IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTH REPUBLIC INSURANCE COMPANY, Plaintiff, on behalf of itself and all others similarly situated, vs. THE UNITED STATES OF AMERICA, Defendant.	No. 1:16-cv-00259-MMS (Judge Sweeney)

PLAINTIFF HEALTH REPUBLIC INSURANCE COMPANY'S MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM OF LAW IN SUPPORT

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Plaintiff Health Republic Insurance Company ("HRIC" or "Plaintiff"), on behalf of itself and the QHP Issuer Class (the "Class"), respectfully requests summary judgment for the Class on its claims for unpaid risk corridors amounts for the 2014 and 2015 benefit years. After the opt-in deadline has passed, HRIC requests the right to supplement this brief with the final amount of the award it requests on the Class's behalf, so that the Court may enter judgment for liability and the amounts the Government must pay the class for the 2014 and 2015 benefit years.

INTRODUCTION

In its January 10, 2017 Order denying Defendant the United States of America's (the "Government" or "Defendant") motion to dismiss (Dkt. 31) (the "Order"), the Court held that Section 1342 of the Patient Protection and Affordable Care Act (the "ACA"), 42 U.S.C. § 18062, requires the Department of Health & Human Services ("HHS") "to make annual risk corridors payment to eligible qualified health plans." Dkt. 31 at 23. The Court further held that "the only remaining issue is whether plaintiff was entitled to full payment for 2014 in December 2015 and full payment for 2015 in December 2016." *Id.* at 25. Because there are no genuine issues of disputed material fact regarding the Government's obligation to pay full risk corridors amounts annually, HRIC respectfully moves for summary judgment to compensate QHP Issuers the amount they are owed and begin to remedy the substantial harm the Government's failure to pay owed risk corridor amounts has caused to ACA health exchange markets and consumers.

The unavoidable conclusion is that the Government must make full, annual risk corridor payments. The plain language, context, and purpose of Section 1342 and its interlocking provisions (the other 3R programs) make this clear. These are the same reasons the Court identified in concluding that HHS must make annual payments (and the reasoning Judge Wheeler recently relied upon in an opinion consistent with this Court's denial of the Government's motion to dismiss HRIC's claims). *See Moda Health Plan, Inc. v. United States*,

Case No. 1:16-cv-00649-TCW, 2017 WL 527588 (Fed. Cl. Feb. 9, 2017). There is no language, anywhere, in Section 1342 or its implementing regulations that would allow for any other result, and the Government's arguments to the contrary are simply an attempt to manufacture a nonexistent exception to the annual payment obligation under the statute. If the Government's arguments were accepted, and full, annual payments were somehow not required, this would serve to destabilize the market—the exact result the risk corridors program was designed to prevent. This is not just argument. It is a fact, as has been conclusively demonstrated by the Government's failure to pay full risk corridor amounts in 2015 and 2016 and the catastrophic results to the market that resulted therefrom.

In addition to the statute's language, context, and purpose, HHS's own longstanding conduct and interpretation of its statutory obligations—*e.g.*, repeated statements in the Federal Register, multiple admissions in official agency announcements, its insistence that QHP issuers making "payments in" do so in full every year, and several other acts—show that HHS understood both it and QHP issuers must make full, annual payments in the amounts specified by statute. Indeed, HHS has repeatedly admitted that the risk corridors program is meant to "provide[] for the sharing *between a QHP issuer and the Federal government* of profits *and losses* resulting from inaccurate rate-setting during the early years of Exchanges."[1] By withholding full payments, the Government is not sharing in QHP issuers' risk as intended by the statute and QHP issuers were forced to bear all the risk that was intended to be mitigated by the risk corridors program. According to HHS itself, that is inconsistent with the program's structure and purpose.

[1] CMS, "HHS Notice of Benefit and Payment Parameters for 2014," at 18-19 (Mar. 2013), *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/payment-notice-3-11-2013.pdf (emphases added).

HRIC has pursued this claim on behalf of itself and the Class since February 2016. Although HHS's initial decision to implement a budget neutral approach on an annual basis may have been forced upon it by political considerations, the harm that unlawful decision has caused the hundreds of Class members and millions of their patients is directly contrary to the ACA's and risk corridors program's purpose. *See King v. Burwell*, 135 S. Ct. 2480, 2496 (2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter."). The Government used the risk corridors program to incentivize health plan issuers to enter the highly risky ACA health exchange markets in their early years, despite the enormous perils in doing so. But the Government's refusal to pay the full amounts now due has destroyed and continues to threaten to destroy those very same issuers, who were justifiably concerned about entering the markets in the first place. It is time for the Government to abide by its obligations, and HRIC therefore respectfully requests that the Court grant it summary judgment.

I. STATEMENT OF THE ISSUES PRESENTED

Is the Government liable for its failure to meet its statutory obligation to make full Risk Corridors payments to HRIC and the Class under a money-mandating statute?

II. STATEMENT OF THE CASE AND OF UNDISPUTED MATERIAL FACTS[2]

A. None Of Section 1342, HHS's Implementing Regulations, Or The Medicare Part D Risk Corridors Program Provide For Partial Payments

Section 1342 mandates that HHS establish and administer a "program [singular] of risk corridors [plural]." 42 U.S.C. § 18062(a). It further requires that the risk corridors program be "based on" the risk corridors program established for Medicare Part D (42 U.S.C. 1395w–101 *et seq.*). *Id.*

In setting forth the methodology to calculate the program's annual payments, Section 1342 states that, if a QHP issuer's allowable costs exceed its target amount by specified amounts "for any plan year," the Government "shall pay" a specified percentage of the difference between those two amounts. 42 U.S.C. § 18062(b)(1). If, on the other hand, a QHP issuer's target amount exceeds its allowable costs by certain specified amounts, then the QHP issuer "shall pay" the Government a specified percentage of the difference between those two amounts. *Id.* § 18062(b)(2). "Allowable costs" and "target amount" are each annual calculations specific to a QHP issuer, *id.* § 18062(c), and allowable costs may be reduced by payments from one or both of the other 3R programs, both of which are annual. *Id.* § 18062(c)(1)(B); *see also* Dkt. 31 at 23 ("Reinsurance and risk adjustment payments are to be made on an annual basis. And, the risk

[2] In light of the Court's extensive discussion in its prior Order regarding the history of the ACA, the health exchanges the Act created, and the way in which the risk corridors program fit into the ACA's broader framework, HRIC will not repeat those points here. For purposes of the present motion, HRIC will instead focus on the statutory language, context, and facts demonstrating why risk corridor payments must be made in full each year. The following discussion proceeds based on the Court's conclusion—which HRIC believes is correct in every respect—that Section 1342 requires annual payments.

