IN THE UNITED STATES COURT OF FEDERAL CLAIMS

HEALTHNOW NEW YORK INC., Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	Case No. 17-1090C Judge Robert H. Hodges

PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT AND MEMORANDUM OF LAW IN SUPPORT

Plaintiff HealthNow New York Inc. ("Plaintiff" or "HealthNow") respectfully submits this Motion for Summary Judgment and Memorandum of Law in Support of its complaint for damages against the Defendant the United States of America ("Government"), acting through the Centers for Medicare & Medicaid Services ("CMS") (and CMS's parent agency, the U.S. Department of Health and Human Services ("HHS")).

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INTRODUCTION

In 2010, Congress passed the Affordable Care Act ("ACA"),[1] creating a new health insurance marketplace—the health insurance "exchanges"—through which individuals and small groups could purchase health insurance. The creation of the exchanges, in combination with certain other ACA provisions, dramatically increased the number of individuals purchasing health insurance, including many individuals who had previously been uninsured. At the time of the ACA's passage, nobody—neither the Government nor the health insurers—knew how much it would cost to insure large numbers of previously uninsured and underinsured individuals. Recognizing this uncertainty, Congress created the "risk corridors program" ("RCP") as a mechanism through which both the Government and insurers would share in the risk of the substantial uncertainty of the exchanges during the first three benefit years[2] (2014, 2015, and 2016). Congress knew that without such a measure it could not achieve the ACA's twin goals of increased *and* affordable coverage because insurers would either opt not to offer plans on the exchanges or offer plans only at unaffordable premiums.

The RCP focused on a plan's costs. As designed, it facilitated risk sharing between plans and the Government by requiring plans that realized lower-than-expected allowable costs in a benefit year to pay a share of their realized savings *to* the Government ("payments in"), and, conversely, entitling plans that realized higher-than-expected allowable costs in a benefit year to a payment *from* the Government to cover a share of their losses ("payments out"). The amounts of the payments, both in and out, are calculated under a formula dictated in the statute itself.

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[1] The ACA is actually comprised of two pieces of legislation: (1) the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (Mar. 23, 2010), and (2) the Health Care and Education Reconciliation Act, Pub. L. No. 111-152, 124 Stat. 1029 (Mar. 30, 2010).

[2] 45 C.F.R. § 155.20 ("*Benefit year* means a calendar year . . . ."); 45 C.F.R. § 153.20.

At issue in this case is the extent of the Government's obligation to make "payments out" to insurers like HealthNow. The RCP does not discriminate between the Government and insurers: both have payment obligations under the statutory formula. When HealthNow experienced lower-than-expected costs,[3] it made ***full*** "payment in" to HHS as required by the RCP. Although the Government required full "payments in," it refused to make full "payments out" when HealthNow experienced "losses" triggering the Government's payment obligations. Specifically, although conceding on multiple occasions that RCP payments are an "obligation of the United States Government for which full payment is required,"[4] CMS has made no payment at all to HealthNow for benefit years 2015 and 2016 and has publicly stated that none will be forthcoming anytime soon (if ever). *See* CMS, "Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year" (Nov. 18, 2016) ("2015 Payment Memo") (Add. A at 38). The Government's refusal to make full payments violates its obligation under Section 1342 of ACA.

STATEMENT OF THE ISSUE

Congress created the RCP to attract health insurers into the exchanges and help keep premiums affordable and stable for Americans by limiting the effects of adverse selection, thereby limiting the uncertainty inherent to establishing rates for new, unquantifiable health insurance risks. The RCP mandates full and annual "payments in" and "payments out," once costs from the previous benefit year have been calculated. This is how Congress wrote the law and it is how HHS originally construed, and announced it would administer, the program.

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[3] HealthNow experienced lower-than-expected costs for its participation on the New York State marketplace for benefit year 2014 and made timely payment to CMS in accordance with the RCP.

[4] *See infra* note 10. Attached to this Memorandum is Addendum A ("Add. A") containing public HHS statements cited in this Memorandum, of which this court may take judicial notice. *See* Fed. R. Evid. 201.

But the Government later reversed course and adopted evolving positions regarding the Government's obligation to pay insurers like HealthNow the full amount they are owed under the RCP.

The Government's revised rationale is that the RCP must be administered in a budget-neutral manner, *i.e.*, "payments out" cannot exceed "payments in." This novel position is not reflected in the text of the ACA; was never raised for public comment during the notice-and-comment rulemaking process on HHS's RCP implementing regulations; directly contradicts HHS's earlier positions; and has never been explained by HHS. It also violates the logical premise of the RCP: A budget neutral payment scheme places all the risk *of the federal Government's new program* on insurers and thus does nothing to "stabilize" premiums; it instead creates (as history has now proven) the very *instability* the RCP was designed to prevent.

HealthNow brought high-quality, affordable health insurance to the people of New York State just as Congress envisioned when it crafted the ACA's system of requirements and incentives. *See* Compl. ¶¶ 7, 16-17. Under the RCP, the Government owes HealthNow payments for the 2015 and 2016 benefit years based on HealthNow's higher-than-budgeted costs in those years.

There are three questions to answer in this case: (1) How much does the Government owe HealthNow?; (2) When does the Government owe it?; and (3) Has the Government been relieved of its obligation to make payment by later acts of Congress?

The answers are simple. (1) Based on the undisputed facts, the Government owes HealthNow $9,619,385.01 for benefit year 2015, and $29,119,555 for benefit year 2016. *See infra* Argument I.A.1, I.B, II (For benefit year 2014, HealthNow owed the Government

$5,236,811.41 and made ***full payment***). (2) The money is presently due. *See infra* Argument I.A.2, I.B, II. And (3) the Government's payment obligation under the RCP has *not* been abrogated. *See infra* Argument I.C. Accordingly, HealthNow is entitled to judgment.

STATEMENT OF RELEVANT BACKGROUND

I. THE ACA CREATED EXCHANGES TO PROVIDE AFFORDABLE HEALTHCARE TO PREVIOUSLY UNDERINSURED AND UNINSURED POPULATIONS.

The ACA changed the healthcare industry landscape. Its provisions require, among other things: individuals to carry health insurance; states to facilitate online exchanges for buying and selling insurance; and private health insurance companies to guarantee coverage and provide myriad essential health benefits to insured individuals at no cost. The ACA sought to prioritize the consumer by promoting affordability and competitiveness in the marketplace. To entice insurers to enter the individual and small group markets served by the exchanges, where consumers can purchase health plans that meet certain standards established by CMS and the exchanges ("qualified health plans" or "QHPs"), Congress implemented several risk mitigation programs, including the RCP. A "QHP issuer" is any health insurer selling a QHP on the exchanges.

II. CONGRESS CREATED THE RCP INTENTIONALLY AS AN INCENTIVE TO DRAW ENTITIES SUCH AS HEALTHNOW INTO THE MARKETPLACE.

Expanding healthcare coverage came at substantial cost. For example, under the ACA, QHP issuers must cover a variety of essential health benefits, including preventive health benefits at no additional cost to enrollees. The ACA's myriad mandates, when coupled with the uncertainty of a new and untested pool of health insurance enrollees, would have led insurers under normal market conditions to set higher premiums to compensate for that uncertainty, or simply to decline entering the exchanges in the first place. Congress knew that. To mitigate the

risk to insurers, while at the same time preventing unaffordable premiums for the millions of Americans that the ACA sought to bring into the health insurance marketplace, Congress included three marketplace premium-stabilization programs, commonly referred to as the "Three Rs": (1) the RCP; (2) a transitional reinsurance program (which, like the RCP, was a temporary program for the first three benefits years under the exchanges); and (3) a permanent risk adjustment program. *See* CMS, "The Three Rs: An Overview" (Oct. 1, 2015) *available at* https://www.cms.gov/ Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html ("Three Rs Overview"). The "Three Rs" were intended to serve a specific objective within the framework of the ACA: to mitigate the risk that QHP issuers operating on the new exchanges would otherwise face in light of the ACA's many coverage requirements and their attendant costs. *See, e.g.*, 42 U.S.C. § 18021(a)(1)(B) (requiring coverage of "essential health benefits.").[5] The RCP was one of the enticements that drew insurers such as HealthNow into the marketplaces in the first place.[6]

Congress expressly modeled the ACA's RCP on the RCP created under Medicare Part D. *See* § 1342(a) ("The Secretary shall establish and administer a program of risk corridors for

[5] Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment ("Final RCP Rule"), 77 Fed. Reg. 17,220, 17,220 (Mar. 23, 2012) ("These risk-spreading mechanisms [the Three Rs] . . . are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets.").

[6] The Society of Actuaries explained how the RCP was understood when issuers set premiums for the 2014 benefit year: "The goal of the [RCP] is to protect health insurance issuers against this pricing uncertainty of their plans, temporarily dampening gains and losses in a risk-sharing arrangement between issuers and the federal government. Since the protection is only available for QHPs, it also provides a strong incentive for issuers to participate in the health insurance exchanges set up by the ACA. Lastly, it provides an incentive for issuers to manage their administrative costs optimally." Doug Norris *et al*., *Risk Corridors under the Affordable Care Act—A Bridge over Troubled Waters, but the Devil's in the Details*, Health Watch at 5 (Oct. 2013), *available at* https://www.soa.org/library/newsletters/ health-watch-newsletter/2013/october/hsn-2013-iss73-norris.aspx.

calendar years 2014, 2015, and 2016 . . . [which] shall be based on [the Medicare Part D RCP].”). Medicare Part D’s RCP is not budget neutral and payments (both in and out) are made annually. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that “[f]or each plan year, the secretary shall establish a risk corridor” and referencing “[t]he risk corridor for a plan for a year . . .”); 42 C.F.R. § 423.336 (same); GAO, 15-447, Patient Protection and Affordable Care Act (Apr. 2015) (“GAO Rep.”) at 14, *available at* http://www.gao.gov/assets/670/669942.pdf (“the payments that CMS makes to issuers [under the Medicare Part D program] are not limited to issuer contributions”).

HHS implemented the RCP in the Code of Federal Regulations through notice-and-comment rulemaking as directed by ACA Section 1342, largely parroting the statute. *See* 45 C.F.R. § 153.510. HHS also required QHP issuers to submit their revenue and cost data on an annual basis, at which point QHP issuers were determined eligible to receive (or obligated to make) payment as calculated under the RCP’s payment formula. *Id.* §§ 153.510, 153.530.

HHS made no mention of budget neutrality when it proposed its RCP implementing regulations. By contrast, HHS indicated in the preamble to the proposed rule that the RCP’s companion program, the risk adjustment program, was, in fact, budget neutral. *See* Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,938 (July 15, 2011) (“Proposed RCP Rule”) (Add. A at 5). That different treatment made sense because the risk adjustment program was designed to share risk *among QHP issuers,* whereas the RCP was designed to share risk between QHP issuers *and the Government*. *See* Three Rs Overview. Accordingly, the final, codified regulations do not reflect a budget-neutral RCP. Indeed, in its preamble, HHS said just the opposite—that HHS anticipated making ***prompt*** payment to QHP issuers after making the annual determination of the

amount due (or owed by the QHP issuer). *See* Final RCP Rule, 77 Fed. Reg. at 17,238-39 (Add. A at 10-11). A year later, in its first annual "Payment Rule" articulating the payment policies and requirements for marketplace participation, HHS stated:

> ***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.

HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013) ("2014 Payment Rule") (emphasis added) (Add. A at 14).

III. HEALTHNOW WAS ENTICED BY THE RCP TO PARTICIPATE ON THE NEW YORK STATE EXCHANGE.

HealthNow is a corporation organized under the laws of New York, with its principal place of business in Buffalo, New York. HealthNow participated on the ACA exchange in New York during benefit years 2014, 2015, and 2016, providing health insurance to approximately 56,000 individuals on the exchange in each of those benefit years. HealthNow pursued the ACA's goal of connecting uninsured or underinsured individuals to health insurance opportunities with the understanding that a broader base of insured enhances the functioning of the marketplaces and ultimately better serves the insured individuals.

The ACA's success depended on QHP issuers participating in the marketplaces at a reasonable price point for the millions of uninsured Americans Congress intended to obtain insurance. Congress knew that a new and vastly expanded health insurance market for which there was insufficient data would make it difficult for entities like HealthNow to accurately set premiums. Like any health insurer facing an uncertain risk profile, *but for* the risk mitigation provided by the RCP, HealthNow would have had to set premiums at higher rates to account for market uncertainty or decline to enter the market altogether. Either approach would have driven up premiums, reduced competition, or both, which would have undermined the ACA's

purpose and objectives. The RCP was central to HealthNow's decision to offer competitive premiums for high-quality health benefits to consumers.

IV. THE GOVERNMENT'S POSITION ON ITS RISK CORRIDORS OBLIGATIONS HAS FLUCTUATED.

In March 2013, HHS issued its first Payment Rule ("2014 Payment Rule") to set the payment parameters for the Three Rs for the 2014 benefit year.[7] In it, HHS stated unambiguously (in response to a commenter) that the RCP "is not statutorily required to be budget neutral" and HHS would make payments "regardless of the balance of payments and receipts." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). QHP issuers then submitted their rates for review and their participation in the exchanges was fixed and irrevocable no later than October 2013. *See* Compl. ¶ 58.

Although HHS's comment in the 2014 Payment Rule was fully consistent with the ACA's text, it caused the ACA's opponents in Congress to threaten to defund the ACA entirely. Of particular note, in November 2013, legislation was introduced in the Senate seeking to strike the RCP from the ACA. *See* Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013). Citing HHS's commitment to meeting its statutory obligations, the bill's sponsor (Senator Rubio) pledged that he would refuse to agree to any forthcoming annual appropriation unless it defunded the ACA.[8]

Other members of Congress shared that sentiment and a budget impasse ensued that shut down the Government for over two weeks.[9] Subsequently, in March 2014, HHS indicated *for*

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[7] The "Payment Rule" is an annual CMS rule that identifies any changes CMS intends to make in the next year with respect to, among other things, the three premium stabilization programs.
[8] Rubio, Marco, The Wall Street Journal, "No Bailouts for ObamaCare" (Nov. 18, 2013), *available at* http://www.wsj.com/articles/SB10001424052702303985504579205743008770218.
[9] *See, e.g.*, Weisman, Jonathan and Jeremy W. Peters, The New York Times, "Government Shuts Down in Budget Impasse" (Sept. 30, 2013), *available at* http://www.nytimes.com/2013/10/01/us/politics/congress-shutdown-debate.html.

the first time in the preamble to its 2015 Payment Rule that it now intended to administer the risk corridors program in a "budget-neutral" manner, and that if "payments in" were not sufficient to cover "payments out" in a given year, it would offset current-year liabilities with future collections, directly contradicting its statement in the preamble to the 2014 Payment Rule it had issued a year earlier. HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014) ("2015 Payment Rule") (Add. A at 17). HHS's reversal occurred after HealthNow had already set premiums and enrolled members for the 2014 benefit year. HHS had never expressed its novel point of view during the notice-and-comment rulemaking on its RCP implementing regulations, and it did not even acknowledge that it was reversing course. In a follow-up guidance letter, HHS stated that it anticipated RCP "payments in" would cover "payments out," but that it would "establish in future guidance or rulemaking" what it would do if that assumption proved wrong. *See* CMS, "Risk Corridors and Budget Neutrality" (Apr. 11, 2014), *available at* https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf ("April 2014 Memo") (describing how payments would be calculated) (Add. A at 19-20).

Even then, however, CMS acknowledged that, notwithstanding its newly announced intent to administer the RCP in a budget-neutral manner, ***full payment*** remained due to QHP issuers.[10] Exactly *when* full payment would be remitted has never been clarified. Indeed,

[10] *See, e.g.*, Exchange and Insurance Market Standards for 2015 and Beyond ("Exchange Establishment Rule"), 79 Fed. Reg. 30,240, 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 23). That acknowledgment would be repeated numerous times over the next two-and-a-half years. *See* HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015) ("2016 Payment Rule") ("HHS recognizes that the Affordable Care Act requires the Secretary to make ***full payments*** to issuers . . .") (emphasis added) (Add. A at 26); CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) ("HHS is recording those amounts that remain unpaid following our 12.6 percent payment

despite stating in its April 11, 2014 guidance that it would announce through future rulemaking or guidance how the Government would cover RCP obligations in the event amounts collected were less than amounts owed, HHS has never done so.

Meanwhile, having failed at trying to substantively repeal the ACA, either in whole or in part, Congress took aim, through the appropriations process, at HHS's ability to administer the RCP. In the fiscal year 2015, 2016, and 2017 appropriations bills, enacted well after QHP issuers like HealthNow had begun performance of their obligations as QHP issuers, Congress prohibited CMS and HHS from using two specified funds, as well as funds transferred from other accounts funded by congressional appropriations, to make RCP payments owed to QHPs.[11] The Spending Riders did not nullify or modify the Government's RCP obligations.

STATEMENT OF UNDISPUTED MATERIAL FACTS

1. HealthNow is a corporation organized under the laws of New York, with its principal place of business in Buffalo, New York.

2. HealthNow participated on New York State's ACA exchange in benefit years 2014, 2015, and 2016.

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this winter as a fiscal year 2015 obligation of the United States Government for which ***full payment is required***.") (emphasis added) (Add. A at 33); CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) ("[T]he Affordable Care Act requires the Secretary to make ***full payments*** to issuers" and HHS will "record payments due as an obligation of the United States Government for which ***full payment*** is required") (emphases added) (Add. A at 35); Press Release, The Energy and Commerce Committee, Obamacare Insurance Bailout Scheme (Sept. 20, 2016), *available at* https://energy commerce.house.gov/news-center/press-releases/ec-leaders-press-administration-lawsuit-scheme-circumvent-congress-and (quoting Acting Administrator of CMS's testimony as part of hearing entitled "The Affordable Care Act on Shaky Ground: Outlook and Oversight") (Add. A at 41-42).

[11] *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015) ("2016 Spending Rider"); Consolidated Appropriations Act, 2017, Pub. L. No. 115-31, § 223, 131 Stat. 135, 543 (2017) ("2017 Spending Rider") (collectively, the "Spending Riders"). Congress had done the same for benefit year 2014 in its 2015 Spending Rider, but we do not address that further here since HealthNow does not claim a 2014 payment. *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014).

3. Pub. L. No. 111-148, § 1342 (ACA Section 1342), as codified at 42 U.S.C. § 18062, created the risk corridors program, or RCP. In relevant part, that Section states:

> (a) IN GENERAL.—The Secretary ***shall*** establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market ***shall*** participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums. Such program ***shall*** be based on the program for regional participating provider organizations under [the Medicare Part D program].
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> (b) PAYMENT METHODOLOGY.—
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> (1) PAYMENTS OUT.—The Secretary shall provide under the program established under subsection (a) that if—
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> (A) a participating plan's allowable costs ***for any plan year*** are more than 103 percent but not more than 108 of the target amount, the Secretary ***shall pay to the plan*** an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
>
> (B) a participating plan's allowable costs ***for any plan year*** are more than 108 percent of the target amount, the Secretary ***shall pay to the plan*** an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the allowable costs in excess of 108 percent of the target amount.
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> Pub. L. No. 111-148, § 1342 (emphases added). Section 1342 also includes a provision dealing with "payments in," requiring QHP issuers to pay amounts to HHS if the plans' actual costs are less than its targeted costs. *Id.* § 1342(b)(2). For both "payments out" and "payments in," the statute defines "allowable costs" and "target amount." *Id.* § 1342(c).

4. HHS recognized in the preamble to its proposed RCP implementing regulations that the RCP "serves to protect against uncertainty in the Exchanges by limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930 (Add. A at 4).

5. HHS implemented the RCP at 45 C.F.R. § 153.510, stating in part (emphases added):

> (b) HHS payments to health insurance issuers. QHP issuers will receive payment from HHS in the following amounts, under the following circumstances:
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> (1) When a QHP's allowable costs ***for any benefit year*** are more than 103 percent but not more than 108 percent of the target amount, ***HHS will pay the QHP issuer*** an amount equal to 50 percent of the allowable costs in excess of 103 percent of the target amount; and
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> (2) When a QHP's allowable costs ***for any benefit year*** are more than 108 percent of the target amount, ***HHS will pay to the QHP issuer*** an amount equal to the sum of 2.5 percent

of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

6. In the preamble to that rule, HHS recognized that "QHP issuers who are owed these amounts will want ***prompt payment, and payment deadlines should be the same for HHS and QHP issuers.***" Final RCP Rule, 77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 10). And HHS reiterated that the RCP "serves to protect against uncertainty in rate setting by qualified health plans ***sharing risk in losses and gains with the Federal government***." *Id.* at 17,220 (emphasis added) (Add. A at 8).

7. In the 2014 Payment Rule (published on March 11, 2013) HHS stated in the preamble: "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. at 15,473 (emphasis added) (Add. A at 14).

8. On May 27, 2014, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and committed to "***use other sources of funding for the risk corridors payments***, subject to the availability of appropriations" if there is a shortfall. *See* Exchange Establishment Rule, 79 Fed. Reg. at 30,260 (emphases added) (Add. A at 23).

9. On February 27, 2015, HHS recognized that the ACA "requires the Secretary to make ***full payments*** to issuers . . . ." and indicated that "***HHS will use other sources of funding for the risk corridors payments***, subject to the availability of appropriations." *See* 2016 Payment Rule, 80 Fed. Reg. at 10,779 (emphases added) (Add. A at 26).

10. On November 19, 2015, HHS stated that "HHS is recording those amounts that remain unpaid following [its] 12.6 percent payment this winter as a fiscal year 2015 obligation of the United States Government for which full payment is required." *See* CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33). HHS stated further that it "will explore other sources of funding for the risk corridors payments, subject to the availability of appropriations. This includes ***working with Congress on the necessary funding for outstanding risk corridors payments***." *Id.* (emphasis added).

11. On September 9, 2016, in a memorandum, HHS recognized that the ACA "requires . . . ***full payments*** to issuers" and it will "record risk corridors payments due as an obligation of the United States Government for which ***full payment is required.***" *See* CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) (emphases added) (Add. A at 35).

12. On September 14, 2016, in testimony before the House Energy and Commerce Committee, regarding whether CMS must make RCP payments even in the absence of an appropriation, the Acting Administrator of CMS Andrew Slavitt testified: "Yes, ***it is an obligation*** of the federal government." *See* Energy and Commerce Committee Press Release (emphasis added) (Add. A at 41-42).

