No. 18-1028

IN THE

Supreme Court of the United States

MODA HEALTH PLAN, INC.,

Petitioner,

v.

UNITED STATES,

Respondent.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,

Petitioner,

v.

UNITED STATES,

Respondent.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Federal Circuit

BRIEF FOR THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS AS AMICUS CURIAE IN SUPPORT OF PETITIONERS

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INTEREST OF AMICUS CURIAE[1]

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

The NAIC's purpose is to provide insurance regulators with a national forum to enable them to work cooperatively on matters transcending the boundaries of their own jurisdictions. This allows for consistency in regulating insurance companies and a central point of communication and facilitation for initiatives with federal and international regulators. The NAIC regularly assists federal regulators, federal agencies, members of Congress, and the Government Accountability Office by providing

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[1] Pursuant to Supreme Court Rule 37.2(a), all parties have consented to the filing of this brief. Pursuant to Rule 37.6, amicus curiae certifies that no counsel for a party authored this brief in whole or in part, and no persons other than amicus curiae or its counsel made a monetary contribution to the brief's preparation or submission.

information and data related to state insurance regulation, health insurance, terrorism insurance, annuities, insurance fraud, and many other topics. Through the NAIC, the insurance commissioners work to develop model legislation, rules, regulations, handbooks, white papers, and guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers, promote competitive markets, and maintain the financial stability of the insurance industry.

Hundreds of state and federal laws, including the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), assign duties to the NAIC and incorporate NAIC standards, models, and other publications. Insurers are statutorily required to file annual and quarterly financial statements with the NAIC, which maintains them in databases on behalf of the states. NAIC model laws, regulations, and other standards are a critical part of the robust regulatory structure in place to monitor the financial solvency of insurers.

The NAIC provided technical guidance and input to Congress as it drafted and debated the ACA. State insurance commissioners generally, and the NAIC specifically, are mentioned more than 15 times in the ACA. The NAIC was asked to develop standards for or provide expert input to the Secretary of the Department of Health and Human Services ("HHS") on the ACA, including the medical loss ratio standard, the summary of benefits and coverage template, the health insurance exchanges, age bands, the temporary reinsurance program, and external review standards. The NAIC also developed model laws and regulations to assist states in the

implementation of the ACA and provided comments on federal regulations.

The interest of the NAIC in this case arises out of the adverse effect of statutorily required, unpaid risk corridor amounts on state insurance commissioners' ability to protect consumers through stable health insurance markets. The essential functions through which insurance commissioners promote financial solvency and the fair treatment of policyholders have been impaired by the government's default on risk corridor payments. This has complicated state regulatory functions (particularly rate review) and destabilized the market. The government's default has undermined competition and unfairly burdened insurers that sold health plans to a population with accumulated unaddressed healthcare needs. Insurance commissioners, already walking a careful line between companies' financial health and consumer protection, must manage the impact of huge shortfalls due to the government's default.

Just as the government relied upon state regulators to develop laws and standards in order to implement the ACA, regulators relied on the government to comply with the ACA, including the risk corridors mandate.

SUMMARY OF ARGUMENT

This Court's review is essential to ensure not only the integrity of the government's financial commitments, but also the ability of state regulators to effectively manage their industry and protect consumers. The ACA recognized the essential regulatory functions of insurance commissioners and created a partnership. The risk corridor program was vital to keeping insurance markets, and this

partnership, healthy. State insurance departments have virtually transformed—shifting limited resources, investing in innovation, and enacting new law—in order to fulfill their obligations. But the government has not been a fair partner.

The failure to make full risk corridor payments to insurers operating on the exchanges has hindered state insurance commissioners' essential mission to protect consumers. Through the ACA, the government induced insurers into the market only to directly compromise these companies' financial condition once committed. The government's default created uncertainty and adversely impacted health insurance rates, which are set at the state level. Additionally, the government's default has deterred insurers from offering plans on the exchanges, dampening competition and hurting consumers.

