among DCBS, MODA and MODA INC. with respect to the subject matter hereof, and supersedes any prior communication, understanding or agreement, whether written or oral, concerning the matters set forth herein.

13. In the event that any one or more provisions of this Consent Order or the RBC Plan shall for any reason be held invalid, illegal or unenforceable in any respect, such invalidity, illegality or unenforceability shall not affect any other provision of this Consent Order or the RBC Plan.

14. No amendment or waiver of any provision of this Consent Order or the RBC Plan shall be valid unless in writing and signed by the party to be charged with such amendment or waiver. No waiver by any party of any default or breach of any provision of this Consent Order or the RBC Plan, whether intentional or not, shall be deemed to extend to any prior or

subsequent default or breach, or affect in any way any rights arising by virtue of any prior or subsequent such occurrence.

15. This Consent Order may be executed in one or more counterparts, each of which shall be deemed an original and all of which together shall constitute one instrument.

* * *

DATED this 6th day of February, 2016.

OREGON DEPARTMENT OF CONSUMER AND BUSINESS SERVICES

By: _____
Patrick M. Allen
Director

MODA HEALTH PLAN, INC.

By: _____
Name: ROBERT G GOOTEE
Title: CEO

MODA, INC.

By: _____
Name: Robert G Gootee
Title: CEO

Alaska Dispatch News

Health

Alaska kicks Moda Health out of individual insurance market

Author: Tegan Hanlon Updated: September 30, 2016 Published January 28, 2016

The Alaska Division of Insurance announced Thursday that it is forcing Portland-based health insurer Moda Health out of the state's individual marketplace for now, leaving Alaskans with only one choice for coverage: Premera Blue Cross Blue Shield.

Lori Wing-Heier, the division's director, said in a statement Thursday afternoon that staff has been closely monitoring Moda's financial status and consumer complaints, determining that Moda has inadequate capital to operate in Alaska in 2016.

The announcement followed a day after Oregon regulators put new state controls on Moda, citing ongoing financial losses and giving the company until the end of the day Friday to devise a new business plan, The Oregonian newspaper reported in Portland.

At the end of 2015, Moda reported a net loss of $58 million and lower enrollments than it had projected, according to a letter to Alaska legislators signed by Chris Hladick, commissioner of the state's Department of Commerce, Community and Economic Development.

Paying premiums

Wing-Heier said that Alaskans enrolled in Moda insurance plans through the individual marketplace should continue to pay their premiums and the state will ensure that Moda continues to pay their claims.

However, Moda cannot renew Alaskans' plans once they expire. The company also cannot issue any new plans, Wing-Heier said.

"So for plans that renew in February, they have a very short period to find a new insurer as most plans renew once a year," Wing-Heier said in an email. "However if you renewed in Nov. 15, your plan is good until Nov. 16."

According to Hladick's letter, about 9,800 Alaskans currently have individual insurance plans through Moda. Right now, Premera offers the only other insurance plans on the individual market — both on and off the federally run healthcare.gov, set up by the Affordable Care Act.

"It's certainly not great news to be down to one insurer because there are no options," Wing-Heier said. "So we're going to have to work hard at trying to get another insurer into the market to provide competition."

Last year, Aetna, State Farm and Assurant Health all decided to stop offering individual health insurance plans in Alaska. At that time, Wing-Heier said that having only one insurer left in the individual market was a scenario "you never want."

Wing-Heier said in an interview Thursday that it was too soon to say how the loss of Moda would affect 2017 health insurance premiums.

The company's departure will not affect this year's premiums, already approved by the Division of Insurance, she said. It will also not affect state employee and retiree dental plans, which are through Moda but based on contracts with another company, Wing-Heier said.

Melanie Coon, Premera spokeswoman, said she couldn't say Thursday how Moda's exit from Alaska's market for individuals would affect next year's premiums. She said the number of new customers Premera gets and their levels of medical needs will factor into the 2017 rates.

"It really depends on the types of members we get from Moda," Coon said. "I know that Moda was hit pretty hard with some sick people."

Alaskans on the individual market have already seen huge increases in their health insurance rates over the past two years. Premera's rate increases averaged 37.2 percent in 2015 and 38.7 percent in 2016, while Moda's increases were 27.4 percent and 39 percent, Hladick said in his letter to legislators.

"Despite these increases, Moda's financial condition has continued to deteriorate," he said.

Coon said that Premera has also lost money in Alaska in 2015 and 2014. She said the company is committed to staying in the state's individual market. Premera also operates in Washington with a subsidiary company in Oregon, she said.

"I think we have some strong reserves to make sure we can continue to serve," she said. About 10,000 people have individual health insurance plans through Premera, she said.

Modas finances

Alaskans could enroll in new health insurance plans through Moda until Thursday. On healthcare.gov, the company offers the "metallic" health care plans with the lowest monthly premiums, compared to plans offered by Premera.