HRIC concurs with Judge Wheeler's findings and conclusions as to why Section 1342 requires full annual payments to QHP issuers based on the facts he recites therein, and respectfully directs the Court to that discussion as a supplement to this brief. *See Moda*, 2017 WL 527588, at *2-9.

corridors payment that HHS owes an eligible insurer for a particular year depends upon the amount of reinsurance and risk adjustment payments that insurer received for that same year."). Notably, the risk corridor payments owed to or from QHP issuers for a benefit year are calculated according to the profits or losses each individual issuer experienced that year and are in no way dependent upon (or even compared to) other QHP issuers' results. 42 U.S.C. § 18062.

HHS's implementing regulations provide (as they must) the same structure for calculating the amounts owed under the risk corridors program. "When" a QHP issuer's allowable costs exceed its target amount "for any benefit year" by specified amounts, the QHP issuer "will receive payment from HHS in the following [specified] amounts." 45 C.F.R. § 153.510(b). In the opposite situation, "when" a QHP issuer's target amount in any plan year exceeds its allowable costs by certain amounts, then the QHP issuer "must remit charges to HHS in the following [specified] amounts." *Id.* § 153.510(c). Finally, just like Section 1342, allowable costs are reduced by annual payments received from the reinsurance and/or risk adjustment programs. *Id.* §§ 153.500, 153.530(b)(2).[3]

Neither Section 1342 nor the implementing regulations make any provision for partial payments of annual risk corridor amounts. *See generally* 42 U.S.C. § 18062; 45 C.F.R. 153.510. As the Court held, the program requires each side to make annual payments, Dkt. 31 at 23, and both Section 1342 and the implementing regulations define only one way to calculate the amounts of those annual payments, *i.e.*, the full amounts owed under the "payments out" and "payments in" methodology. 42 U.S.C. § 18062(b); 45 C.F.R. § 153.510(b), (c).

[3] In the implementing regulations, allowable costs may also *increase* from any annual payments made as part of the risk adjustment program. 45 C.F.R. § 153.530(b)(1).

In addition to Section 1342 and its implementing regulations, the Part D risk corridors program on which the ACA program is based provides (by statute and course of conduct) only for full annual payments. The regulations implementing the program, which were issued in 2005, provide that HHS will make owed payments "in the following payment year." 42 C.F.R. § 423.336(c) (2009). Just the same as Section 1342 and its implementing regulations, the Part D program does not provide for partial annual payments, *see generally* 42 C.F.R. § 423.336, and HHS has consistently made full payments pursuant to those regulations every year since the program's establishment. *See, e.g.*, HHS Office of Inspector General, "Medicare Part D Reconciliation Payments for 2006 and 2007," at 14 (September 2009), *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf (last visited Feb. 23, 2017).; *see also* Dkt. 31 at 21 (noting "for the first year of the [Part D] program—2006—HHS paid funds owed to eligible plan sponsors in November and December 2007"). Part D is also clear that each "risk corridor" is for a single plan year, requiring full payments for that specific risk corridor. *See* 42 U.S.C. § 1395w-115(e)(3)(A) ("***For each plan year*** the Secretary shall establish ***a risk corridor*** for each prescription drug plan and each MA–PD plan. The ***risk corridor for a plan for a year*** shall be equal to a range as follows . . . .") (emphasis added); 42 C.F.R. § 423.336(a)(2)(i) ("***For each year***, CMS establishes ***a risk corridor*** for each Part D plan. The ***risk corridor for a plan for a coverage year*** is equal to a range as follows . . . .") (emphasis added).

B. HHS Requires Full Annual Payments From QHP Issuers And Admits Payment Deadlines Should Be The Same For HHS And QHP Issuers

In 2015 and 2016, HHS required QHP issuers owing risk corridor amounts for the previous year to pay the Government *in full* within 30 days of its announcement of risk corridor calculations. *See* CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015), at 1 ("2014 Results Announcement") ("HHS will begin collection of risk

corridors charges [from QHP issuers] in November, 2015 . . . ."); CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year," at 2 (Nov. 18, 2016) ("2015 Results Announcement") ("HHS is collecting 2015 risk corridor charges [from QHP issuers] in November 2016 . . . .").[4] HHS previously codified this obligation in its implementing regulation for the risk corridors program, 45 C.F.R. § 153.510(d), which states that "[a] QHP issuer must remit charges to HHS within 30 days after notification of such charges." HHS has never permitted QHP issuers to make partial annual payments and, as noted in previous briefing (as well as in the Court's Order), HHS has previously admitted "that the payment deadlines should be the same for HHS and QHP issuers." Dkt. 31, at 4 (quoting Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, at 41,943 (to be codified at 45 C.F.R. pt. 153)), at 5 (citing Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Premium Stabilization Rule"), 77 Fed. Reg. 17,220, at 17,238 for the same statement).

C. HHS Has Repeatedly Admitted It Must Make Full Risk Corridor Payments

From the ACA's inception to the present, HHS has admitted multiple times that the statute requires full payments. For example, in 2013 (and of particular relevance to this motion), HHS admitted, "The Risk Corridors program is not statutorily required to be budget neutral. ***Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act.***" 78 Fed. Reg. 15,410, at 15,473 (emphasis added). HHS made similar admissions several times since, even after instituting its "budget neutral" approach to annual payments. *See*, *e.g.*, Exchange and Insurance Market Standards for

[4] *Available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf (last visited Feb. 23, 2017).

2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, at 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, at 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF#sthash.F6vymHRx.dpuf ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation[5] of the United States Government for which full payment is required.").

HHS has also demonstrated through its practice that it understands the risk corridor payment obligation is to be paid in full each year. For example, the ACA's medical loss ratio ("MLR") program is designed to limit the portion of premium dollars QHP issuers may spend on administration, marketing, and profits. The MLR program does so by requiring QHP issuers to rebate a portion of their premiums if the ratio between the issuer's health care claim costs to their "premium" is less than 80 percent. 42 U.S.C. § 300gg-18. The "premium" for this program—*i.e.*, the denominator for purposes of the MLR equation—includes the ***full amount*** of the issuer's risk corridor payment or receipt from the previous benefit year, and MLR calculations are made

[5] The recording of risk corridor payments as an "obligation" has independent significance. Pursuant to the guidance set forth in the GAO's Red Book, an agency should record as an "obligation" non-discretionary expenditures "imposed by law." GAO, *Principles of Federal Appropriations Law*, 3d Ed., Vol. II, 2006 rev., p. 7-43, GAO-06-382SP.

on an annual basis following the applicable benefit year. *Id.*; *see also* 45 C.F.R. § 158.130(b)(5); 45 C.F.R. § 158.103; 45 C.F.R. § 158.240.[6]

With it thus firmly established that HHS itself understands the statute requires full risk corridor payments annually, it is notable that neither HHS nor the Government's attorneys have ever identified any statutory provisions permitting HHS to make anything less than full annual payments under the program. Instead, the Government has argued that there is ambiguity over when payments must be made, and that this ambiguity provided HHS "discretion" to establish a payment framework of its choosing. *See* Dkt. 8 at 15-18; Dkt. 14 at 4-8. But the Court rejected that argument in a detailed, in-depth exploration of the relevant statutes, regulations, and evidence, and instead concluded that Section 1342 requires annual payments. *See generally* Dkt. 31 at 19-23. Thus, the record demonstrates that: (a) the risk corridor program requires annual payments, (b) HHS believes (correctly) that Section 1342 requires it to make full risk corridor payments as defined in the statute, and (c) HHS has never identified any statutory basis allowing it to make partial annual payments.