The insurance market cannot function properly with the disruption caused by the government's default. "As any actuary will tell you, insurance hates uncertainty." *Examining the Affordable Care Act's Premium Increases: Hearing Before the H. Comm. on Oversight & Gov't Reform*, 114th Cong. 19, 23 (2016) (statement of Comm'r Al Redmer Jr., on behalf of the NAIC) (hereinafter "Redmer Statement"). As insurance companies increasingly find no advantage to participating in the exchanges, consumers suffer from the lack of affordable health coverage.

The NAIC urges review of this issue of extraordinary importance to the insurance industry and consumers. Holding the government accountable for its obligation under the ACA is essential to protect consumers, stabilize the market,

promote competition, and boost financial solvency across the industry.

While the havoc imposed upon the industry by the government's default should ultimately aid this Court's decision on the merits, it is of particular importance when evaluating the petition. Because nearly all risk corridor cases are on file in the Court of Federal Claims, the Federal Circuit's incorrect decision will continue to adversely impact insurers, regulators, and consumers nationwide absent this Court's review. The government must be seen as a reliable business partner—and a reliable regulatory partner—for the insurance industry to function. Only this Court can ensure that is so, by reviewing this case and requiring the government to live up to the unambiguous promises Congress expressly made.

For these reasons, this Court should grant the petition.

ARGUMENT

Petitioners focus on the financial pain inflicted upon insurers that relied on legislatively and contractually committed assistance from the government. These insurers, however, are not the only ones forced to navigate the chaos resulting from the government's broken promises. The NAIC's members—the chief insurance regulators in all the states and territories—were partners with the government in creating new insurance markets to implement the ACA. State regulators participated in good faith, met their obligations under the law, and sought a smooth transition for insurers and consumers. They could not have known the government would attempt to strip away funding

required by the ACA through an after-the-fact appropriations rider.

In its decision in favor of petitioner Moda, the Court of Federal Claims noted:

> Consideration is a bargained-for performance or return promise. Restatement (Second) of Contracts § 71. Here, the Government offered consideration in the form of risk corridors payments under Section 1342. In return, Moda offered performance under the contract by providing QHPs[2] to consumers on the Health Benefit Exchanges. Therefore, there was consideration.

Moda Health Plan, Inc. v. United States, 130 Fed. Cl. 436, 465 (2017).

Similarly, the NAIC's members facilitated the implementation of the ACA based upon safeguards for those insurers willing to sell plans to the previously uninsured and underinsured. One important safeguard was the risk corridor program. This program induced insurers and state regulators to build a new infrastructure to give life to the ACA.[3] Once the risk corridor payments were withheld, the core functions of the NAIC's members—monitoring solvency, promoting competitive markets, and

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[2] "QHP" stands for "qualified health plan" under the ACA.

[3] "The federal government has entered into a contract with insurers that provide coverage through the exchanges. That contract incorporates the federal laws and regulations governing the exchanges, including the risk corridor program. Insurers relied on the terms of the ACA, including the risk corridor program, in setting their premiums." *Obamacare: Why the Need for An Insurance Company Bailout?: Hearing Before the H. Comm. on Oversight & Gov't Reform*, 113th Cong. 42 (2014) (statement of Timothy Stolzfus Jost).

protecting consumers—were seriously compromised. The effects were most detrimental in the area of rate review and competition.

I. Refusing to honor the obligations of the risk corridor program impaired state regulators' ability to calculate and approve prospective insurance rates.

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

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

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

Robert W. Klein, *A Regulator's Introduction to the Insurance Industry* 19 (2d ed. 2005).[4]

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

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

Brief for Penn. Ins. Dep't as Amicus Curiae Supporting Plaintiffs at 5, *First Priority Life Ins. Co. v. United States*, No. 16-587C (Fed. Cl. Oct. 14, 2016), ECF No. 11-2 (hereinafter "Penn. Ins. Dep't Amicus Br.").

The fact that the government reneged on its promises, resulting in massive deficits, forces state regulators to evaluate the fairness of rates in an environment where (1) insurers have tremendous financial exposure through no fault of their own, and

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[4] http://www.naic.org/documents/rod_serv_marketreg_rii_zb.pdf.