HealthNow executed its Health Benefit Exchange Contract ("NY Agreement") with New York State to participate in the exchange effective October 1, 2013 through December 31, 2018, which includes participation in the RCP for benefit years 2014, 2015, and 2016 (the full duration of the temporary program), at which point its participation became fixed and irrevocable. *See* Compl. ¶ 58.

13. For benefit year 2014:

- Pursuant to its NY Agreement, HealthNow began selling its QHP to New York consumers on or about November 15, 2013, with coverage effective January 1, 2014. *See* Compl. ¶ 59.

- HealthNow submitted all data required for the RCP payment and charge calculations for the 2014 benefit year by the statutory deadline of July 31, 2015. *See* 45 C.F.R. § 153.530(d); CMS, "Risk Corridors Payment and Charge Amounts for Benefit Year 2014" (Nov. 19, 2015) ("2014 Payment Memo") (Add. A at 30-31); Compl. ¶ 60.

- HealthNow timely paid the Government $5,236,811.41 pursuant to its RCP payment obligation. Compl. ¶ 60.

14. For benefit year 2015:

- Pursuant to its NY Agreement, HealthNow began selling its QHP to New York consumers on or about November 15, 2014, with coverage effective January 1, 2015. *See* Compl. ¶ 61.

- HealthNow submitted all data required for the RCP payment and charge calculations for the 2015 benefit year by the statutory deadline of July 31, 2016. *See* 45 C.F.R. § 153.530(d); 2015 Payment Memo (Add. A at 38-39); Compl. ¶ 62.

- HHS has conceded the Government owes HealthNow $ 9,619,385.01 under Section 1342, which the Government has not paid. 2015 Payment Memo (Add. A at 39).

15. For benefit year 2016:

- Pursuant to its NY Agreement, HealthNow began selling its QHP to New York consumers on or about November 15, 2015, with coverage effective January 1, 2016. *See* Compl. ¶ 64.

- HealthNow submitted all data required for the RCP payment and charge calculations for the 2016 benefit year by the statutory deadline of July 31, 2017 using the same methodology HealthNow applied to its 2014 and 2015 data, both of which have been validated by CMS. *See* 45 C.F.R. § 153.530(d); Compl. ¶ 73 n.7.

- The Government owes HealthNow $29,119,555 under Section 1342, which the Government has not paid. Compl. ¶ 65.

16. To insurers who were owed a payment for benefit year 2014, the Government paid approximately 12.6% of what it owed—equating to the percentage of the Government's debt to QHP issuers that the Government was able to cover using "payments in" from issuers such as HealthNow. CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Add. A at 33).

17. The Government has not paid any issuers who (like HealthNow) are owed RCP payments for benefit years 2015 or 2016.

JURISDICTION

This Court has jurisdiction under the Tucker Act because the RCP is a statutory provision that: (1) "can fairly be interpreted as mandating compensation for damages sustained as a result of the breach of the duties [it] impose[s]," and (2) is "reasonably amenable to the reading that it mandates a right of recovery in damages." 28 U.S.C. § 1491(a)(1); *see United States v. White Mountain Apache Tribe*, 537 U.S. 465, 472-73 (2003); *Fisher v. United States*, 402 F.3d 1167, 1173-74 (Fed. Cir. 2005) (en banc in relevant part) (citations omitted). The Federal Circuit has "repeatedly recognized that the use of the word 'shall' generally makes a statute money-mandating." *Greenlee Cty., Ariz. v. United States*, 487 F.3d 871, 876-77 (Fed. Cir. 2007) (citing *Agwiak v. United States*, 347 F.3d 1375, 1380 (Fed. Cir. 2003)). The RCP mandates that HHS "shall pay" to QHP issuers certain statutorily dictated amounts. And since HealthNow is a QHP issuer under the ACA, it falls within "the class of plaintiffs entitled to recover under the money-mandating source [and] the Court of Federal Claims has jurisdiction." *Jan's Helicopter Serv., Inc. v. FAA*, 525 F.3d 1299, 1307 (Fed. Cir. 2008).

Tucker Act jurisdiction is also "limited to actual, presently due money damages from the United States." *See Todd v. United States*, 386 F.3d 1091, 1093-94 (Fed. Cir. 2004) (citations and quotations omitted). HealthNow is entitled to presently due money damages because it has fulfilled all statutory requirements for payment. *See Doe v. United States*, 100 F.3d 1576, 1580, 1582 (Fed. Cir. 1996) (jurisdiction existed where plaintiff had fulfilled all statutory conditions

for payment). HealthNow has submitted all required information to HHS demonstrating its entitlement to payment in specific amounts under the formula contained in Section 1342 of the ACA and HHS has confirmed the total amounts due to HealthNow for benefit year 2015. Applying the same formula it used to determine its 2014 and 2015 RCP amounts, which were validated by HHS, HealthNow has also determined the total amount it is owed for 2016.

Whether a statute is money-mandating for jurisdictional purposes is based on "the source as alleged and pleaded." *Fisher*, 402 F.3d at 1173. HealthNow has pled that the ACA is money-mandating, requires full and timely payment, sets forth statutory requirements for receipt of payment that HealthNow fulfilled, and requires payment the Defendant has not made. *See, e.g.*, Compl. ¶¶ 9-17, 21-23, 27, 60-69. Accordingly, this Court's jurisdiction is plain. *See Molina Healthcare of Calif., Inc. v. United States*, 133 Fed. Cl. 14, 28-30 (2017); *Maine Cmty. Health Options v. United States*, 133 Fed. Cl. 1, 3 (2017), *appeal docketed*, No. 17-2395 (Fed. Cir. Aug. 7, 2017); *Blue Cross & Blue Shield of N.C. v. United States*, 131 Fed. Cl. 457, 472-75 (2017), *appeal docketed*, No. 17-2154 (Fed. Cir. June 14, 2017); *Moda Health Plan, Inc., v. United States*, 130 Fed. Cl. 436, 449-51 (2017), *appeal docketed*, No. 17-1994 (Fed. Cir. May 9, 2017); *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757, 776 (2017); *Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 95-98 (2016), *appeal docketed*, No. 17-1224 (Fed. Cir. Nov. 16, 2016).

SUMMARY OF ARGUMENT

Judgment in HealthNow's favor is appropriate because the Government has refused to pay HealthNow money that the ACA mandates it pay.

1. *Statutory Mandate to Pay*. Under Section 1342, for each benefit year, a QHP issuer's costs are to be calculated. If there is a cost overrun above a certain amount, the Government owes the issuer money, and if there is a cost savings above a certain amount, the issuer owes

money to the Government. Both calculations are governed by the statutory formula. *Moda*, 130 Fed. Cl. at 451-57 (holding that the Government was liable to Moda Health as a QHP issuer because the ACA RCP requires full annual payments as evidenced by: the text of Section 1342; HHS's implementing regulations; Congress's obvious object and purpose in creating the RCP; and Congress's modeling of Section 1342 on Medicare Part D's annual RCP); *Molina*, 133 Fed. Cl. at 35-38 (same).

The plain text of the statute answers the question of "how much" money the Government owes HealthNow by stating, in mandatory terms, that *if* a QHP issuer's allowable costs are more than a specified percentage above the target amount, *then* the Government "shall" reimburse the QHP pursuant to the prescribed formula. It is a long-accepted principle of statutory interpretation that when Congress uses the term "shall," it creates a mandatory obligation that the Government cannot, in its discretion, dispense with. *See Lexecon, Inc. v. Milberg Weiss Bershad Hynes & Lerach*, 523 U.S. 26, 35 (1998). Not surprisingly, HHS has acknowledged on multiple occasions that full payment is due. *See supra* note 10. Because, as Judge Wheeler recognized in *Molina*, "[t]he plain language of Section 1342 leaves the Secretary of HHS with no discretion whether to make risk corridor payments and how much those payments should be," *Molina*, 133 Fed. Cl. at 40, the Court should find that, under the statutory formula, the Government owes HealthNow $9,619,385.01 for benefit year 2015 and $29,119,555 for benefit year 2016.

Section 1342 also answers the question of "when" the Government's RCP obligations are due. Section 1342's express language states that if a plan's allowable costs "for any ***plan year***" exceed the target amount, the Secretary "***shall pay to the plan***" the statutorily specified amounts. Although it does not expressly state that payments must be made on an annual basis, the statute cannot logically be read to require anything other than payment at the conclusion of the "plan

year."[12] *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015) ("[T]he words of a statute must be read in their context and with a view to their place in the overall statutory scheme." (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2441 (2014) (internal quotations omitted))).

Finally, whether the Government's obligation under Section 1342 has changed on account of subsequent legislative acts is also apparent by reference to its text, which remains in the U.S. Code unchanged.

The Government posits that it need not make the mandated RCP payments to HealthNow and other QHPs for benefit years 2015 and 2016. Under the Government's current view of the statute, payment would only ever be due after the conclusion of the third year of the RCP, and even then it is obligated to pay out only to the extent of RCP collections received from issuers who realized lower-than-anticipated costs. This ignores the plain language of Section 1342. Most notably, Congress specifically modeled the ACA RCP on the Medicare Part D RCP, which requires full annual payments. *See* GAO Rep. at 14. In the ACA RCP, Congress also directed HHS to establish risk *corridors* (plural) for each "plan year" 2014, 2015, and 2016. "[P]lan year" means 12 consecutive months under the ACA[13] and Congress *intentionally* used the plural "corridors." *See Metro. Stevedore Co. v. Rambo*, 515 U.S. 291, 296 (1995) ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing" (quotation and citations omitted)).

Congress knew what it was doing. The RCP's entire purpose was to *stabilize* insurance premiums in each of the first three years of the exchanges' existence. Withholding payment (if paying at all) until long after the year for which Congress intended the payment to be made only

[12] HHS reiterated that when allowable costs "for any ***benefit year***" exceeded the target amount, "***HHS will pay the QHP issuer***" the specified amounts. 45 C.F.R § 153.510 (emphases added).
[13] *See* 45 C.F.R. § 155.20.

exacerbates premium rate inflation for subsequent years (which history proved all too true). *See King*, 135 S. Ct. at 2494 ("It is implausible that Congress meant the Act to operate in this manner."); *see also Bob Jones Univ. v. United States*, 461 U.S. 574, 586 (1983) (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters. v. United States*, 88 Fed. Cl. 350, 406 (2009) (same); *Fluor Enters., Inc. v. United States*, 64 Fed. Cl. 461, 479 (2005) (same).

Nor did Congress's subsequent appropriations negate the Government's obligation to make the required payments under a money-mandating statute. First, Congress's intent in 2010 when it passed the ACA is unambiguous: Congress said the United States "shall pay" when QHP issuers satisfied the statutory "payments out" trigger. Second, as a matter of law, that payment obligation was not dependent on Congress simultaneously specifying the source for the obligated payments. Finally, Congress's subsequent acts barring RCP payments from specific sources through the annual appropriations process merely hampered HHS's ability to make payment; they did not abridge the Government's underlying statutory obligation. *See* Add. B at 3.

2. *Breach of Implied-in-fact Contract*. Judgment in HealthNow's favor is also appropriate because the Government breached its unilateral implied-in-fact contract with HealthNow. All elements of an implied-in-fact contract are met.