D. Congress Established The Risk Corridors Program (Along With The Other 3R Programs) To Stabilize Annual Premiums

As the Court noted in its Order, the ACA included three premium stabilization programs to mitigate the risk faced by QHP issuers in the newly created health exchanges: a transitional reinsurance program, a permanent risk adjustment program, and a temporary risk corridors program. Dkt. 31 at 2 (citing 42 U.S.C. §§ 18061-18063). These are colloquially known as the "3R" premium stabilization programs. *See, e.g.*, CMS, "The Three Rs: An Overview" (Oct. 1, 2015) ("The Three Rs") (CMS admitting the 3Rs are designed "to assist insurers through the

[6] *See also* HHS NBPP for 2014, 78 Fed. Reg. at 15,413, 15,505, 15,513 (Mar. 11, 2013); HHS NBPP for 2015, 79 Fed. Reg. at 13,843, AR 630 (Mar. 11, 2014).

transition period, and to create a stable, competitive and fair market for health insurance").[7] The 3Rs—and particularly the reinsurance and risk corridors programs—are specifically meant to "provide issuers with greater payment stability as [the ACA's] insurance market reforms are implemented." Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, at 73,119 (Dec. 7, 2012) (to be codified at 45 C.F.R. pts. 153, 155-158). As HHS admitted, the risk corridors program was one in which "the Federal government and QHPs" would "share in profits or losses resulting from inaccurate rate setting from 2014 through 2016." 78 Fed. Reg. 15,410, at 15,413 (Mar. 11, 2013). By its terms, the risk corridors program was a risk-sharing program between the Government and QHP issuers. In contrast, the risk adjustment program was a risk-sharing program between QHP issuers only. *See* 42 U.S.C. § 18063.[8]

In its Order, the Court further noted that payments under the reinsurance and risk adjustment programs are made in full annually. Dkt. 31 at 21-23; *see also* 42 U.S.C. §§ 18061(c)(1), 18063(a). This is consistent with the goal of stabilizing premiums in the early years of the ACA health exchanges, because those premiums are annual in nature; *i.e.*, they must be set and approved *each year*. *See* 42 U.S.C. § 18031(c)(6)(B) (providing for "annual open enrollment periods" in advance of "calendar years" for plans on the Exchanges); 42 U.S.C. § 18031(e)(2) (providing for review of premiums for certification of Exchange plans). Indeed,

[7] *Available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html (last visited Feb. 23, 2017).

[8] As discussed below, the Government's budget neutral approach to the risk corridors program has effectively turned it into yet another risk-sharing program between QHP issuers only; *i.e.*, by simply transferring profits from some QHP issuers to other, less fortunate QHP issuers.

HHS recognized this fact when it set "an annual schedule for the [risk corridors] program and standards for [risk corridors] data submissions." 77 Fed. Reg. at 73,121.

The Government has also more generally recognized the importance of making full, annual cost-sharing payments to insurers under the ACA's provisions. Specifically, in connection with another ACA risk mitigation program, the Government noted that a failure to make payments in a way that provided certainty about the "existence and amount of payments" would be "inefficient and destabilizing," and "would also inevitably lead to increased premiums—and correspondingly greater federal expenditures," even if Congress ultimately appropriated funds for the payments. Br. for Defs. at 23, *United States House of Representatives v. Burwell*, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (No. 1:14-cv-01967), ECF No. 55-1.[9]

E. HHS Told Class Members They Would Receive Full, Annual Risk Corridor Payments From The Government

In addition to its public statements, the Government also stated privately to QHP issuers that it planned to pay them in full each year for owed risk corridor amounts. For example, in late February and early March 2014, HRIC was setting prices for its 2015 plans and conducted a call with representatives from CMS. Declaration of Dawn Bonder ("Bonder Decl.") ¶ 7. During that

[9] The Government has also admitted that portions of the ACA are "interdependent" and failing to implement some could lead to "skyrocketing premiums" or even "death spirals." *See* Br. for Resp't at 14-15, *King v. Burwell*, 135 S. Ct. 2480 (2015) (No. 14-114), 2015 WL 349885, at *14-15 (Jan. 21, 2015) ("the individual-coverage provision could not perform its market-stabilizing function in the absence of subsidies making coverage broadly affordable" and "[t]he denial of tax credits and the resulting loss of customers would thus have disastrous consequences for the insurance markets in the affected States"); Br. for Resp't at 26, *Nat. Fed'n of Indep. Businesses v. Sebelius*, 132 S. Ct. 2566 (2012) (Nos. 11-393, 11-398, 11-400), 2012 WL 273133, at *26 (Jan. 27, 2012) ("without a minimum coverage provision, the guaranteed-issue and community-rating provisions would drive up costs and reduce coverage, the opposite of Congress's goals"). These are, admittedly, different provisions of the ACA, but demonstrate that the ACA is an interlocking statute designed to improve, not destroy, health insurance markets, and that full, annual payment regimes are critical to this functioning.

conversation, the CMS representatives attempted to convince HRIC to lower its proposed rates in line with another QHP issuer in the area. *Id.* ¶ 8. If HRIC did not lower its rates, CMS said that could be cause to terminate HRIC's federal CO-OP loans. *Id.* In reply, HRIC responded that it believed its competitor had set unreasonably low rates, and that HRIC could not afford to price its plan in a similar way without damaging its business. *Id.* The CMS representatives then stated that the ACA's 3R programs were designed to protect carriers from that risk and that HRIC needed to remember that other carriers would be pricing their plans with the 3Rs in mind, which included full risk corridor payments. *Id.*

Similarly, Kevin Counihan, CEO of Healthcare.gov, assured Common Ground Healthcare Cooperative's ("Common Ground") CEO during a July 2015 telephone call that Common Ground would receive its full 2014 risk corridor payment. Declaration of Cathy Mahaffey ("Mahaffey Decl.") ¶ 7. At the time of the call, due to a submission oversight, Common Ground owed a significant risk adjustment payable, and Common Ground's CEO requested permission to submit additional data for its 2014 risk adjustment submission. *Id.* Mr. Counihan declined that request and, when Common Ground's CEO expressed concerns about Common Ground's continued financial viability, Mr. Counihan pointed out that Common Ground had only booked 80% of its 2014 risk corridor payment in its financial statements. *Id.* Mr. Counihan further stated that the 2014 risk corridor payment would be 100%, so Common Ground would have the 20% differential to assist in addressing any shortfall created by the risk adjustment error. *Id.*[10]

[10] HRIC expects that there are numerous other examples of such statements available within the Government's files, but does not believe the discovery of those statements is necessary for the current motion.