(2) the market is populated by these disadvantaged insurers, while other financially stronger insurers are dis-incentivized from participating. The sum of this equation is higher premiums and a higher burden on consumers. As Maryland Insurance Commissioner Al Redmer testified with respect to risk corridor lawsuits, "[Carriers] would still be legally obligated to provide these more costly plans, but the courts could prohibit Treasury from reimbursing them without an appropriation. . . . Uncertain funding streams lead to higher premiums." Redmer Statement at 25.

State insurance commissioners rose to the challenge of rate review for an emerging marketplace, but the government's risk corridor default made it nearly impossible to determine an appropriate rate in relation to insurers' financial exposure. And while this affected each insurer individually, it is the state regulators who felt the enormity of the problem. The exchanges now represented serious business risk. Regulators' best efforts at supplying the exchanges with financially strong insurers could not truly succeed once the government decimated the risk corridor safeguard. This decline in quality works its way down to harm vulnerable consumers of health insurance.

II. Insurers and state regulators were set up to fail after the government defaulted on risk corridor safeguards.

The very purpose of the ACA, to expand affordable healthcare coverage to additional millions of Americans, created an urgent demand for companies willing to offer QHPs to consumers who would otherwise face a financial penalty for declining

to purchase health coverage. Many consumers who purchased health insurance through the exchanges were previously uninsured, creating a concern for pent up demand for health services once they secured coverage.[5] Large, well-established insurers did not dominate the exchange market, despite the millions of new customers created by the federal individual mandate and federal subsidies. Rather, the ACA incentivized new entities to move into this space.

State insurance commissioners worked diligently to implement the ACA's Consumer Operated and Oriented Plan ("CO-OP") program.[6] This program provides for federal loans to "foster the creation of qualified nonprofit health insurance issuers to offer qualified health plans in the individual and small group markets in the States in which the issuers are licensed to offer such plans." 42 U.S.C. § 18042. Across the country, new non-profit health cooperatives applied for licenses to transact business on state exchanges. In states like Maine, Montana, and Kentucky, CO-OP plans were more competitive than Blue Cross & Blue Shield, and the CO-OPs' market share was, in some cases, twice what they

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

[6] Petitioner Moda is not a health cooperative, but the petitioner in companion case *Land of Lincoln v. United States*, No. 18-1038, did operate as such. *See, e.g.*, Petition for Writ of Certiorari at 7, *Land of Lincoln v. United States*, No. 18-1038 (U.S. Feb. 4, 2019).

projected. *See* Sabrina Corlette, et al., *Why Are so Many CO-OPs Failing? How New Nonprofit Health Plans Have Responded to Market Competition*, The Commonwealth Fund (Dec. 2015).[7]

Market dominance was not advantageous to these start-up insurers. The unknown health needs of this newly insured population soon became known:

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

Id. at 16.

The CO-OPs were largely unable to withstand the capital demands of participating on the exchanges. There were 24 CO-OPs operating at peak participation, but only four are offering plans in 2019. Full risk corridor payments may have given some of these companies time to shore up not only capital, but the underwriting experience that strengthens an insurer's financial condition. The problem of a generally sicker population on the exchanges continues to intensify still today. Alternative, non-ACA compliant coverage has become more prevalent, and the uninsured rate has risen due to repeal of the

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

federal individual mandate penalty and ever rising premiums that make coverage unaffordable for many. *See* Tax Cut and Jobs Act of 2017, Pub. L. No. 115-97, 131 Stat. 2054, § 1108 (2017). Health plans that are not compliant with the ACA are now available and "will attract disproportionately healthy individuals away from ACA-compliant coverage, thus having an upward effect on premiums in the ACA-compliant individual market." Rabah Kamal et al., *How Repeal of the Individual Mandate and Expansion of Loosely Regulated Plans are Affecting 2019 Premiums*, Kaiser Family Foundation (Oct. 26, 2018).[8]

While petitioner Moda was capitalized well enough to survive to this point, state insurance commissioners are contending with many more companies that are not. The NAIC's members have long supported innovation in the insurance industry and continue to work with new companies with the potential to improve outdated practices and better fulfill customer needs, but the government's refusal to fulfill its obligation to make risk corridor payments has been hazardous, particularly for new companies.