Empowered by the ACA's authorization to contract with QHP issuers, the Government held out a unilateral offer of RCP payments to induce HealthNow and other QHP issuers to begin performance by expanding coverage for millions of Americans, and HealthNow accepted by beginning performance. Consideration flowed both ways, where the Government benefited from

HealthNow's performance as a QHP issuer, and HealthNow benefited from the Government's promise of payment.

HealthNow has fulfilled its contractual duty and condition precedent to the Government's full payment. The Government's failure to uphold its side of the bargain is a clear contractual breach.

SUMMARY JUDGMENT STANDARD

This case presents a question of statutory interpretation appropriate for summary disposition, as all material facts are undisputed. Summary judgment is appropriate when "the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." RCFC 56(c); *Johnson v. United States*, 80 Fed. Cl. 96, 115-16 (2008). 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), and a dispute of material fact is genuine "if the evidence is such that a reasonable finder of fact could return a verdict for the nonmoving party." *Johnson*, 80 Fed. Cl. at 116 (citing *Liberty Lobby, Inc.*, 477 U.S. at 248). "Issues of statutory interpretation and other matters of law may be decided on motion for summary judgment." *Id.* at 116 (quoting *Santa Fe Pac. R. Co. v. United States*, 294 F.3d 1336, 1340 (Fed. Cir. 2002)). The existence of a contract is a mixed question of law and fact, and the court may grant summary judgment when there is no genuine issue for trial. *See La Van v. United States*, 53 Fed. Cl. 290 (2002), *aff'd*, *La Van v. United States*, 382 F.3d 1340 (Fed. Cir. 2004).

ARGUMENT

I. THE GOVERNMENT IS LIABLE FOR ITS FAILURE TO MAKE RCP PAYMENTS UNDER A MONEY-MANDATING STATUTE (COUNT I).

A. Section 1342 Requires RCP Payments to be Made Annually and in Full, Without Regard to Budget Neutrality.

HealthNow is entitled to summary judgment because, based on the undisputed facts and as a matter of law, the Government owes it an unpaid balance of RCP payments for 2015 and 2016. This Court's analysis necessarily "starts where all such inquiries must begin: with the language of the statute itself." *Ransom v. FIA Card Servs., N.A.*, 562 U.S. 61, 69 (2011) (citation and quotations omitted)). The RCP's text and the ACA's structure require full, annual payment.

1. *Congress Intended QHP Issuers to Receive Full Payment.*

The enacting Congress effectuated the RCP's risk mitigating purpose by plainly and unambiguously mandating full payment to QHP issuers as defined in its "Payment Methodology" without regard to budget neutrality. First, the text mandates that the Government "***shall pay to the plan***" payments calculated under the RCP's provisions. ACA § 1342(a) (emphasis added). "[T]he mandatory 'shall' . . . normally creates an obligation impervious to judicial discretion." *Lexecon*, 523 U.S. at 35. Moreover, Congress used "shall" and "may" throughout the ACA, often within the same section of the law, underscoring Congress's deliberate intent to invoke their distinct meanings. *See, e.g.*, ACA §§ 2713, 2717(a)(2), and 1104(h); *see also Lopez v. Davis*, 531 U.S. 230, 241 (2001) ("Congress' use of the permissive 'may' . . . contrasts with the legislators' use of a mandatory 'shall' in the very same section."). The enacting Congress used "shall" to signify mandatory obligations and "may" to impose discretionary ones. Unsurprisingly, in its public statements made prior to HealthNow and other QHP issuers finally and irrevocably committing to provide insurance on the exchanges, HHS agreed and acknowledged that the RCP "is not statutorily required to be budget neutral" and, in

recognition of the statutory mandate to make payment, promised payment "[r]egardless of the balance of payments and receipts." 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). *See, e.g.*, *Moda*, 130 Fed. Cl. at 456 (finding "the unambiguous language of Section 1342 dispositive" of the fact that Congress did not intend the RCP to be budget neutral).[14]

Second, Congress explicitly modeled the ACA's RCP on the Medicare Part D RCP, which is not budget neutral. *See* ACA § 1342(a); GAO Rep. at 14 ("for the Medicare Advantage and Medicare Part D risk mitigation programs, the payments that CMS makes to issuers is not limited to issuer contributions."). Government sharing in the risk is a critical design feature of the ACA's RCP no less than it is of the Medicare Part D RCP[15]: it is inherent to the incentive to QHP issuers to enter the exchanges and offer affordable premiums; it is also what differentiates the RCP from the risk adjustment program (which by design redistributes payments from plans serving healthier populations to plans serving less healthy populations). A budget-neutral program eliminates the Government's share of the risk and thus negates the central tenet of the RCP. Indeed, if "payments out" were subject to "payments in" and issuers experienced losses across the board, issuers would not receive anything. The Government's position would have the Court ignore the very benefit the RCP was created to provide. *Cf. Engel v. Davenport*, 271 U.S. 33, 38-39 (1926) ("The adoption of an earlier statute by reference makes it as much a part of the

[14] In *Moda*, Judge Wheeler found, as HealthNow argues here, that the RCP is unambiguously *not* budget neutral under the plain meaning of Section 1342, as HHS/CMS contemporaneously and repeatedly recognized (as did everyone in the industry). *Moda*, 130 Fed. Cl. at 455-57; *see also Molina*, 133 Fed. Cl. at 32-38. HHS's multiple and consistent statements shortly after the ACA's passage buttress HealthNow's interpretation that the statute is unambiguously not budget neutral.

[15] MedPAC, "Chapter 6: Sharing Risk in Medicare Part D," Report to the Congress: Medicare and the Health Care Delivery System (June 2015) at 140, *available at* http://www.medpac.gov/docs/default-source/reports/chapter-6-sharing-risk-in-medicare-part-d-june-2015-report-.pdf?sfvrsn=0 ("Also, risk corridors limit each plan's overall losses or profits if actual spending is much higher or lower than anticipated. Corridors provide a cushion for plans in the event of large, unforeseen aggregate drug spending.").

later act as though it had been incorporated at full length." (citations omitted)). In modeling the ACA RCP on the Medicare Part D RCP, it is presumed that Congress legislated with awareness of how the Part D RCP is administered. *See Lorillard v. Pons*, 434 U.S. 575, 580-81 (1978). If Congress had intended the ACA *not* to track this defining characteristic of Part D, surely Congress would have said so explicitly.

Third, the enacting Congress specifically made numerous sections of the ACA budget neutral, *see, e.g.*, ACA § 3007(p)(4)(C) ("The payment modifier established under this subsection shall be implemented in a budget neutral manner."), yet it *omitted* from Section 1342 any reference to budget neutrality. To suppose that Congress carefully considered budget neutrality throughout the ACA yet neglected to do so in connection with the RCP is patently unreasonable; it would insert into Section 1342 a budget-neutrality requirement that Congress chose not to insert. Courts "may not add terms or provisions where Congress has omitted them . . . ." *Sale v. Haitian Ctrs. Council, Inc.*, 509 U.S. 155, 168 n.16 (1993).

Congress's *exclusion* of words specifically limiting RCP payments to appropriated funds underscores its intent to accomplish the opposite. Congress often uses explicit language, such as "subject to the availability of appropriations," to limit a statute's budget impact. *See, e.g.*, *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2188-89 (2012) (noting that certain payments were "subject to the availability of appropriations" under the statute at issue); *see also Prairie Cty., Mont. v. United States*, 113 Fed. Cl. 194, 199 (2013), *aff'd*, 782 F.3d 685 (Fed. Cir. 2015) ("the language 'subject to the availability of appropriations' is commonly used to restrict the government's liability to the amounts appropriated by Congress for the purpose." (citing *Greenlee Cty*, 487 F.3d at 878-79)). In the RCP, however, Congress chose not to include such limiting language in any form, despite having done so elsewhere within the ACA itself. *See,*

e.g., 42 U.S.C. § 280k(a) ("The Secretary . . . shall, ***subject to the availability of appropriations***, establish a 5-year national, public education campaign . . . ." (emphasis added)). Especially when read in the context of the ACA as a whole, the lack of any language of budgetary limitation in Section 1342 confirms that Congress did not intend the RCP to be budget neutral or "subject to the availability of appropriations." *See United Sav. Ass'n. of Tex. v. Timbers of Inwood Forest Assocs., Ltd.*, 484 U.S. 365, 371 (1988) ("A provision that may seem ambiguous in isolation is often clarified by the remainder of the statutory scheme—because the same terminology is used elsewhere in a context that makes its meaning clear, or because only one of the permissible meanings produces a substantive effect that is compatible with the rest of the law." (citations omitted)); *see also Brown v. Gardner*, 513 U.S. 115, 118 (1994) ("Ambiguity is a creature not of definitional possibilities but of statutory context."). The Government cannot add words to § 1342 that Congress excluded, particularly where those very words appear *elsewhere* in the law.

The Congressional Budget Office (CBO) did not score Section 1342 prior to the ACA's enactment. The Government has posited in other RCP litigation (and likely will again here) that Congress must have relied on that lack of scoring to mean it intended that Government payments would not exceed amounts collected under the RCP. This logic is faulty for multiple reasons. First, whatever the CBO had to say (or not say) is irrelevant to the Court's interpretation of what Congress actually said in the statutory text. *See Sharp v. United States*, 580 F.3d 1234, 1238-39 (Fed. Cir. 2009) (stating "the CBO is not Congress, and its reading of the statute is not tantamount to congressional intent"). Second, and in any event, as Judge Wheeler pointed out in granting judgment for the insurers in *Moda* and *Molina*, the CBO's "failure to speak on Section 1342's budgetary impact" says nothing about the CBO's viewpoint on the subject. *Moda*, 130 Fed. Cl. at 455; *Molina*, 133 Fed. Cl. at 32. As Judge Wheeler went on, if anything, the opposite

inference should be drawn from the CBO's failure to address the budgetary impact given that it did expressly score the reinsurance and risk-adjustment programs as budget neutral, and presumably would have done the same for the RCP had it thought the RCP would be budget neutral. *See Moda*, 130 Fed. Cl. at 455. Third, in the only report in which the CBO actually addressed the budgetary impact of the RCP, it concluded the RCP was *not* budget neutral. *See* CBO, "The Budget and Economic Outlook: 2014 to 2024" (Budget Outlook) at 9 (Feb. 2014), *available at* https://www.cbo.gov/publication/45010.

Finally, ACA opponents in Congress have repeatedly introduced (but failed to pass) legislation intended to make the RCP budget neutral. *See infra* Section I.C.1. Obviously, if the RCP were budget neutral, such legislative efforts would have been unnecessary. *See, e.g.*, *ARRA Energy Co. I v. United States*, 97 Fed. Cl. 12, 22 n.6 (2011) (noting that congressional attempts to amend a law provide support for the proposition that the law in its current form does not already do what the amendment proponents are seeking). The RCP's sole purpose was to induce participation in an uncharted healthcare insurance market by mitigating the risk that would otherwise lead QHP issuers under normal market conditions to either steer clear or charge significantly higher premiums. HHS's acknowledgment of this fact on multiple occasions illustrates its awareness that the Government is liable for full payment. *See supra* note 10.