F. HHS Calculated Full, Not Partial, Risk Corridor Amounts Owed To Class Members For Each Of 2014 And 2015

In late 2015, and again in late 2016, HHS released its calculations of the risk corridor amounts it owed to each QHP issuer for the preceding plan year. *See* 2014 Results Announcement, at 1 ("Today, HHS is releasing issuer-level risk corridors payments and charges based on the most current risk corridors data submitted by issuers . . . for the 2014 benefit year."); 2015 Results Announcement, at 1 ("The tables below show risk corridors payments and charges calculated for the 2015 benefit year . . . ."). These were not calculations of partial payments; they included the full amount owed to or from each QHP issuer for the previous plan year, as required by Section 1342 and the implementing regulations. *Id.*[11]

G. The Government's Failure To Pay Even A Substantial Portion Of Annual Risk Corridor Amounts Has Sown Widespread Chaos In The Exchange Markets

As Judge Wheeler recently observed in the *Moda* opinion, HHS adopted a transitional policy in 2013 that caused QHP issuers to incur much higher costs than they originally anticipated:

> Shortly after [QHP issuers] began selling QHPs, it became apparent that some consumers' health insurance coverage would be terminated because it did not comply with the ACA. To minimize the hardship that these large-scale health insurance terminations would cause, HHS announced a transitional policy in November 2013. Under the transitional policy, health plans in the individual or small group market that were in effect on October 1, 2013 were "not . . . considered to be out of compliance with the [ACA's] market reforms" for the 2014 plan year. Transitional Policy Letter at 1–2. This change was significant because consumers with non-compliant healthcare plans now were not required to

[11] In those same announcements, of course, HHS disclosed the amount of money it planned to pay each QHP issuer *pro rata* from risk corridor collections for that same year. *Id.* The Class's damages are the difference between (a) what HHS calculated it owed each Class member, and (b) the *pro rata* amounts those Class members received from HHS from risk corridor collections. Given HHS's own statements and admissions, the Government still owes each Class member the vast bulk of their risk corridors amounts for 2014 and 2015. *Id.*

> purchase insurance on the Exchanges from insurers like Moda. These consumers tended to be healthier, so excluding them from the exchanges left a sicker (and therefore, potentially more expensive) group of potential insurance buyers. HHS acknowledged the transitional policy's impact on insurers in its announcement, stating, "Though this transitional policy was not anticipated by health insurance issuers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue. We intend to explore ways to modify the risk corridor program final rules to provide additional assistance." Transitional Policy Letter at 3. HHS has renewed the transitional policy twice, and it will now extend through October 1, 2017.

Moda, 2017 WL 527588, at *5.

The Government's unilateral decision to adopt this transitional policy had serious repercussions on QHP issuers. Since the policy took healthier insureds with preexisting health plans out of the ACA exchange markets only *after* issuers began selling QHPs, QHP issuers suffered much-higher-than-expected losses in the 2014 and 2015 benefit years. The risk corridors shortfalls for each of those benefit years are themselves proof of the impact the transitional policy had, but what is most important for the current motion is that, had the risk corridors program operated as intended, it would have mitigated QHP issuers' risk and helped them stabilize premiums despite the Government's after-the-fact change in policy. For example, had the Government paid even 30% of the full risk corridor amount it owed HRIC for the 2014 benefit year, HRIC would have been able to continue operations and keep offering QHPs to Oregon citizens for the 2016 benefit year. Bonder Decl. ¶ 11. Instead, due to the shortfall in funds, HRIC had insufficient capital reserves to continue on and made the business decision to not offer QHPs after the 2015 benefit year. *Id.* ¶ 11. The same trend can be found throughout the ranks of QHP issuers, including CO-OPs like HRIC, as well as much larger companies such as Moda and the largest QHP issuers in the nation.

III. SUMMARY JUDGMENT STANDARD

Summary judgment is appropriate when there is no genuine issue of material fact and the

moving party is entitled to a judgment as a matter of law. RCFC 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322 (1986). A fact is material if it "might affect the outcome of the suit under the governing law." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). An issue is genuine if it "may reasonably be resolved in favor of either party." *Id.* at 250. The moving party bears the initial burden of demonstrating the absence of any genuine issue of material fact. *Celotex Corp.*, 477 U.S. at 323. The nonmoving party then bears the burden of showing that there are genuine issues of material fact for trial. *Id.* at 324.

IV. ARGUMENT

In its recent opinion, the *Moda* Court noted that this Court "dealt exhaustively with the Government's arguments in its comprehensive opinion." *Moda*, 2017 WL 527588, at *12. Given that it "concur[red] in full with the *Health Republic* court's analysis," the *Moda* Court stated "there is no need to reinvent a perfectly good wheel. Still, for the sake of clarity, the Court will summarize that analysis here." *Id.*

In the *Moda* opinion, the Court conducted a similarly exhaustive analysis of why Section 1342 requires full annual payments to insurers. *Id.* at *15-22. HRIC concurs in full with that analysis and believes it is an excellent resource and precedent for this motion. However, just as the *Moda* Court did with its own opinion, HRIC believes it is prudent to summarize and expand upon why this Court should also grant summary judgment on behalf of HRIC and the QHP Issuer Class.

A. Under The Rules Of Statutory Construction, There Is No Other Conclusion Than That HHS Must Make Full, Annual Payments

1. Principles Of Statutory Construction

When interpreting a statute, a Court must first look to the statute's plain language in order to "inquire whether Congress has clearly spoken on the subject" in dispute. *Bath Iron Works*

Corp. v. United States, 27 Fed. Cl. 114, 125 (1992) (citing *Norfolk & W. Ry. Co. v. Am. Train Dispatchers Ass'n*, 499 U.S. 117, 128 (1991)). If the statute is plain on its face, that is the end of the inquiry. *Id.* Assuming there is an ambiguity in the statute's plain meaning, however, the next step is to look at "other extrinsic aids, such as legislative history." *Id.* (citing *Richards Medical Co. v. United States*, 910 F.2d 828, 830 (Fed. Cir. 1990)).

"Where a statute's text and legislative history are silent on an issue of statutory construction, the overriding purpose of the provision is highly relevant in resolving the ambiguity." *Augustine v. Dep't of Veterans Affairs*, 429 F.3d 1334, 1342 n.4 (Fed. Cir. 2005). To this point, "the court will not look merely to a particular clause . . . , but will take in connection with it the whole statute (or statutes on the same subject) and the objects and policy of the law, as indicated by its various provisions, and give it such a construction as will carry into execution the will of the Legislature." *Warner–Lambert Co. v. Apotex Corp.*, 316 F.3d 1348, 1355 (Fed. Cir. 2003) (quoting *Kokoszka v. Belford*, 417 U.S. 642, 650 (1974)); *see also King*, 135 S. Ct. at 2490 (refusing to read portion of the ACA "out of context" with the broader Act, because it would render other provisions in the Act senseless or contradictory).