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

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[8] https://www.kff.org/health-costs/issue-brief/how-repeal-of-the-individual-mandate-and-expansion-of-loosely-regulated-plans-are-affecting-2019-premiums/.

III. The government's failure to make full risk corridor payments has suppressed competition in the exchanges, burdening consumers and regulators.

Promoting competition stands alongside financial solvency and consumer protection as an essential mission of the NAIC and its members. Approval of policy rates and forms, scrutiny of health plans for the inclusion of mandated benefits, and ongoing monitoring of reserves and investments to improve financial solvency are critical regulatory functions and serve the public well. But the infusion of competition is frequently beyond the regulator's control: "market competition can apply pressure that the Department cannot. Without this pressure, insurers may choose to eliminate certain plan offerings or attributes that consumers have enjoyed in the past." Penn. Ins. Dep't Amicus Br. at 10.

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

Insurance companies began the exchange venture with a new subpopulation of policyholders whose health needs were virtually unknown, and they relied on financial inducement from the government in deciding to market plans to this new demographic. Insurers' profit margins are under constant scrutiny from state regulators, meaning companies do not have unfettered ability to raise prices in order to

cover losses. They simply could not afford to stay in the exchanges once the government withheld risk corridor funds.

Congress intended the risk corridor program to provide full reimbursement for the years 2014 through 2016. The consequences of the withheld payments were clear by 2017, when consumers in approximately one-third of all U.S. counties had access to only one insurer's plan through the exchanges. Olga Khazan, *Why So Many Insurers Are Leaving Obamacare, How Rejecting Medicaid and Other Government Decisions Have Hurt Insurance Markets,* The Atlantic (May 11, 2017).[9] The ACA's goal of creating state exchanges with innovative products and abundant consumer choice fell far short in these regions. The large-scale nonpayment of risk corridor funds directly contributed to this ultimate lack of competition.[10]

The risk corridor program was specifically developed to incentivize greater participation by

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

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

insurers on the exchanges.[11] When full payments under the program were not forthcoming and HHS issued guidance in conflict with the ACA, it was inevitable that insurers were deterred: "Private companies cannot be expected to participate in a market where the rules and regulations are not made clear in advance and where there is no faith that the government will uphold its end of the bargain." Erin Trish, et al., *To Promote Stability in Health Insurance Exchanges, End the Uncertainty Around Cost-Sharing and Other Rules,* Brookings (April 20, 2017).[12]

The states are not likely to see intervention from the government to maintain basic standards of availability and competition. It falls immediately to the state insurance commissioner to conduct outreach and solicit participation by insurers.[13] In

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[11] "By compensating issuers for the risks related to the individuals they enroll, these provisions are designed to lessen the financial risk issuers and state health benefit exchanges . . . will face under the [ACA]. This will mitigate the impact of adverse selection and encourage issuers to compete based on cost and quality, rather than attracting the healthiest, lower-cost enrollees. Thus, these provisions are critical to the successful implementation of the ACA's coverage expansion provisions." Wakely Consulting Group, *Analysis of HHS Final Rules on Reinsurance, Risk Corridors and Risk Adjustment*, State Health Reform Assistance Network, at 1 (April 2012), http://www.statenetwork.org/wp-content/uploads/2014/11/State-Network-Wakely-Analysis-of-HHS-Final-Rules-On-Reinsurance-Risk-Corridors-And-Risk-Adjustment.pdf.

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

[13] "States also employed various regulatory levers to encourage insurer participation, such as clarifying regulatory standards regarding network adequacy, allowing flexibility in

this environment of suppressed competition, commissioners have less leverage to contain premium rates. The environment produces higher rates, little choice, and a problematic concentration of risk for the remaining insurers. Some insurers failed, and state regulators put them into liquidation. In many such instances, the government has taken an interest, not to preserve resources, but to drain them by claiming a priority over policyholders.