For instance, Moda's cheapest bronze plan in Anchorage has an estimated, average $554 monthly premium this year and $5,750 deductible. Premera's cheapest bronze plan has a $620 monthly premium and a $6,350 deductible, according to the website. (Those totals are without federal subsidies for low-income Alaskans.)

As Alaskans enrolled in 2016 health insurance plans, Moda battled ongoing financial problems.

In the fall, Moda pulled out of Washington and California. It also learned that it would not get all of the money it expected from the "risk corridor" provisions of the Affordable Care Act.

The provisions were supposed to help insurance companies if they had too many sick people and not enough money from premiums to pay medical bills. But Republican lawmakers inserted a provision into a 2014 federal spending bill that limited the risk corridor payments, The New York Times reported.

Moda expected to get $82 million from the risk corridor payments in 2014 and $69 million in 2015. "To date, they have received approximately $10.5 million," Hladick said in the letter, dated Thursday.

Coon said Moda appeared more optimistic than Premera about the payments.

Aimee Crocker, vice president at Enroll Alaska, said she noticed during this year's open enrollment period that Moda had some delays in processing applications. The company also stopped accepting credit cards as a means of payment to save money, she said.

Wing-Heier said that this month she requested Moda's year-end financial documents and enrollment numbers for testimony she had to give in Juneau. The results were grim.

"I ended up calling Oregon myself," she said, alerting regulators there this week.

Oregon has given Moda seven days to raise its capital, Wing-Heier said. She said she couldn't say how much Oregon had asked the company to raise its capital by, just saying it was a "huge number."

Robert Gootee, chief executive officer of Moda, Inc., the parent company of Moda Health, said in a brief statement Thursday that "bringing tens of thousands of people into the ACA marketplace, many of them with acute healthcare needs, has been a difficult process to manage."

"The cost of providing this level of care, with all its attendant uncertainties, has put an unprecedented financial strain upon our health plan," Gootee said. "So, at the direction of the Insurance Commissioners in both Oregon and Alaska, we have resolved to exit the Individual ACA marketplace in both states."

Gootee said Moda will make sure individuals have no interruption in their coverage as they transition to new carriers.

Wing-Heier said in the statement that Moda's insurance policies may still appear on Alaska's federally-run health insurance marketplace through the end of open enrollment on Jan. 31. However, she said the division is advising consumers to not buy Moda plans.

Alaskans already enrolled in Moda plans on the individual marketplace will have to switch once their policies end, she said. There will be a special enrollment period for that transition.

Wing-Heier said the state made the decision to restrict Moda's ability to issue health insurance plans to protect Alaska consumers.

The state's Division of Insurance has advised people with questions to contact their staff at 269-7900. The division has also published an online list of questions and answers about Thursday's announcement.

About this Author

Tegan Hanlon

Tegan Hanlon covers education and general assignments. She also covered the 2016 and 2017 Iditarod Trail Sled Dog Race. Reach her at 907-257-4589 or thanlon@alaskadispatch.com.

Moda Health pullout from Washington health insurance market doesn't affect its participation with PEBB Program in 2016

Monday, November 2, 2015

Moda Health has notified the Office of the Insurance Commissioner that it will not participate in the Washington Health Benefit Exchange during the open enrollment period (Nov. 1, 2015 – Jan. 31, 2016) for 2016 coverage. Moda Health Plan, Inc.—based in Portland—was previously approved to sell insured health plans inside and outside of the exchange, but is voluntarily withdrawing from the Washington state insurance market.

The Health Care Authority (HCA) contracts with Moda Health to support our Washington Prescription Drug Purchasing Consortium (/about-hca/prescription-drug-program). As part of this contract, Moda Health serves as the pharmacy benefit manager for our Public Employees Benefits Board (PEBB) Program (/public-employee-benefits) Uniform Medical Plan.

Moda Health's pullout from the Health Benefit Exchange does not affect its work with HCA next year.

The Washington Prescription Drug Purchasing Consortium was created by the 2005 Legislature to allow state agencies, local governments, businesses, labor organizations, and uninsured or underinsured consumers to pool their purchasing power to get better prices on prescription drugs. HCA administers the program.