2. Section 1342's Plain Language, Context, And Purpose Require Full, Annual Payments

There is no genuine question that Congress clearly intended for the Government ***and*** QHP issuers to pay risk corridor amounts in full on an annual basis.

As the Court has already held, the plain language of Section 1342 requires annual payments. Dkt. 31 at 23. The statute is also plain on its face as to how much each side "***shall pay***"—or, as stated in the implementing regulations, "***will receive***"—after each plan year. Section 1342's "payments in" and "payments out" calculation methodologies do not contain any caveats for partial payments, halfway calculations, or any mechanism to split payments beyond a

single, lump sum. 42 U.S.C. § 18062(b). This, of course, is consistent with the Part D program on which the ACA program is based; *i.e.*, Part D requires full, annual payments from both sides every year, a process that had long been in place when Congress included Section 1342 in the ACA.[12] The plain text of Section 1342 provides no other alternative than that those payments be made in full every year.

Indeed, if Congress intended to provide for only partial payments, or limit risk corridor payments out to amounts paid in, it knew how to accomplish that. The ACA's reinsurance program explicitly limits payments out to amounts paid into that program. 42 U.S.C. § 18061(b)(1)(B).[13]

The plain text is thus the full extent of the necessary inquiry regarding whether full payments are required in this case, and they plainly are. *See LCM Energy Sols. v. United States*, 107 Fed. Cl. 770, 774 (2012) (noting that a money mandating statute with "a clear standard for the payment of money and states a precise amount of money to be paid" could only be "fairly interpreted" as mandating "the exact amount of the full grant" to which a plaintiff was entitled);

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[12] *See* 42 C.F.R. § 423.336(c) (2009) (providing that HHS will make owed payments "in the following payment year"); *see also* 42 U.S.C. § 1395w-115(e)(3)(A) ("***For each plan year*** the Secretary shall establish ***a risk corridor*** for each prescription drug plan and each MA–PD plan. The ***risk corridor for a plan for a year*** shall be equal to a range as follows . . . .") (emphasis added); 42 C.F.R. § 423.336(a)(2)(i) ("***For each year***, CMS establishes ***a risk corridor*** for each Part D plan. The ***risk corridor for a plan for a coverage year*** is equal to a range as follows . . . .") (emphasis added).

[13] The statute states in pertinent part: "the applicable reinsurance entity collects payments under subparagraph (A) and *uses amounts so collected* to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market (excluding grandfathered health plans) for any plan year beginning in such 3-year period." 42 U.S.C. § 18061(b)(1)(B) (emphasis added); *see also id.* at § 18061(b)(4)(A) ("the contribution amounts collected for any calendar year may be allocated and used in any of the three calendar years for which amounts are collected based on the reinsurance needs of a particular period or to reflect experience in a prior period").

Sharp v. United States, 80 Fed. Cl. 422, 427 (2008) ("In the absence of any effective required offset under section 1450(c)(1), these surviving spouses are statutorily mandated to receive their full SBP payments, because 10 U.S.C. § 1450(a)(1) requires the payment of SBP annuities to surviving spouses.").

In practice, the plain-language conclusion is confirmed by how much QHP issuers must pay each year under Section 1342's "payments in" methodology. All QHP issuers owing risk corridor amounts to the Government for a benefit year must pay ***in full*** the following year. *See* 45 C.F.R. § 153.510(d) ("A QHP issuer must remit [risk corridors] charges to HHS within 30 days after notification of such charges"); *see also* 2014 Results Announcement, at 1 ("Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated."); 2015 Results Announcement, at 2 ("HHS intends to collect the full 2015 risk corridors charge amounts . . . ."). There are no exceptions to this rule, *see* 45 CFR § 153.510(d), and the "payments in" methodology is substantively identical to the "payments out" methodology.

Even if the text were somehow unclear, HHS has always admitted, by words and actions, that the statute requires full payments. Each year, HHS has paid out every cent available to it for the risk corridor amounts it owed, and stated that it would continue to do so to the best of its ability. *See, e.g.*, 2014 & 2015 Results Announcements. This begs the question: if the program did not require full payments, why did HHS pay out any amounts at all, and would it have paid out more if it had the funds available? Of course it would have, as its actions demonstrate.

Furthermore, HHS could not have been clearer on this point when, in 2013, it stated that "[r]egardless of the balance of payments and receipts" (*i.e.,* regardless of whether the Government owed more under the risk corridors than it received for a benefit year) "HHS will

remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473. It then repeated this sentiment ever more forcefully in the ensuing years, always concluding that the statute requires "full payments." *See* 79 Fed. Reg. at 30,260 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); 80 Fed. Reg. at 10,779 ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers."); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers.").

These are not innocuous statements; they are repeated admissions that HHS reads Section 1342 exactly as the Class does here; *i.e.*, that Section 1342 explicitly requires full, annual payments. Annual payments are also consistent with the purpose of the risk corridors program, as stated by HHS, for "the Federal government and QHPs to share" risks from rate setting in each of 2014, 2015, and 2016. *See* 78 Fed. Reg. 15,410, at 15,412 (Mar. 11, 2013). The Government's position has been that it had the discretion whether to make annual payments at all. *See*, *e.g.*, Dkt. 8 at 16 ("Section 1342 requires CMS to calculate risk corridors payments and charges based on claims and other costs for a 'benefit year,' but it *does not require CMS to pay risk corridors on an annual basis*.") (emphasis added). The Court, however, rejected that position based on an in-depth analysis of the ACA, as well as HHS's own actions and interpretations of its obligations. Dkt. 31 at 23 ("HHS is required to make annual risk corridors payments to eligible qualified health plans."). The situation in which the parties thus find themselves is that HHS admits it must make full payments by statute, but has withheld portions of those payments on the basis of a legally incorrect—and now rejected—theory of discretion. This motion seeks an order requiring HHS to comply with its own interpretation of the statute:

one where full payments are made according to the timelines set forth in the statute (*i.e.*, annually).

Notwithstanding the statutory text and HHS's admissions, Section 1342 still must be construed to require full, annual payments to avoid a construction that has and would continue to undermine the risk corridors' and other 3R programs' fundamental purpose: annual premium stabilization. Under the ACA, QHP issuers must set annual premiums in order to offer QHPs on the health exchanges. 42 U.S.C. § 18031(c)(6)(B); 42 U.S.C. § 18031(e)(2). As noted above, the 3R programs, including the risk corridors program, were meant to help stabilize these annual premiums in the first three years of the ACA exchanges. 77 Fed. Reg. at 73,119. To this end, HHS established "an annual schedule for the [risk corridors] program and standards for [risk corridors] data submissions," 77 Fed. Reg. at 73,121, and, consistent with Section 1342's requirements (*see* 42 U.S.C. § 18062(c)(B)) ensured that the annual payments QHP issuers received or made under the other 3R programs were similarly reflected in risk corridor payments or charges. 45 C.F.R. § 153.510(g). All of these interlocking parts (had the Government abided by its full, annual payment obligations) would have worked to reduce risk on QHP issuers and help them keep insurance premiums and healthcare fees stable in the early years of the exchanges. *See* Bundorf Decl., at ¶¶ 8-9.