2. *Congress Intended QHP Issuers to Receive or Remit Timely Annual Payments.*

The ACA's text and structure unambiguously anticipate that RCP payments—both "in" and "out"—will be made on an annual basis. And this is exactly how HHS originally understood and stated it would apply its congressional mandate. *See* RCP Final Rule, 77 Fed. Reg. at 17,238-39 (stating that the same deadlines should apply to both "payments in" and "payments out") (Add. A at 10-11); 2014 Payment Rule, 78 Fed. Reg. at 15,473 (setting a 30-day deadline

from determination of charges for QHP issuers to make "payments in") (Add. A at 14).

a. *The Text and Structure of the ACA Require Annual RCP Payment.*

The RCP's text requires HHS to pay QHP issuers the amount owed annually. First, the RCP explicitly states that "for any plan year . . . [HHS] shall pay to the plan" the delineated amounts. "Plan year" means 12 consecutive months under the ACA. 45 C.F.R. § 155.20 (in related Exchange Establishment Rule, defining "*Plan year*" as a "consecutive 12 month period during which a health plan provides coverage for health benefits. A plan year may be a calendar year or otherwise."); *see Moda*, 130 Fed. Cl. at 451-53 (the calculation of payment amounts in and out of the program on a "plan year" basis reflects an annual program).

Second, the RCP's "Payment Methodology" also constructs an annual program by predicating the appropriate payment amounts on figures that are calculated annually. The RCP mandates payments to any QHP issuer that, for the applicable year, had "allowable [health care] costs" that were more than three percent greater than a "target amount." *See* ACA § 1342(b). The RCP defines "allowable costs" and the "target amount" with reference to "a plan for any year" and the "amount of a plan for any year." *See* ACA §§ 1342(c)(1)(A), 1342(c)(2), 1342(b). "Target amounts" necessary to calculating RCP payments are based on payments and receipts under the related risk adjustment and reinsurance provisions, which are annual. 45 C.F.R. § 153.510(a)-(d), (g). The scheme is annual.

Third, the enacting Congress, by referencing the plural "corridors" when it directed that HHS "shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016," did so intentionally to create separate risk corridors for each of the calendar years referenced. ACA § 1342(a); *see Metro. Stevedore*, 515 U.S. at 296 ("Ordinarily the legislature by use of a plural term intends a reference to more than one thing") (quotation and citations omitted); *Dakota, Minn. & E.R.R. Corp. v. Schieffer*, 648 F.3d 935, 938 (8th Cir. 2011) (finding

that Congress's use of the plural was evidence of its intent); *Moda*, 130 Fed. Cl. at 451-52 (holding that Section 1342 requires *annual* payments and finding that Section 1342 "offer[s] clues as to Congress's intent" by requiring an RCP for "calendar years 2014, 2015, and 2016" rather than "calendar years 2014-2016"). Congress is presumed to draft law purposefully. *See Arcadia v. Ohio Power Co.*, 498 U.S. 73, 79 (1990) ("In casual conversation, perhaps, such absentminded duplication and omission are possible, but Congress is not presumed to draft its laws that way."). Congress intended to create three sets of risk corridors, one for each year the RCP was in effect.

Fourth, Congress further underscored the annual payment structure dictated by the RCP's plain text by mandating that the RCP "shall be based on the program for regional participating provider organizations under [the Medicare Part D risk mitigation program]," which provides for a distinct risk corridor in each year, to be paid annually. ACA § 1342(a). Medicare Part D explicitly provides for a "risk corridor" specific to each year. *See* 42 U.S.C. § 1395w-115(e)(3)(A) (noting that "[f]or each plan year, the secretary shall establish a risk corridor" and referencing "[t]he risk corridor for a plan for a year . . ."); *see also* 42 C.F.R. § 423.336(a)(2)(i) (same). Part D also requires payment for each risk corridor in the year following the corridor. *See* 42 C.F.R. § 423.336(c)(2) (CMS makes payments "in the following payment year . . . ."). *See Moda*, 130 Fed. Cl. at 452 (noting Congress's explicit directive that the RCP be "based on" the Medicare Part D's annual RCP). Congress reinforced its explicit provision for annual "payments in" within the text of the RCP by reference to the only other comparable risk mitigation program—a program premised on annual payments.[16]

[16] *See, e.g.*, HHS OIG, "Medicare Part D Reconciliation Payments for 2006 and 2007" (Sept. 2009) at 14, *available at* https://oig.hhs.gov/oei/reports/oei-02-08-00460.pdf.

b. *HHS Interpreted the RCP to Require Timely Annual Payments.*

HHS's original interpretation of Section 1342 was consistent with the text of the law and HealthNow's expectation of annual payment, and it is the only interpretation that is consistent with the RCP's purpose. First, HHS immediately recognized that the RCP "serves to protect against uncertainty in rate setting by qualified health plans *sharing risk* in losses and gains *with the Federal government*," Final RCP Rule, 77 Fed. Reg. at 17,2220 (Add. A at 8) (emphasis added), and will do so by "limiting the extent of issuer losses (and gains)." Proposed RCP Rule, 76 Fed. Reg. at 41,930 (Add. A at 4). It reiterated that principle in its final rule, and accordingly indicated that it would "address the risk corridors payment deadline in the HHS notice of benefit and payment parameters," noting that:

> HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. ***QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers***.

Final RCP Rule, 77 Fed. Reg. at 17,238 (emphasis added) (Add. A at 10).

In its first Payment Rule, HHS set a 30-day deadline for issuers to remit payment upon notification of charges. *See* 2014 Payment Rule, 78 Fed. Reg. at 15,473 (Add. A at 14). And, as HHS stated in the preamble to its implementing regulations, it believed the same deadline should apply to both "payments in" and "payments out" of the program. Significantly, HHS requires issuers to submit their data to HHS annually to facilitate calculation of RCP payments. 45 C.F.R. § 153.530(d).

Thus, not so long ago, there was no disagreement that Congress intended both RCP payments to the Government and from the Government to be made annually. And for good reason: that is the only reading that is consistent with the overall purpose and structure of the ACA. A premium rate stabilization program would not do much good if insurers could not rely

on complete and timely payment. As the Supreme Court pointed out, Congress designed the ACA to prevent an economic "death spiral," in which "premiums rose higher and higher, and the number of people buying insurance sank lower and lower, [and] insurers began to leave the market entirely." *King*, 135 S. Ct. at 2486. A program by which the Government mitigated insurers' risk by sharing in that risk was necessary to incentivize health insurance companies to enter and remain on the exchanges. *See, e.g.*, *Health Republic*, 129 Fed. Cl. at 776 ("If these programs did not provide for prompt compensation to insurers upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges. Further, if enough insurers left the exchanges, one of the goals of the Affordable Care Act—the creation of 'effective health insurance markets,'—would be unattainable." (internal citations omitted)).

HHS's original interpretation is fully supported by the fact that the very "death spiral" the Supreme Court recognized, and that the RCP was intended to avoid, has resulted, at least in part, from Congress's failure to appropriate sufficient funds to satisfy the Government's RCP obligations.[17] To suggest, as HHS has, that QHP issuers of all sizes that sustain significant short-term losses, and report on their costs and receipts on an annual basis as the ACA requires them to do, can readily bear those losses over multiple years, all while keeping premiums affordable for enrollees in each successive year, is anathema to the structure and purpose of the ACA. "It is implausible that Congress meant the Act to operate in this manner." *King*, 135 S. Ct. at 2494

[17] *See* HHS, ASPE Research Brief, "Health Plan Choice and Premiums in the 2017 Health Insurance Marketplace" at 6 (Oct. 24, 2016), *available at* https://aspe.hhs.gov/sites/default/files/pdf/212721/2017MarketplaceLandscapeBrief.pdf (predicting average premium increase of 25 percent); Kaiser Family Foundation, "2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces" (Oct. 25, 2016), *available at* http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/ ("As a result of losses in this market, some insurers . . . have announced their withdrawal from the ACA marketplaces or the individual market . . . .").

(citations omitted); *Bob Jones*, 461 U.S. at 586 (statutory interpretations that frustrate the object and purpose of the statute are disfavored); *Global Computer Enters.*, 88 Fed. Cl. at 406 (same); *Fluor Enters.*, 64 Fed. Cl. at 479 (same).

B. The Government's Liability Does Not Depend on There Also Being a Dedicated Source of Funding for That Liability.

The Government will likely contend (as it has in other RCP litigation) that, notwithstanding Section 1342's "shall pay" directive, Congress never specified an appropriation to fund the RCP in the first instance, so there can be no obligation. This position finds no support in the law.

As discussed *supra* at Section I.A.1, Congress did not limit the Government's RCP liability with its typical words of limitation (*e.g.*, "subject to appropriations"). Nor, as a matter of fiscal law, does the Government's liability for full and annual RCP payments turn on whether Congress specifically appropriated funds. The Government's error is its conflation of two distinct concepts: (1) Congress's creation of a legal "obligation" to pay in the first instance; and (2) the means by which the Government later satisfies its obligation. The Government's position also ignores the role of the Judgment Fund. *See, e.g.*, *Moda*, 130 Fed. Cl. at 461-62.

It has long been understood that:

> ***This court***, established for the sole purpose of investigating claims against the government, ***does not deal with questions of appropriations, but with the legal liabilities incurred by the United States*** under contracts, express or implied, ***the laws of Congress***, or the regulations of the executive departments. (Rev. Stat., § 1059.) That ***such liabilities may be created where there is no appropriation of money to meet them*** is recognized in section 3732 of the Revised Statutes.

Collins v. United States, 15 Ct. Cl. 22, 35 (1879) (emphases added); *see also Strong v. United States*, 60 Ct. Cl. 627, 630 (1925) (awarding statutorily mandated military pay despite lack of an appropriation); *Parsons v. United States*, 15 Ct. Cl. 246, 246-47 (1879) (awarding statutorily mandated payment despite lack of an appropriation, noting that "*[t]he absence of an*

appropriation constitutes no bar to the recovery of a judgment in cases where the liability of the government has been established."). Under the Tucker Act, HealthNow may recover unpaid funds when the Government fails to meet its obligation under a money-mandating statute. *See, e.g.*, *Price v. Panetta*, 674 F.3d 1335, 1338-39 (Fed. Cir. 2012); *District of Columbia v. United States*, 67 Fed. Cl. 292, 302-05 (2005). The RCP is unequivocally money-mandating because, *inter alia*, it dictates that the Government "shall pay" RCP payments. Whether, when, and how Congress appropriates the required funds are irrelevant to this Court's decision regarding the Government's legal *obligation* to make the "payments in" the first instance. There is no requirement for Congress to create a specific appropriation. *See, e.g.*, *United States v. Langston*, 118 U.S. 389, 391-94 (1886) (finding the Government liable for statutory promise of payment in absence of a specific appropriation).

The Federal Circuit's seminal decision in *Slattery v. United States*, 635 F.3d 1298 (Fed. Cir. 2011) (*en banc*), drives home the point. *Slattery* addressed whether the Government could be sued under the Tucker Act for breaches committed by a Government entity that was not funded by appropriations ("NAFI"). The Government argued that because a NAFI is not funded by appropriations, this Court lacks jurisdiction to adjudicate claims for a NAFI breach. After canvassing the long line of cases from the Court of Claims, Federal Circuit, and Supreme Court, the Federal Circuit abrogated its own contrary precedent[18] and held that the Tucker Act's broad grant of jurisdiction for any claim "founded either upon the Constitution, or any Act of Congress or any regulation of an executive department, or upon any express or implied contract with the United States . . .," 28 U.S.C. § 1491(a)(1), was *not* limited to the subset of instances where a specific appropriation could be identified. It held, "the jurisdictional foundation of the Tucker

[18] *See Kyer v. United States*, 369 F.2d 714 (Ct. Cl. 1966), *abrogated by Slattery*, 635 F.3d 1298 (Fed. Cir. 2011).