IV. The government breached its obligations under the risk corridor program but demands to be made whole in the event of insolvency.

The ACA reformed the health insurance arena in many ways, but one thing it did not change is the application of state law to adjudicate insurer insolvency proceedings.[14] Insurance commissioners

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plan offerings, and sharing data on claims history. Some states also committed to future policies to stabilize the marketplace, including proposals for 1332 waivers (ultimately withdrawn in two of our study states). Another lever utilized by states was offering an advantage in Medicaid managed care contracts bidding to insurers that promise[] to participate in the state's marketplace." CHIR Faculty, *Insurers, State Regulators Avoid Bare Counties in 2018, but Seek Long-Term Solutions*, Georgetown University Health Policy Institute Center on Health Insurance Reforms (Nov. 9, 2017), http://chirblog.org/insurers-state-regulators-avoid-bare-counties-2018-still-seek-long-term-solutions/.

[14] *See, e.g.*, 42 U.S.C. § 18041(d) (stating, in a section titled "No interference with State regulatory authority": "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."); Proposed Rules, 45 C.F.R. Part 156, 76 Fed. Reg. 43237-01 (July 20, 2011) ("State law establishes a variety of required regulatory actions if an insurer's RBC [risk-based capital] falls

commit many resources to solvency monitoring, including regular financial examination and annual reporting requirements. The regulators have additional authority to identify when a company enters a hazardous financial condition and issue orders to prevent further distress, including increasing reserve amounts or limiting new business accepted. *See* Model Regulation to Define Standards and Commissioner's Authority for Companies Deemed to be in Hazardous Financial Condition, *NAIC Model Laws, Regulations and Guidelines*, MDL-385, 20XX WL 8342884 (1985, amended 2008).[15] This early intervention can provide cushion from the kind of financial distress that would ultimately hurt policyholders.

In situations where an insurer is not able to recover from financial distress, state regulators continue to guide the process through rehabilitation, receivership, or possible liquidation. Under state law, [16] the insurance commissioner becomes responsible for rehabilitating or liquidating the

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below established levels or percent of RBC. These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State-regulated function."); Final Rules, Responses and Comments, 45 C.F.R. Part 156, 76 Fed. Reg. 77392-01 at E.6 and F, Dec. 13, 2011 ("In the potential case of insurer financial distress, a CO-OP follows the same process as traditional insurers and must comply with all applicable State laws and regulations.").

[15] https://www.naic.org/store/free/MDL-385.pdf.

[16] Most states have enacted insurance company liquidation statutes that are patterned after one of three model acts adopted by the NAIC over the years.

company, depending on the severity of financial distress. In the event of total failure:

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

Insurer Receivership Model Act, *NAIC Model Laws, Regulations and Guidelines*, MDL-555, art. V, § 501(A), 20XX WL 8342898 (1936, amended 2007).[17]

It is up to the insurance commissioner to continue the company's struggle to collect unpaid risk corridor amounts.[18] The NAIC's members are concerned about immense unpaid risk corridor amounts, particularly as it relates to policyholder protection. The determination of whether the government must fulfill its risk corridor promises will dictate whether policyholders are treated fairly.

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[17] https://www.naic.org/store/free/MDL-555.pdf.

[18] The state insurance statutes normally vest the Commissioner, as receiver, with title to all of the assets of the insolvent company and, by statute, the Commissioner becomes the "successor" to the company with respect to its assets and the enforcement of its contracts and other pre-receivership rights. In addition to a receiver's authority to assert claims on behalf of the insolvent company, the receiver also has authority to assert claims on behalf of policyholders, creditors, and other impacted parties. *See, e.g., Reider v. Arthur Andersen, LLP*, 784 A.2d 464, 475-78 (Conn. Super. Ct. 2001).