Instead, the Government paid only a portion of its owed amounts for the 2014 and 2015 benefit years—effectively making the risk corridors program a risk-sharing program between QHP issuers rather than between QHP issuers and the government, *see* 78 Fed. Reg. at 15,413 (admitting risk corridors program was designed to be one in which "the Federal government and QHPs" would "share in profits or losses")—and the chaos that decision caused is still being felt

by QHP issuers and their patients today.[14] Many different QHP issuers throughout the United States, including HRIC, were required to shut their doors following the 2015 plan year to their insured, thus reducing choice in the marketplace. *See* Section II.G, *supra*.[15] Similarly, those left in the market had to raise premiums or fees in order to maintain capital reserves and account for the higher-than-expected risks to their businesses from outsized losses in the first two years of the exchanges.[16] This resulting market impact (skyrocketing annual premiums) creates the exact conditions for insurance market "death spirals" the Supreme Court cautioned the ACA was designed (and must be interpreted) to avoid. *See King*, 135 S. Ct. at 2496 ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter.").

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[14] The ACA has a separate interlocking risk-sharing program between QHP issuers: the risk adjustment program, which, on an annual basis (and in full), redistributes funds from plans with lower-risk enrollees to plans with higher-risk enrollees. *See* 42 U.S.C. § 18063(a); *see also* Dkt. 31 at 21-23.

[15] *See also, e.g.*, Tara Bannow, *Final Oregon health insurance rates approved,* THE BULLETIN (Bend, Or.) (July 1, 2016), *available at* http://www.bendbulletin.com/home/4470743-151/final-oregon-health-insurance-rates-approved?referrer=fpblob (last visited Feb. 23, 2017); Louise Norris, *CO-OP health plans: patients' interests first*, HEALTHINSURANCE.ORG (Dec. 22, 2016), *available at* https://www.healthinsurance.org/obamacare/co-op-health-plans-put-patients-interests-first/ (last visited Feb. 23, 2017).

[16] *See, e.g.*, Paul Demko, *Obamacare's sinking safety net*, POLITICO (July 13, 2016) (calling the risk corridors program "an unmitigated debacle" and blaming rising premiums on the government's nonpayment), http://www.politico.com/agenda/story/2016/07/obamacare-exchanges-states-north-carolina-000162 (last visited Feb. 23, 2017); Tara Bannow, *Final Oregon health insurance rates approved,* THE BULLETIN (Bend, Or.) (July 1, 2016), available at http://www.bendbulletin.com/home/4470743-151/final-oregon-health-insurance-rates-approved?referrer=fpblob (last visited Feb. 23, 2017); Louise Radnofsky & Anna Wilde Mathews, *Health Insurers Struggle to Offset New Costs*, WALL ST. J. (May 4, 2016), http://www.wsj.com/articles/health-insurers-struggle-to-offset-new-costs-1462404298 (last visited Feb. 23, 2017); *see also* Bundorf Decl., at ¶¶ 10-11.

Nowhere—not in this case or any other—has the Government ever articulated why partial risk corridor payments are consistent with the program's purpose. It simply makes no sense, particularly because:

- The other two of the 3R programs require and make full, annual payments.
- Other HHS programs, such as the MLR program, assume that QHP issuers received or paid full risk corridor amounts for the previous benefit year.
- The Government requires full, annual payment from QHPs under the risk corridors program and pays out in full all the funds it can pay under the program.
- The 3R programs were designed to collectively stabilize annual premiums, and the risk corridors program was designed to specifically protect QHP issuers that were unable to accurately judge risk in the rate-setting process due to the ACA exchange's revolutionary demographics.
- The risk corridors program is meant to share risk between the Government and QHP issuers, rather than just between QHP issuers. The Government's budget neutral approach to annual risk corridor payments, however, converts the risk corridors program into a risk-sharing program between QHP issuers. The 3R regime already has such a program—the risk adjustment program.
- QHP issuers with huge losses must make up in the next year what they lost in the previous by increasing premiums or fees—unless they have a full backstop for the previous year's losses.

These straightforward, logically consistent points lead to one inevitable conclusion: without full payments every year, the risk corridors program will do nothing (and has done nothing) to stabilize premiums. One can only surmise as to the political motivations for destabilizing premiums for American insureds in the new ACA health exchanges, but the unswerving point is that the Government has never offered any explanation for why or how less than full, annual risk corridors payments serves Congress's explicit goals for the program.

3. It Is Immaterial Whether Congress Appropriated Funds To Pay HHS's Monetary Obligations

The Government previously has argued that Courts should place significance on the fact that Congress failed to appropriate funds in 2015, 2016, or (now) 2017 to pay HHS's risk

corridor obligations.[17] Presumably, the Government will argue in opposition to this motion that Congressional failure to appropriate funds for full, annual risk corridor amounts to QHP issuers should inform this Court's interpretation of the ACA. There is no merit to these arguments.

"[T]here is a very strong presumption" that appropriation acts do not substantively change existing law. *Calloway v. District of Columbia*, 216 F.3d 1, 9 (D.C. Cir. 2000). Nothing in Congress's 2015 or 2016 Spending Bills modifies HHS's obligations under the ACA; the Bills only state that HHS may not draw upon certain funds to satisfy its obligations under the risk corridors program.[18] *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, 2491, § 227 (the "2015 Spending Bill"); Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242, 2624-25, § 225 (the "2016 Spending Bill"). The law is clear: such limitations on funding do nothing to modify the existing law. Rather, such a modification must be done unambiguously, and Congress did not do so here. *See Moda*, 2017 WL 527588, at *17-22 (collecting and discussing cases, and concluding Congress did not amend Section 1342 with the 2015 and 2016 Spending Bills).[19]

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[17] *See, e.g.*, Dkt. 8, at 9-11, 17-18; U.S. Mot. to Dismiss at 9-11, 24-29, *Moda Health Plan, Inc. v. United States*, Case No. 1:16-cv-00649-TCW (Fed. Cl. Sept. 30, 2016), ECF No. 8; Def.'s Mot. to Dismiss and Opp'n to Pl.'s Mot. for Summ. J., at 34-40, *Maine Community Health Options v. United States*, Case No. 1:16-cv-00967-EGB (Fed. Cl. Jan. 13, 2017), ECF No. 22.