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. Critically, the Court ruled that any resulting judgment—despite the lack of appropriations involved in creating the original obligation—*could be satisfied by the Judgment Fund*. *See id.* at 1317 (Judgment Fund's purpose "was to avoid the need for specific appropriations to pay [Court of Claims] judgments").

Although *Slattery* specifically addressed jurisdiction over a claim for breach of a NAFI contract, the holding applies with equal force here because the Tucker Act draws no distinction between constitutional, statutory, or contract claims against the Government. And while the Government has framed this as a "merits" issue in its other RCP cases, the Government's attempts to force RCP plaintiffs to identify a specific appropriation as a predicate condition to state a claim under Section 1342 amounts to a second "jurisdictional" test of the very sort rejected in *Slattery*. *See id*. at 1316 (reasoning that Tucker Act jurisdiction is determined by identification of a money-mandating statute and there is no need to identify a specific appropriation for what in essence would amount to a "second waiver" of sovereign immunity (citing *Mitchell v. United States*, 463 U.S. 206, 218 (1983))).

The point is this: because Congress did not condition "payments out" on "payments in," the only limitation on HealthNow's right to payment on its statutory claim is its ability to demonstrate, as a factual matter, that it performed as a QHP issuer on the exchanges and qualifies for RCP payments under the Section 1342 formula (as echoed in CMS's implementing regulation). If it can make that showing (as it has), then the Government is liable for its statutory obligation and judgment may be executed against the Judgment Fund. *See, e.g.*, *Moda*, 130 Fed. Cl. at 461 ("The Judgment Fund pays plaintiffs who prevail against the Government in this Court, and it constitutes a separate Congressional appropriation."); *Gibney v. United States*, 114

Ct. Cl. 38, 52 (1949) ("Neither is a public officer's right to his legal salary dependent upon an appropriation to pay it. Whether . . . Congress appropriate an insufficient amount . . . or nothing at all, are questions . . . which do not enter into the consideration of case in the courts.").

Judge Wheeler's decision on behalf of the insurer in *Molina* is instructive. He aptly pointed out that the Government's argument that Section 1342 could not have created an obligation on the part of the United States absent Congress *also* creating a dedicated appropriation "is completely contrary to a mountain of controlling case law holding that when a statute states a certain consequence 'shall' follow from a contingency, the provision creates a mandatory obligation." *Molina*, 133 Fed. Cl. at 36. Similarly, addressing Section 1342 specifically and a GAO report about how the RCP was to be funded, the federal district court for the District of Columbia observed that "not only is it possible for a statute to authorize and mandate payments without making an appropriation, but GAO has found a prime example in the ACA." *U.S. House of Representatives v. Burwell*, 185 F. Supp. 3d 165, 185 (D.D.C. 2016). The Government itself acknowledged this principle in its brief submitted in *Burwell*, contending that

> a plaintiff may establish liability irrespective of an appropriation, and then if successful – it can receive the amount to which it is entitled from the permanent appropriation Congress has made in the Judgment Fund, 31 U.S.C. § 1304(a). The mere absence of a more specific appropriation is not necessarily a defense to recovery from that Fund.

Def.'s Mem. In Supp. of Mot. Summ. J. at 11, *U.S. House of Representatives v. Burwell*, No. 1:14-cv-01967-RMC, 2015 WL 9316243 (D.D.C. Dec. 2, 2015) (citing *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2191-92 (2012)).

In short, the fact that Congress did not appropriate funds specifically for the RCP is immaterial to the question of whether, in Section 1342, it created an obligation for which the Government can be held liable.

C. Later Appropriations Acts Did Not Nullify or Modify the Government's RCP Obligations.

The Government will also argue that, in any event, a subsequent Congress, through the applicable Spending Riders, prohibited HHS from making RCP payments from certain program funds, thus abrogating any mandate to pay that the Government otherwise had. This argument, too, lacks merit.

The fact that Congress curtailed HHS's ability to make RCP payments through appropriations legislation, well after the exchanges were under way and after the Government's obligations to HealthNow (and other issuers) had accrued, cannot alter the Government's RCP *liability for its extant obligations*. As discussed above, the existence of a legal obligation is distinct from the means by which the Government fulfills the Government's obligation. That Congress imposed temporary restrictions on specific funding sources for HHS to fulfill those obligations did nothing to modify the obligations. Indeed, as noted, the very fact that Congress has tried on multiple occasions to modify or repeal the ACA as a whole and the RCP specifically, and yet failed to do so, highlights the important distinction between appropriations legislation (for annual funding of discretionary government operations) and substantive legislation (which fixes rights and obligations, including of the United States itself). *See Moda*, 130 Fed. Cl. at 455-62 (finding that Congress did not intend Section 1342 to be budget-neutral and that neither the 2015 nor 2016 Spending Riders abrogated or effectuated a repeal or amendment of the RCP).

1. *Congress Tried but Failed to Amend the RCP.*

Congress knows how to amend or repeal laws it does not like. The 113th Congress, which passed the 2015 Spending Rider, directly considered two pieces of proposed legislation to amend the ACA to limit or eliminate RCP payments. *See* Obamacare Taxpayer Bailout

Protection Act, S. 2214, 113th Cong. (2014) (seeking to amend the RCP to "ensur[e] budget neutrality."); Obamacare Taxpayer Bailout Prevention Act, S. 1726, 113th Cong. (2013) (seeking to eliminate the RCP). Neither bill passed. During the 2016 budget process, Congress considered an amendment expressly indicating that "Effective January 1, 2016, the Secretary shall not collect fees and shall not make payments under [the RCP]." 161 Cong. Rec. S8420-21 (daily ed. Dec. 3, 2015) (statement of Sen. McConnell). Senator Patty Murray spoke against the amendment, raising a point of order to strike the proposed amendment, because RCP "is a vital program to make sure premiums are affordable and stable for our working families. Repealing it would result in increased premiums, more uninsured, and less competition in the market." *Id.* at S8354. The Senate then voted against the amendment. Congress also considered more narrow legislation that would have required the RCP to be administered on a budget-neutral basis. *See, e.g.*, S. Rep. No. 114-74, 12 (June 25, 2015); *see also id*. at 121, 126. Those efforts, too, failed.[19]

In other words, Congress considered modifying or repealing the RCP—but *did not do so*. Its efforts to do so highlight what is patently clear about the RCP as enacted in 2010, which remains unmodified to date: *the Government's obligation to make "payments out" was not constrained by budget neutrality*. *See, e.g.*, *ARRA Energy*, 97 Fed. Cl. at 22 n.6.

2. *Eliminating a Funding Source Does Not Negate the Obligation.*

Having failed to actually amend the ACA generally and the RCP specifically, Congress aimed lower, curtailing through the Spending Riders certain funding sources available to CMS to make RCP payments beginning with the 2015 Spending Rider, passed December 16, 2014. The Government will make much of this, but in substance it is immaterial to this lawsuit. As an initial observation, to interpret appropriations bills to have accomplished what Congress did not

[19] To date, Congress has considered dozens of amendments to the ACA generally and the RCP specifically. *See* Add. B at 3.

have the votes to accomplish through substantive legislation would render our constitutional system of checks and balances a nullity. Congress tried to repeal the ACA. It failed. Congress tried to amend the RCP. It failed. When all was said and done, all Congress did was abridge CMS's funding authority to make RCP payments from certain accounts. That is a mere administrative point; it did not modify the Government's legal obligation. *See Blanchette v. Conn. Gen. Ins. Corps.*, 419 U.S. 102, 134 (1974) ("Before holding that the result of the earlier consideration has been repealed or qualified, it is reasonable for a court to insist on the legislature's using language showing that it has made a considered determination to that end . . . ." (citations and quotations omitted)).

But even without the benefit of that additional legislative history, the Spending Riders cannot be interpreted to have accomplished what the Government suggests. The legal standard for finding that an appropriation act negated an existing statutory right is stringent—it is presumed not to happen. In this case, three related, bedrock principles undermine the Government's position. *First*, even where the change would have only prospective effect, Congress is presumed not to amend preexisting substantive statutory obligations except where it signals otherwise "expressly or by clear implication." *Prairie Cty.*, 782 F.3d at 689 (citations omitted); *accord United States v. Welden*, 377 U.S. 95, 102 n.12 (1964) ("Amendments by implication, like repeals by implication, are not favored."). Nothing in the Spending Riders expresses or clearly implies an intent to abolish the obligation created by Section 1342.

Second, this general rule of statutory interpretation "applies with especial force when the provision advanced as the repealing measure was enacted in an appropriations bill." *United States v. Will*, 449 U.S. 200, 221-22 (1980) (emphasis added). Because appropriations laws "have the limited and specific purpose of providing funds for authorized programs," the statutory

instructions included in them are presumed not to impact substantive law. *See TVA v. Hill*, 437 U.S. 153, 190 (1978). "[I]t can be strongly presumed that Congress will specifically address language on the statute books that it wishes to change." *United States v. Fausto*, 484 U.S. 439, 453 (1988); *Greenlee Cty.*, 487 F.3d at 877 ("It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear implication, the substantive law, does not in and of itself defeat a Government obligation created by statute." (citing *N.Y. Airways*, 369 F.2d at 748)). By their terms, the 2016 and 2017 Spending Riders merely restricted HHS's ability to use certain sources of money to make payments under the RCP; they did not change the law or the Government's legal obligation under Section 1342, or signal an intent to modify what Congress had previously legislated in Section 1342.[20] Restricting appropriations alone, without more, does not amend the underlying legislation. *See Greenlee Cty.*, 487 F.3d at 877; *Gibney*, 114 Ct. Cl. at 53 (noting that the court "know[s] of no case in which any of the courts have held that a simple limitation on an appropriation bill of the use of funds has been held to suspend a statutory obligation"). Nor does it absolve the Government of its obligation to make payments mandated by law. *See id.*

Third, even if the Government could overcome the presumption against implied repeal or amendment generally—which it cannot—it would run headlong into an insurmountable wall in this case given that its position, if adopted, would result in the *retroactive* negation of the Government's obligation. After all, by the time Congress said anything about appropriations for RCP payments for the respective benefit years, HealthNow had already acted in reliance on the RCP. For benefit years 2014, 2015, and 2016, the Government's obligation (albeit undefinitized) accrued no later than October 2013, when HealthNow and the New York State

[20] *See* 2016 Spending Rider; 2017 Spending Rider.

Department of Health fully executed a Health Benefit Exchange Contract effective October 1, 2013. That contract required HealthNow to undertake myriad obligations in connection with offering QHPs on the exchanges well *before* Congress enacted any appropriation restricting RCP funding for that year. Judge Wheeler recognized this in *Molina*, where he flatly rejected—as "wholly without merit"—the Government's argument that any obligation existing under Section 1342 could not accrue until, at the earliest, the time that costs are tabulated, in the year following the applicable benefit year. *Molina*, 133 Fed. Cl. at 38. That may be when a QHP issuer's legal claim to its payment accrues, but it is bedrock fiscal law that the obligation can accrue long before the purely administrative task of tabulating the definite amount owed. *See* II GAO, *Principles of Fed. Appropriations Law*, at 7-4 - 7-5, *available at* http://www.gao.gov/legal/redbook/overview (emphasis added) (An "obligation arises when the definite commitment is made, *even though the actual payment may not take place until a future fiscal year*. . . . [T]he term 'obligation' includes both matured and unmatured commitments . . . . An unmatured commitment is a liability which is *not yet payable* but for which a definite commitment nevertheless exists.").