The application of these issues in actual state proceedings has not been encouraging so far. On July 17, 2017, the Iowa Insurance Commissioner, in his capacity as receiver for a failed CO-OP (CoOportunity Health, Inc.), filed suit in the Court of Federal Claims alleging the government refused to pay approximately $130 million owed that CO-OP under the risk corridor program. *See* Complaint ¶ 104, *Ommen v. United States*, No. 17-957 (Fed. Cl. July 17, 2017). Although the government had identified $16.4 million as owing (12.6% of the $130 million figure), it placed this amount—along with reinsurance and risk adjustment payments—in an "administrative hold" to set off against debts from a start-up loan the government provided at the inception of the entity. *See ibid.* The complaint alleged:

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

Id. ¶ 106.

As the *Ommen* complaint points out, "The ACA did not provide the Government with any unique or preemptive rights with respect to insolvent insurance carriers that are placed into liquidation in their respective domiciles." *Id.* ¶ 93. The ACA specifically provides that its provisions shall not be construed to preempt a non-conflicting state law. *See* 42 U.S.C. § 18041. Furthermore, state laws regulating the

business of insurance, including insurer insolvency proceedings, have the power of reverse federal preemption pursuant to the McCarran-Ferguson Act. *See generally* 15 U.S.C. §§ 1011-1015; *U.S. Dep't of Treasury v. Fabe*, 508 U.S. 491, 508-09 (1993). There is no justification for the government to prioritize its claims over policyholders' claims.

The Iowa case demonstrates an alarming capacity for the government to undermine consumers twice: first as a debtor exacerbating an insurer's financial distress by over $100 million, and second as a creditor who seeks to leapfrog policyholders' valid claims.

More fundamentally, the government's strategy in the Iowa liquidation reveals an inconsistent approach to contractual obligations. In 2014, the government felt free to breach the risk corridor obligations of the ACA. But a CO-OP that has struggled and failed to survive in the marketplace, *even in liquidation*, is expected to make the government whole for a 2013 start-up loan. Indeed, the government takes no responsibility although its own default may have exacerbated the failure of many CO-OPs. Between private parties in a dispute, such tactics may be expected as typical "hardball." They are much more sobering when employed by the government against its partners in sweeping health reform.

The NAIC and its members urge the Court to consider the consequences to the government's reputation as a regulatory partner if the Court were to deny review. The judicial branch must exercise a check on the government's conduct in this instance. Otherwise, there will be little incentive for

contractors to pursue opportunities offered at the federal level, and state regulators will not have confidence in the federal assignment of regulatory responsibilities.

There is every indication that major policy initiatives in the United States will continue to proceed through a federal, state, and private partnership. The ACA was intended to function in all these respects, and the NAIC's members appreciate the deference shown to its effective regulation of the insurance industry for many decades. The combined expertise of the federal government, state regulators, and insurance companies can maximize return on the legislative investment. But this modern approach to healthcare regulation can only succeed with reliable partners. Simply put, it is impossible for state regulators to effectively execute the role prescribed by Congress when the government refuses to play by its own rules.

As Judge Wallach noted below in dissent, "To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government's credibility as a reliable business partner." *Moda Health Plan, Inc. v. United States*, 908 F.3d 738, 748 (Fed. Cir. 2018) (Wallach, J., dissenting). This Court has also recognized the importance of holding the government to its obligations, warning against "undermining the Government's credibility at the bargaining table and increasing the cost of its engagements." *United States v. Winstar Corp.*, 518 U.S. 839, 884 (1996). In finding the government breached a contractual and statutory duty to provide cost sharing reduction payments under the ACA, the Court of Federal

Claims ruled that insurers "should not be left 'holding the bag' for taking our Government at its word." *Local Initiative Health Authority for L.A. County v. United States*, ___ Fed. Cl. ___, ___, 2019 WL 625446, at *16 (2019).

State insurance commissioners will evaluate future joint efforts with the government knowing it has failed to honor its statutory commitments in this case. The important work of consensus building, so central to the NAIC's mission of balancing the financial health of the insurance industry with consumer protection, demands fair dealing on all sides.

CONCLUSION

This Court should grant the petition.

Respectfully submitted,

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