Connect with us

Contact HCA (/contact-hca)

(http://www.facebook.com/WAHealthCareAuthority) (http://www.twitter.com/WA_Health_Care) (https://public.govdelivery.com/accounts/WAHCA/subscriber/new) (/about-hca/hcaconnect) (https://www.youtube.com/channel/UC2_tBoglUnVye4GBwbVXxNw)

Website feedback: Tell us how we're doing (https://www.surveymonkey.com/r/HCA-Website-Feedback)

STATE OF OREGON
DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
DIVISION OF FINANCIAL REGULATION
OFFICE OF THE DIRECTOR

In the Matter of:	) Case No. INS-FR 17-06-001
	)
HEALTH REPUBLIC INSURANCE COMPANY	) ORDER EXTENDING SUPERVISION
	)

On October 21, 2015, the Director, Department of Consumer and Business Services (DCBS), had reasonable cause to believe and determine that Health Republic Insurance Company (HRIC), an Oregon health care service contractor, was in such condition that its continuation of business in the manner currently being conducted was hazardous to the public or to its insureds. The Director, therefore, issued an order of immediate supervision, Case No. INS 15-10-018. The order set forth the requirements to abate the conditions set forth in the order and placed HRIC under the immediate supervision of the director for 60 days. On December 21, 2015, the Director issued an extension order. On February 19, 2016, the Director issued an extension order. On April 19, 2016, the Director issued an extension order. On June 18, 2016, the Director issued an extension order. On August 17, 2016, the Director issued an extension order. On October 16, 2016, the Director issued an extension order. On December 15, 2016, the Director issued an extension order. On February 13, 2017, the Director issued an extension order. On April 14, 2017, the Director issued and extension order.

Determinations

Pursuant to ORS 734.047(2), the Director determines that the conditions giving rise to the supervision still exist at the end of the supervision period.

The Director has additionally determined that should HRIC's Capital and Surplus be reduced to a level below $3.0 million, or its board of directors composition no longer meets the requirements of ORS 750.015, or its board of directors no longer has at least three members, the Director will require that HRIC be placed in liquidation under ORS 734.170.

Order Extending Appointment of Supervisor

The Director notified HRIC that commencing from Wednesday, October 21, 2015, HRIC was under supervision of the Director for 60 days (subject to extension under ORS 734.047(2))

and that the Director appointed Laura Cali Robison (formerly known as Laura Cali), Insurance Commissioner and Administrator, as the special deputy director to act for the Director as supervisor of HRIC with authority to employ such counsel, clerks, and assistants as she deems necessary. The supervision was extended for 60 days on the following dates: December 21, 2015; February 19, 2016; April 19, 2016; June 18, 2016; August 17, 2016; October 16, 2016; December 15, 2016; February 13, 2017; and April 14, 2017. The Director is hereby extending the supervision, without change except as stated herein, for a period of 60 days under ORS 734.047(2).

This order is effective June 14, 2017.

DATED this 2nd day of June, 2017.

Laura Cali Robison, Administrator
Division of Financial Regulation

Notice of Right to Hearing

Pursuant to ORS 731.385(3) and 734.043(7), HRIC may during the period of supervision file a written request for a hearing to review this order with the Division of Financial Regulation. Such request will not stay the effect of the order. HRIC must specify in its request the manner in which the action complained of would not result in improving the condition of HRIC. If requested, a hearing will be held within 30 days after the filing of the request before the director. The director will notify HRIC of the procedures, time, and place of the hearing. The director shall complete the review within 30 days after the record for the hearing is closed, and shall discontinue the action taken under this order if the director determines that none of the conditions giving rise to the action exists. ORS 731.385(3) and 734.043(7).

Oregon insurer Health Republic to shut down in 2016, cites $20 million federal hit

By Nick Budnick | The Oregonian/OregonLive
Email the author
on October 16, 2015 at 10:36 AM, updated October 16, 2015 at 3:01 PM

An Oregon insurer, Health Republic, has announced plans to pull its health plans from the 2016 market and shut down, saying recent federal and state regulatory decisions put its financial health in jeopardy.

The plan was one of 23 nonprofit consumer-owned and operated startups founded with federal loans across the country in 2014, an aspect of the Patient Protection and Affordable Care Act intended to increase competition. Already, seven other co-ops are folding - including a second one announced Friday in Colorado.

The insurer plans to pay its more than 10,000 members' claims this year but not sell plans for next year, CEO Dawn Bonder said. She said the company wants to begin an orderly wind-down to "make sure that we can pay the obligations we've incurred from 2015 and not leave people hanging."

The move was sparked by the recent news that the federal government was paying less than 13 cents on the dollar of an expected subsidy to help cover costs for insurers hit hard by claims. The decision will cost Health Republic $20 million between 2014 and 2015.

"We have to be sure that we have the capital to go forward and at this point in time I don't think we do," Bonder said.

Just weeks ago Bonder had reassured members that the firm's finances were healthy. Three things have happened to change that, she said.

The first has to do with the "risk corridor" program that the federal government recently announced would pay far less than insurers had been expecting. While Health Republic was prepared to deal with the effects on its 2014 finances, it is looking increasingly likely that regulators will not allow insurers to count on any of those funds in 2015 either, Bonder said.

Other bad news came with the Oregon Insurance Division's announcement Thursday that the small group employer-based market would not be expanded as planned to include businesses of up to 100 employees. Health Republic had been counting on expanding its small group book of business.