[18] Before Congress passed the Spending Bills, the GAO had concluded that HHS program funds were available to make payments under Section 1342. *See* The Hon. Jeff Sessions, the Hon. Fred Upton, B-325630 (Comp. Gen.), 2014 WL 4825237, at *5 (Sept. 30, 2014) ("The CMS PM appropriation for FY 2014 also would have appropriated to CMS user fees collected pursuant to section 1342(b)(2) in FY 2014."). Thus, if Section 1342 restricted risk corridors payments to risk corridors charges as HHS now argues, the program fund would have been unavailable and unnecessary.

[19] Congress demonstrated in the 2015 and 2016 Spending Bills that it knew the "silver bullet" language it could use to unambiguously change such obligations—because it used that language in connection with a non-ACA program—but affirmatively chose ***not*** to use such language for the risk corridors program. *Moda*, 2017 WL 527588, at *21 (citing 128 Stat. at

The statute's plain language and the Government's representation it "shall pay" certain, defined amounts in certain, defined situations means it is irrelevant for determining the Government's payment obligation whether Congress makes a specific appropriation to satisfy that obligation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389 (1886) (holding that Congress owed Haitian ambassador $2,500 where statute mandated that he be paid $7,500 annually and Congress only appropriated $5,000 for that purpose); *Slattery v. United States*, 635 F.3d 1298, 1321 (Fed. Cir. 2011) (*en banc*) (failure to appropriate funds did not absolve the Government of its obligation to pay amounts owed); *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007) (Congress's failure to appropriate funds does not "defeat a Government obligation created by statute"); *District of Columbia v. United States*, 67 Fed. Cl. 292, 340 (2005) (holding that government had a statutory obligation to pay the plaintiff; statute did not expressly specify that payments made pursuant to it were an "obligation" of the Government); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949) (requiring payment of overtime wages to government workers where such overtime was mandated by statute, but Congress forbade the employing agency from using appropriated funds for that purpose). Indeed, as Health Republic has repeatedly pointed out, the Federal Circuit has previously held that "the jurisdictional foundation of the Tucker Act is not limited by the appropriation status of the agency's funds or the source of funds by which any judgment may be paid." *Slattery*, 635 F.3d at 1321.

Similarly, the passage of an appropriations bill, by a different Congress, years after the initial passage of the ACA is irrelevant to the construction of the Act. *See, e.g.*, *United States v.*

2172 (Section 753 of the appropriations law for fiscal year 2015)). Even if Congress had attempted to change the Government's obligations under the risk corridor provision, an attempt to rescind QHP issuers' vested rights to risk corridor payments would, at a minimum, raise significant constitutional questions.

United Mine Workers of Am., 330 U.S. 258, 281-82 (1947) ("We fail to see how the remarks of these Senators in 1943 can serve to change the legislative intent of Congress expressed in 1932."); *Cobell v. Norton*, 428 F.3d 1070, 1075 (D.C. Cir. 2005) ("The significance of appropriations bills is of course limited and the associated legislative history even more so. . . . [P]ost-enactment legislative history is not only oxymoronic but inherently entitled to little weight."). No "clarification" can be read into the appropriation bills. Any argument that the 2015 or 2016 Spending Bills provide clarity as to the Government's payment obligations under the ACA remains just as incorrect now as it did in previous briefing. If anything, those later Spending Bills reinforce the plain meaning of Section 1342 and its requirement that full payment be made to eligible QHPs regardless of how much CMS receives from other, profitable QHPs. If DOJ's *post hoc* reading of Section 1342 were correct, and Section 1342 from the start only required CMS to pay *out* under that section no more than what it received *in* under that section, there would have been no need for Congress in later Spending Bills to restrict CMS's ability to draw on other funding sources for risk corridor payments. The Government's reliance on these later Spending Bills is misguided and these later enactments simply do not support its position. *See generally* Dkt. 31 (interpreting Section 1342 of the ACA only with reference to its plain language, context, and purpose, and in light of HHS's original conduct and statements).

B. HHS Has No Discretion To Pay Only A Portion Of Annual Risk Corridor Amounts

In its motion to dismiss, the Government urged the Court to defer to HHS's "three-year payment framework" under the *Chevron* doctrine. *See, e.g.*, Dkt. 8 at 16; Dkt. 14 at 5-8. There is no reason to do so. As an initial matter, *Chevron* deference only applies if Congress's intent with respect to the statute in question is unclear. However, Congress's intent with respect to the annual 3R premium stabilization programs is perfectly clear, and a necessary component of that

intent is full, annual payments. The *Chevron* doctrine therefore does not even apply to this case. Even if it did, Supreme Court precedent demonstrates that the Court owes no deference here because HHS originally represented it would pay in full, annually, which created "serious reliance interests"; HHS has never explained its change in position, as it was required to do; and, in any event, the three-year framework is so contrary to the purpose of the ACA that it must be rejected as a matter of law.

1. *Chevron* Deference Does Not Apply To Statutes Where Congress's Intent Is Clear

As an initial matter, *Chevron* deference is inappropriate where the intention of the statute in question is clear. *See Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984) ("If the intent of Congress is clear, that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress."). This is the so-called "step one" of any *Chevron* analysis.

For the reasons discussed at length above, Plaintiff respectfully submits there is no legitimate reading of Section 1342 or its implementing regulations that allows for anything less than full payments every year. Plaintiff will not repeat those points again except to note that they eliminate the notion that HHS's "three-year payment framework" should receive any deference at all.

2. Even If Congress's Intent Were Unclear, *Chevron* Deference To HHS's Failure To Pay Full, Annual Amounts Is Inappropriate

Even assuming, *arguendo*, that Section 1342 and its implementing regulations were not clear that the only payments HHS may calculate and pay are full, annual payments, the Government still may not rely on *Chevron* deference under the "second step" of the doctrine.

"Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125-26

(2016) (citing *Nat'l Cable & Telecommunications Assn. v. Brand X Internet Services*, 545 U.S. 967, 981-82 (2005)). Although the agency need not always provide a more detailed justification for its change than what would be required for a new policy created on a blank slate, the "agency must at least 'display awareness that it is changing position' and 'show that there are good reasons for the new policy.'" *Encino*, 136 S. Ct. at 2126 (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)).

Further, if an agency's original policy creates "serious reliance interests," then a subsequent change is facially arbitrary and capricious—and "receives no *Chevron* deference"—without a reasoned explanation from the agency for that change. *Encino*, 136 S. Ct. at 2125-26. *Chevron* deference is "likewise unwarranted when there is reason to suspect that the agency's interpretation 'does not reflect the agency's fair and considered judgment on the matter in question,'" such as "when the agency's interpretation conflicts with a prior interpretation," *Christopher v. SmithKline Beecham Corp.*, 132 S. Ct. 2156, 2166 (2012), or when the interpretation is "nothing more than an agency's convenient litigating position . . . ." *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 213 (1988). With respect to the ACA specifically, the Supreme Court has noted an interpretation that destabilizes the health insurance exchange regime is manifestly contrary to the statute's purpose. *King v. Burwell*, 135 S. Ct. 2480, 2493 (2015).