Applicable case law amplifies these principles and illustrates the Government's flawed reasoning. In *Langston*, for example, the diplomatic representative to Haiti sued when Congress failed to appropriate sufficient funds to pay his statutorily set salary. 118 U.S. at 390. Under the original statute, "[t]he representative at Ha[i]ti shall be entitled to a salary of $7,500 a year" and a subsequent appropriation set the salary "for the service of the fiscal year ending June 30, 1883, out of any money in the treasury, not otherwise appropriated, for the objects therein expressed" at $5,000. *Id.* at 390-91. The Supreme Court emphasized the importance of clear language repealing or amending a statute. For example, it distinguished the language of the appropriation

at issue from one in which Congress clearly indicated an intent to repeal previously set salaries, because the subsequent appropriation explicitly set out a new compensation system designed to replace the prior one. *Id.* at 392-93. The Court reasoned that the appropriation at issue did not contain "any language to the effect that such sum shall be 'in full compensation' for those years" or other provisions "from which it might be inferred that congress intended to repeal the act." *Id.* at 393. Reiterating that "[r]epeals by implication are not favored," the Supreme Court held that it must give effect to both provisions where possible and:

> While the case is not free from difficulty, the court is of opinion that, according to the settled rules of interpretation, a statute fixing the annual salary of a public officer at a named sum, without limitation as to time, should not be deemed abrogated or suspended by subsequent enactments which merely appropriated a less amount for the services of that officer for particular fiscal years, and which contained no words that expressly, or by clear implication, modified or repealed the previous law.

Id. at 393-94; *see also Gibney*, 114 Ct. Cl. at 49-50 ("There is nothing in the wording of the [appropriations] proviso . . . which would warrant a conclusion that it was intended to effect the repeal of the [original] codified provisions of the act . . . .").

Judge Wheeler analyzed the relevant cases in his decisions in *Moda* and *Molina* and observed two types of cases where courts have found a congressional intent to abridge, by way of appropriations, a substantive legal obligation. The first type involves appropriations that bar the administering agency from using funds from *any* appropriation, signaling an intent to choke off all funding, and thus to negate the obligation. *See Moda*, 130 Fed. Cl. at 459-62 (citing *United States v. Dickerson*, 310 U.S. 554, 554-55, 60-62 (1940); *Will*, 449 U.S. at 205-08, 222-224). A second type involves Congress affirmatively dedicating a specific appropriation to the obligation at issue, signaling exclusivity, and thus a newly imposed limitation on the obligation. *See Molina*, 133 Fed. Cl. at 38-40 (citing *Highland Falls–Fort Montgomery Cent. School Dist. v. United States*, 48 F.3d 1166, 1168-72 (Fed. Cir. 1995)). As Judge Wheeler pointed out, the

Spending Riders invoked in RCP litigation by the Government do not match either type. All Congress did in the 2016 and 2017 Spending Riders was cut off specific funding sources, not "all" funding sources, and Congress was silent as to the RCP obligation itself. Indeed, Judge Wheeler pointed out that Congress used the "any appropriation" limitation in *other* provisions of the Spending Riders, unrelated to the RCP, making its absence from the provision regarding the RCP all the more probative of the limited reach of the RCP funding restrictions. *See Moda*, 130 Fed. Cl. at 462.

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Because Congress has not amended or repealed the RCP, and because nothing in the 2016 and 2017 Spending Riders changes the obligation of the Government under Section 1342, the Government remains liable in full for its RCP obligations.

II. THE GOVERNMENT IS LIABLE FOR BREACH OF THE IMPLIED-IN-FACT CONTRACT WITH HEALTHNOW (COUNT II).

This Court has jurisdiction over implied contract claims, 28 U.S.C. § 1491(a)(1), and the Judgment Fund is available to pay judgments. *Slattery*, 635 F.3d at 1303, 1317-21. All elements of an implied contract are met here,[21] and HealthNow is entitled to the contractually obligated amounts. The Government held out a unilateral offer of RCP payments to induce HealthNow and other QHP issuers to begin performance by expanding coverage for millions of Americans. HealthNow accepted the Government's offer by beginning performance on the Exchange. The Government's offer became irrevocable at the point of acceptance, which occurred prior to the passage of the Spending Riders.

[21] Implied contracts require: (1) mutuality of intent; (2) unambiguous offer and acceptance; (3) consideration; and (4) actual authority of the Government contracting representative, or ratification. *E.g.*, *Lewis v. United States*, 70 F.3d 597, 600 (Fed. Cir. 1995).

1. *There Was Mutuality of Intent to Contract.*

The Government enters contracts when its conduct or language "allows a reasonable inference" that it intended to. *ARRA Energy*, 97 Fed. Cl. at 27. The surrounding circumstances include the statutory purpose, context, legislative history, or any other objective indicia of actual intent.[22] The combination of Section 1342, HHS's implementing regulations, and the Government's conduct (before and after Plaintiff agreed to become a QHP) support that the "conduct of the parties show[], in the light of the surrounding circumstances, their tacit understanding." *Hercules, Inc. v. United States*, 516 U.S. 417, 424 (1996); *see, e.g.*, Compl. ¶¶ 79-92.

This longstanding test is best illustrated in *Radium Mines Inc. v. United States*, 153 F. Supp. 403 (Ct. Cl. 1957), where the court found that a regulation establishing a guaranteed minimum Government purchase price for uranium was not "a mere invitation to the industry to make offers to the Government," and was an intent to contract, because the regulation's purpose was to "induce persons to find and mine uranium." *Id.* at 405-06. In other words, the case focused on the regulations' "promissory" nature in finding an implied-in-fact contract.[23] The

[22] *See, e.g*., *Nat'l R.R. Passenger Corp. v. Atchison Topeka & Santa Fe Ry. Co*., 470 U.S. 451, 468 (1985); *U.S. Trust Co. of N.Y. v. New Jersey*, 431 U.S. 1, 17-18 (1977) (while the statute did not expressly state an intent to contract, it was "properly characterized as a contractual obligation" when considering the purpose of the agreement and the fact that the Government "received the benefit they bargained for"); *Prudential Ins. Co. of Am. v. United States*, 801 F.2d 1295, 1297 (Fed. Cir. 1986) (an implied-in-fact contract "is not created or evidenced by explicit agreement of the parties, but is inferred as a matter of reason or justice from the acts or conduct of the parties"); *Nat'l Educ. Ass'n.-R.I. v. Ret. Bd. of R.I. Emps.' Ret. Sys.*, 890 F. Supp. 1143, 1152 (D.R.I. 1995) (quoting *U.S. Trust Co.*, 431 U.S. at 17 n.14) ("[T]his Court is not limited to an examination of statutory language when it determines whether a statute amounts to a contract," but also should evaluate "the circumstances").

[23] *See also Wells Fargo Bank, N.A. v. United States*, 26 Cl. Ct. 805, 810 (1992) ("'There is ample case law holding that a contractual relationship arises between the government and a private party if promissory words of the former induce significant action by the latter in reliance thereon.' Thus, where a unilateral contract is at issue, the fact that only one party has made a promise does not imply that a contract does not exist. A contract comes into existence as soon as

Supreme Court agreed, describing *Radium Mines* as a case "where contracts were inferred from regulations promising payment" for Tucker Act jurisdiction purposes.[24] *Army & Air Force Exch. Serv. v. Sheehan*, 456 U.S. 728, 739 n.11 (1982).

Applying this precedent, it is clear that the purpose of the RCP was to minimize risks for insurers and thereby *induce* them to offer affordable insurance coverage to previously uninsured or underinsured population. The Government recognized that insurers would be unwilling to enter this untested market without significant risk mitigation to protect against uncertainties. As such, the RCP payment scheme was designed to mitigate the uncertainty, and it—along with HHS's express and repeated assurances of full payment—drew insurers to enter the market and offer affordable coverage. The RCP's promissory nature evidences the Government's intent to enter into a binding contract to make full RCP payments to plans that performed in accordance with RCP's requirements.

The fact that the RCP contained numerous requirements[25] that QHP issuers had to fulfill in order to receive payment further helps establish that the Government was required to make payment once those requirements were met. In *New York Airways*, this Court described the mandatory statutory payment in that case as creating an implied contract once the plaintiff had

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the other party commences performance." (quoting *Nat'l Rural Util. Coop. Fin. Corp. v. United States*, 14 Cl. Ct. 130, 137 (1988)) (internal citations omitted)).

[24] The fact that *Radium Mines* involved a purchase contract for uranium that met the regulatory qualifications is irrelevant, as the crux of *Radium Mines* is that "the regulations at issue were promissory in nature." *Baker v. United States*, 50 Fed. Cl. 483, 490 (2001) (citations omitted).

[25] These include submission of, or compliance with, Government standards regarding: (1) "issuer participation" (45 C.F.R. § 156.200); (2) detailed rate and benefit submissions (45 C.F.R. § 156.210); (3) enrollment data, claims payment policies and practices, and periodic financial disclosures (45 C.F.R. § 156.220); (4) a provider network that meets federal standards (45 C.F.R. § 156.230); (5) enrollment of individuals during specified enrollment periods (45 C.F.R. § 156.260); (6) standards governing termination of coverage or enrollment (45 C.F.R. § 156.270); (7) reporting of prescription drug distribution and costs (45 C.F.R. § 156.295); and (8) cost-sharing reductions and monitoring of cost-sharing payment requirements (45 C.F.R. § 156.410).

satisfied the requirements for payment. 369 F.2d at 751 (holding that the actions of the parties support the existence of a contract at least implied in fact that the agency's order was "in substance, an offer by the Government to pay the plaintiffs a stipulated compensation for the transportation of mail, and the actual transportation of the mail was the plaintiffs' acceptance of that offer").

Similarly, when the Government includes "numerous requirements . . . to receive the payments" those payments are "compensatory in nature," and one can accept such offer for payment through satisfaction of the listed requirements. *See Aycock-Lindsey Corp. v. United States*, 171 F.2d 518, 521 (5th Cir. 1948). Here, the ACA contained a host of requirements for fixed payment, and when the QHP issuers met such requirements, the mutuality of intent formed an implied-in-fact contract, obligating the Government to pay QHP issuers.[26]

2. *HealthNow Accepted the Government's Offer, and the Condition Precedent to Payment Was Satisfied.*

The Government *offered* RCP payments to insurers through the language of Section 1342, regulations, and HHS's numerous publications and affirmations. Insurers then *accepted* the offer by beginning performance and providing QHP services, thus executing an enforceable unilateral contract.[27] Specifically, HealthNow accepted the Government's offer by complying with the numerous and extensive QHP administrative requirements and actually serving the high-cost, at-risk population of formerly uninsured individuals. Courts have found such exchange to constitute unambiguous offer and acceptance without any explicit reference to an offer or

[26] Further, none of the countervailing factors in *Baker* are present here. *See* 50 Fed. Cl. at 491-93.