On top of that, the rapid pace of failure of other nonprofit federal health insurer startups in recent weeks made Health Republic pessimistic about whether brokers would feel comfortable selling its 2016 policies.

The nonprofit qualified for federal startup loans of more than $50 million.

This post will be updated later today.

-- Nick Budnick
nbudnick@oregonian.com
503-294-5083
@nickbudnick

DCBS to place Oregon's Health CO-OP in receivership

July 08, 2016

Consumers must choose new plan by July 31

Salem, OR—The Oregon Department of Consumer and Business Services, Division of Financial Regulation on Monday will file a petition with Marion County Circuit Court to place Oregon's Health CO-OP in receivership in order to protect policyholders.

Oregon's Health CO-OP's board of directors voted today to consent to the receivership order.

As the receiver, the state intends to liquidate the troubled company's assets and help connect policyholders with new health plans.

"We understand changing plans in the middle of the year will be difficult for Oregonians, but this action was necessary given the sudden deterioration of the company's financial position," said Patrick Allen, DCBS director. "We will be working hard over the next few weeks to reach Oregon's Health CO-OP policyholders to ensure they are aware of this change and to help them pick a new plan that best meets their needs."

Oregon's Health CO-OP is a nonprofit consumer operated and oriented health insurer (CO-OP) formed under the Affordable Care Act. The CO-OP lost $18.4 million in 2015, mostly driven by medical claims for individual policies. Last week, the Centers for Medicare and Medicaid Services (CMS) announced that the CO-OP owes about $900,000 to the federal risk adjustment program. The CO-OP was expecting to receive about $5 million from the program.

"Unfortunately, as a startup, Oregon's Health CO-OP is not in a position to sustain these losses while meeting its obligations to policyholders," Allen said. "We are working closely with the company on an orderly wind-down of its business."

As of March 31, 2016, Oregon's Health CO-OP has 20,600 health insurance policyholders in Oregon: 11,800 in the individual market and 8,800 in the small and large group markets.

For all of Oregon's Health CO-OP policyholders, plans will end July 31.

Starting Monday, July 11, individual policyholders can enroll through a special enrollment period and choose a new plan that will take effect Monday, Aug. 1. Consumers should enroll by Sunday, July 31 to ensure their new insurance coverage is active on Aug. 1. They can enroll through HealthCare.gov to access

financial help or enroll directly through an insurance company or broker.

Consumers must pay the premium to their new insurer for the plans to take effect.

Businesses that provide Oregon's Health CO-OP plans to their employees will need to work with their insurance broker and take immediate action to find a new plan with an Aug. 1 effective date.

Individuals and businesses can choose a new plan from an insurer that offers 2016 plans in their county. However, several insurers are discontinuing coverage in certain counties for 2017, so consumers who choose an insurer that is exiting their county in 2017 will not be able to stay with that insurer next year. To find coverage options for your county in 2016 and 2017, go to **http://dfr.oregon.gov/public-resources/Documents/c... (http://dfr.oregon.gov/public-resources/Documents/co-op-individual-coverage.pdf)**

"Today's news heightens our concern about limited options for consumers, particularly in rural areas of the state," Allen said. "In the coming months, we will be working with stakeholders to develop both short-term and long-term solutions to make it more feasible for insurers to offer individual plans throughout the state."

For help with this change, consumers can call the Oregon Health Insurance Marketplace at 1-855-268-3767 (toll-free) or email **info.marketplace@oregon.gov (mailto:info.marketplace@oregon.gov?subject=RE:%20)**. More information and questions and answers are available on **http://dfr.oregon.gov/public-resources/Pages/co-op... (http://dfr.oregon.gov/public-resources/Pages/co-op.aspx)**

###

The Division of Financial Regulation is part of the Department of Consumer and Business Services, Oregon's largest business regulatory and consumer protection agency. Visit **www.dcbs.oregon.gov (http://www.dcbs.oregon.gov)** and **www.dfr.oregon.gov. (http://www.dfr.oregon.gov.)**

For more information:
Lisa Morawski, 503-947-7873
Lisa.m.morawski@oregon.gov (mailto:Lisa.m.morawski@oregon.gov?subject=RE:%20)
Jake Sunderland, 503-947-7897
Jake.w.sunderland@oregon.gov (mailto:Jake.w.sunderland@oregon.gov?subject=RE:%20)

CERTIFICATE OF SERVICE

I hereby certify that on August 28, 2017, 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.

/s/ Benjamin Gutman
Benjamin Gutman
Counsel for amici curiae

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 Rule of Appellate Procedure 32(a)(7)(B) because it contains 3,293 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 28, 2017

/s/ Benjamin Gutman

Benjamin Gutman
Counsel for amici curiae

BG2:dl3/8467328