In *King*, the Supreme Court noted that "Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them. If at all possible, we must interpret the Act in a way that is consistent with the former, and avoids the latter." *King*, 135 S. Ct. at 2496. In *King*, the petitioners proposed an interpretation of the ACA (based upon the "plain language" of the statute) that would limit tax credit eligibility to only those persons in states with state-operated exchanges. *Id.* at 2495-96. The Supreme Court rejected the petitioners' interpretation

and, in so doing, held that ACA provisions must be interpreted in a manner "that is compatible with the rest of the law." *Id*. at 2492. That "statutory scheme compels [courts] to reject" interpretations that "would destabilize the individual insurance market . . . , and likely create the very 'death spirals' that Congress designed the Act to avoid." *Id.* at 2492-93. Importantly, Courts should not apply *Chevron* deference to ACA-related interpretations where the issue involves "a question of deep 'economic and political significance' that is central to the [ACA's] statutory scheme," as well as "billions of dollars in spending each year and [which] affect[s] the price of health insurance for millions of people." *Id.* at 2489.

With this law in mind, the undisputed facts demonstrate why no deference is owed to HHS for its budget neutral approach to annual risk corridor payments. The first is that HHS has contradicted itself and provided no explanation whatsoever for its changed position, as is required under the *Chevron* doctrine. *Encino*, 136 S. Ct. at 2126 (stating that "an '[u]nexplained inconsistency' in agency policy is 'a reason for holding an interpretation to be an arbitrary and capricious change from agency practice'") (quoting *Brand X*, 545 U.S. at 981). For the first several years after Congress enacted the ACA, HHS consistently noted that risk corridor payments from and to the Government should occur at the same time. *See* Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, at 41,943 (July 15, 2011) ("the payment deadlines should be the same for HHS and QHP issuers"); Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, at 17,238 (Mar. 23, 2012) ("QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers."); *see also* Dkt. 31 at 4-5, 24 (noting the same statements from HHS). HHS never qualified these statements by stating that it would accept or make partial payments, *see id.*, and its implementing regulations were clear that

the payments for each benefit year are calculated in full. 45 C.F.R. § 153.510(b) & (c). And when HHS purportedly adopted its new position that full payment is not required, it provided no explanation for the change or even an acknowledgement of its prior policy.

Furthermore, HHS has demonstrated through its course of conduct that it fully understands Section 1342 requires full, annual payments. HHS requires QHP issuers owing "payments in" under the statute for a benefit year to make full payments to HHS in the year following. *See* 2014 Results Announcement, at 1 ("Risk corridors charges payable to HHS are not prorated, and the full risk corridors charge amounts are noted in the chart below. Only risk corridors payment amounts are prorated."); 2015 Results Announcement, at 2 ("HHS intends to collect the full 2015 risk corridors charge amounts . . . ."); *see also* 45 C.F.R. § 153.510(d) ("A QHP issuer must remit [risk corridors] charges to HHS within 30 days after notification of such charges"). HHS also calculates the full amounts it and QHP issuers each owe every year and has specifically noted each time that those payments are for the previous benefit year. *Id.* There are no partial calculations; only the full amounts for the previous benefit year. *Id.* Tellingly, HHS pays out whatever amounts it can each year. Due to the 2015 and 2016 Spending Bills, Congress limited HHS's ability to make full payments by not appropriating funds for the risk corridors program, but HHS still paid the full amount of risk corridors funds available to it—and promised to pay the rest when it could—because it recognized that it ***had to*** pay those full amounts under the statute. *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (admitting the ACA still "requires the Secretary to make full [risk corridor] payments"); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is

required."). What these facts show is that HHS was in a bind due to limitations on its appropriations, but that it believed full payments were necessary under the statute. Thus, the Court owes no deference to HHS's litigation position that it "truly" believed it had discretion to make full payments.

The Court also should not defer to HHS's about-face because the agency's original position, statements, and interpretation of Section 1342 created serious reliance interests among QHP issuers. *See Encino Motorcars*, 136 S. Ct. at 2125-26. Indeed, the entire basis for the risk corridors program was to give QHP issuers comfort that they would still be able to compete in the market even if they were unable to accurately judge risk in the ACA exchanges' early years. *See* CMS, "Regulatory Impact Analysis," (March 2012), at 44, *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf (last visited Feb. 23, 2017) ("Due to uncertainty about the population during the first years of Exchange operation, issuers may not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted."); CMS, "The Three Rs: An Overview" (Oct. 1, 2015) ("The Three Rs"), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html (last visited Feb. 23, 2017) (3Rs designed "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance"). Based on HHS's statements that it would pay owed amounts to QHP issuers at the same time as they paid it, hundreds of insurers and health plans issued QHPs in the 2014 benefit year on ACA exchanges. *See* Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, at 17,238 (Mar. 23, 2012) ("QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers."); 2014

Results Announcement, at Tables 1-51 (listing QHP issuers for 2014 benefit year). Furthermore, during the rate-setting process, HHS encouraged QHP issuers to lower their premiums and reassured them that, if the premiums turned out to underestimate their allowable costs, the issuers would receive full repayment from the risk corridors program for that year. Bonder Decl. ¶¶ 6-8; Mahaffey Decl. ¶¶ 5, 7. QHP issuers relied upon HHS's stated policy positions and representations as to how the risk corridors program would work. Bonder Decl. ¶¶ 6-8; Mahaffey Decl. ¶¶ 5-9. In short, HHS demonstrated through its public and private statements that QHP issuers would be protected from rate-setting risk in the early years of the ACA exchanges, which led those issuers to join the exchanges *en masse*. HHS's subsequent refusal to pay those very same issuers is not owed any deference, particularly because of the chaos it has caused in the markets the ACA established and was designed to help flourish. *Encino Motorcars*, 136 S. Ct. at 2125-26; *King*, 135 S. Ct. at 2496; *Christopher*, 132 S. Ct. at 2166.

C. The Amount Of The Class's Damages Is Uncontested

Unlike many lawsuits, damages in this case are completely uncontested. In 2015 and again in 2016, HHS calculated the amounts it owed to QHP issuers under the risk corridors program and noted what portion of those amounts it would pay. The remainder of unpaid amounts, which HHS's own documents admit, are the Class's damages. The only question remaining as of the date of this motion is which QHP issuers will opt-in to the Class and therefore define the amount of the Class's damages. Once the opt-in deadline passes, Class Counsel will be able to determine the full scope of the Class and its damages. HRIC therefore requests the right to supplement this motion at that time with the full amount of damages for which it seeks summary judgment.

CONCLUSION

For the foregoing reasons, HRIC respectfully requests that the Court grant summary judgment in the Class's favor.

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on March 3, 2017, a copy of the attached Plaintiff Health Republic Insurance Company's Motion for Summary Judgment and Memorandum of Law in Support was served via the Court's CM/ECF system on Defendant's counsel Charles Edward Canter.

/s/ Stephen Swedlow
Stephen Swedlow