[27] In a unilateral contract, the offeree may only accept the offer by performing its contractual obligations. *See Contract*, Black's Law Dictionary (10th ed. 2014) (defining "unilateral contract" as "[a] contract in which only one party makes a promise or undertakes a performance."); *Lucas v. United States*, 25 Cl. Ct. 298, 304 (1992) (explaining that a prize competition is a unilateral contract because it requires participants to submit entries in return for a promise to consider those entries and award a prize).

contract.[28] The Government's offer became irrevocable at the point of acceptance—the subsequent Spending Riders neither unwound the enforceable contract nor relieved the Government of its burden to make full payment.

3. *There Was Consideration.*

Consideration at the time of contract formation flowed both ways. QHP issuers are the backbone of the Government's effort to provide affordable and comprehensive coverage through the exchanges and, *but for* the Government's promise of risk stabilization, insurers would not have offered plans with such restrictive and elaborate conditions, whose financial viability had never before been tested. When HealthNow agreed to offer a QHP, the Government and HealthNow committed to an intricate set of specific, reciprocal obligations.[29] The Government benefitted by HealthNow's servicing of formerly uninsured, high-cost enrollees at reasonable premiums (that accounted for anticipated RCP risk-sharing) in compliance with its extensive QHP standards. Indeed, the calculation of RCP payments is based on the costs incurred by QHP issuers to provide those benefits. In exchange, HealthNow received consideration because HHS committed that *only* QHP issuers would receive RCP payments (to the exclusion of other insurers), 45 C.F.R. § 153.510, and that HHS would make timely and full RCP payments. *Ace-Fed. Reporters, Inc. v. Barram*, 226 F.3d 1329, 1332 (Fed. Cir. 2000) (Government buying from "between two and five authorized sources," to the exclusion of others, was "consideration" with "substantial business value.").

4. *The Secretary of HHS Had Actual Authority to Contract.*

Actual authority to contract can be express or implied—either is sufficient to bind the

[28] *Radium Mines*, 153 F. Supp. at 405-06 (risk stabilization and minimum prices constituted offer which "induced" companies to accept through performance); *N.Y. Airways v. United States*, 369 F.2d 743 (Ct. Cl. 1966) (finding published "board rate" for aviation transportation services constituted an offer that plaintiff accepted through performance).
[29] *See supra* note 25.

Government. *H. Landau & Co. v. United States*, 886 F.2d 322, 324 (Fed. Cir. 1989). Agency Heads have contract-making authority "by virtue of their position." FAR § 1.601(a) (contractual authority in each agency flows *from* the Agency Head to delegated officials).[30]

Moreover, Section 1342's instruction that the Secretary "shall establish" the RCP and "shall pay" RCP payments, along with the Secretary's broad obligation to administer and implement the ACA,[31] give the Secretary the express (or at least implied) authority to enter into binding agreements with QHP issuers to implement the ACA. *See Winstar Corp*., 518 U.S. at 890 n.36; *H. Landau*, 886 F.2d at 324; *California v. United States*, 271 F.3d 1377, 1383-84 (Fed. Cir. 2001) (statute granted Interior Secretary authority to enter into binding agreements). Coverage through exchanges is carried out exclusively through private insurers' QHPs, and the ability to contract with them is "integral" to the Secretary's ability to effectuate her statutory duty to implement the RCP. *See id*. Indeed, where contracts have been inferred from statutes promising payment, the Government's authority to contract is clear. *See, e.g.*, *Radium Mines*, 153 F. Supp. at 405-06; *N.Y. Airways*, 369 F.2d at 751-52.

Even if no appropriated funds were available, the ADA expressly permits agencies to enter into contracts whenever "authorized by law." 31 U.S.C. § 1341(a)(1)(B) (officials restricted from contracting "before an appropriation is made ***unless authorized by law***."). For example, in *California*, 271 F.3d at 1383-84, the Interior Secretary entered into a binding contract which was not *ultra* vires—despite the fact that "[n]o funds were appropriated" and Congress likely did not "contemplate a breach-of-contract claim arising from [the statute]"—

[30] *Accord United States v. Winstar Corp*., 518 U.S. 839, 890 n.36 (1996) ("The authority of the executive to use contracts in carrying out authorized programs is . . . generally assumed in the absence of express statutory prohibitions or limitations." (quoting 1 R. Nash & J. Cibinic, Federal Procurement Law 5 (3d ed. 1977))); *H. Landau*, 886 F.2d at 324 (authority to bind the Government "is generally implied" where such authority is integral to execute program duties).
[31] *See* ACA §§ 1001, 1301(a)(1)(C)(iv), 1302(a)-(b), 1311(c)-(d).

because Congress "expressly authoriz[ed] the Secretary . . . to negotiate and enter into *an agreement* . . . ." Here, similarly, the ACA expressly (1) authorized the HHS Secretary to enter into agreements with insurers to offer QHPs, (2) authorized the HHS Secretary to develop regulations with which QHP issuers were required to comply, and (3) mandated that he "shall pay" RCP funds. Per precedent, the Secretary had actual authority (by position) and was impliedly authorized (by statute) to enter into binding agreements, regardless of appropriations, and the resulting agreements were not *ultra vires*. *See id*.; ACA § 1301(a)(1)(C)(iv).

Third, HHS's "actual authority" (to enter into binding agreements) is separate and distinct from whether HHS's contracts were *ultra vires*. "Actual authority" exists as a function of position, FAR 1.601(a); its existence does not flow from whether a particular action complied with all statutory and regulatory requirements in existence. *Even if* entering into agreements with QHP issuers violated the ADA (it did not), the Secretary's unauthorized commitment still *binds* the Government unless the alleged illegality (vis-a-vis the ADA) was patent and "palpably illegal" at the time of formation. *John Reiner & Co. v. United States*, 325 F.2d 438, 440 (Ct. Cl. 1963) ("[T]he court should ordinarily impose the binding stamp of nullity only when the illegality is plain."); *Trilon Educ. Corp. v. United States*, 578 F.2d 1356, 1360 (Ct. Cl. 1978) ("[Government] officers must find their way through a maze of statutes and regulations . . . . It would be unfair for [contractors] to suffer for every deviation . . . . [T]he court has preferred to allow the contractor to recover on the ground that the contracts were not palpably illegal to the [contractor's] eyes."). Here, the ACA's requirement that QHPs comply with, *inter alia*, regulations developed by the Secretary coupled with its authorization that he "establish," "administer," and "pay" RCP amounts to insurers demonstrate clear authority. ACA § 1301(a)(1)(C)(iv). Any alleged conflict with the ADA was certainly not "palpably illegal"

because HealthNow unquestionably lacked insight into the maze of arcane Government fiscal accounting procedures that existed when HealthNow "accepted" the Government's unilateral offer by beginning performance.

* * * * *

In sum, the ACA created an implied-in-fact contract with insurers like HealthNow under which the Government owed HealthNow RCP payments if HealthNow offered a QHP on the exchange pursuant to QHP issuer standards and suffered losses. HealthNow sold QHPs on the New York exchange as a QHP issuer and suffered losses. The Government breached its reciprocal contractual duty by failing to make full risk corridors payments as promised. Therefore, there is no genuine dispute that the Government is liable to HealthNow under the implied-in-fact contract, and HealthNow is entitled to summary judgment on that basis.

III. THIS COURT CAN GRANT HEALTHNOW THE RELIEF SOUGHT.

This Court can enter judgment for HealthNow irrespective of how such a judgment will be satisfied by the political branches. "This court . . . does not deal with questions of appropriations, but with the legal liabilities incurred by the United States . . . ." *Collins*, 15 Ct. Cl. at 35. As noted, "[t]he judgment of a court has nothing to do with the means—with the remedy for satisfying a judgment. It is the business of courts to render judgments, leaving to Congress and the executive officers the duty of satisfying them." *Gibney*, 114 Ct. Cl. at 52; *see Slattery*, 635 F.3d at 1317 ("The purpose of the Judgment Fund was to avoid the need for specific appropriations to pay judgments awarded by the Court of Claims."); *N.Y. Airways*, 369 F.2d at 748 ("The failure [of Congress] to appropriate funds to meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights are enforceable in [this Court]."). If this Court determines that HealthNow is owed funds under the RCP, it will be for the Government to determine how to fulfill that obligation.

CONCLUSION

HealthNow respectfully requests that its motion for summary judgment be granted because, based on the undisputed facts, the Government owes HealthNow timely annual and complete RCP payments as a matter of law. Specifically, HealthNow requests monetary relief in the amounts to which Plaintiff is entitled under Section 1342 of the Affordable Care Act and 45 C.F.R. § 153.510(b), *i.e.*, $9,619,385.01 (for benefit year 2015), and $29,119,555 for benefit year 2016 (for benefit year 2016), totaling $38,738,940. Given the significance of this matter, undersigned counsel respectfully requests that the Court hold argument on this Motion at its earliest convenience.

Dated: September 18, 2017

Respectfully submitted,

/s/ Stephen McBrady

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CERTIFICATE OF SERVICE

I certify that on September 18, 2017, a copy of the forgoing "Plaintiff's Motion for Summary Judgment and Memorandum of Law in Support," along with (1) Addendum A, and (2) Addendum B, was filed electronically using the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be served on Defendant's Counsel via the Court's ECF system.

/s/ Stephen McBrady
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ADDENDUM A

DOCUMENT 1

FEDERAL REGISTER

Vol. 76 Friday,
No. 136 July 15, 2011

Part III

Department of Health and Human Services

45 CFR Part 153
Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Proposed Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9975–P]

RIN 0938–AR07

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

AGENCY: Department of Health and Human Services.

ACTION: Proposed rule.

SUMMARY: This proposed rule would implement standards for States related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent with title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. These programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges (''Exchanges'') are implemented, starting in 2014. The transitional State-based reinsurance program serves to reduce the uncertainty of insurance risk in the individual market by making payments for high-cost cases. The temporary Federally-administered risk corridor program serves to protect against uncertainty in the Exchange by limiting the extent of issuer losses (and gains). On an ongoing basis, the State-based risk adjustment program is intended to provide adequate payments to health insurance issuers that attract high-risk populations (such as individuals with chronic conditions).

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5 p.m. Eastern Standard Time (E.S.T.) on September 28, 2011.

ADDRESSES: In commenting, please refer to file code CMS–9975–P. Because of staff and resource limitations, we cannot accept comments by facsimile (Fax) transmission.

You may submit comments in one of four ways (please choose only one of the ways listed):

1. *Electronically.* You may submit electronic comments on this regulation to *http://www.regulations.gov.* Follow the instructions under the ''More Search Options'' tab.

2. *By regular mail.* You may mail written comments to the following address *only:* Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–9975–P, P.O. Box 8010, Baltimore, MD 21244–8010.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. *By express or overnight mail.* You may send written comments to the following address *only:* Centers for Medicare & Medicaid Services, Department of Health and Human Services, *Attention:* CMS–9975–P, Mail Stop C4–26–05, 7500 Security Boulevard, Baltimore, MD 21244–1850.

4. *By hand or courier.* If you prefer, you may deliver (by hand or courier) your written comments before the close of the comment period to either of the following addresses:

a. For delivery in Washington, DC: Centers for Medicare & Medicaid Services, Department of Health and Human Services, Room 445–G, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201.

(Because access to the interior of the Hubert H. Humphrey Building is not readily available to persons without Federal government identification; commenters are encouraged to leave their comments in the CMS drop slots located in the main lobby of the building. A stamp-in clock is available for persons wishing to retain a proof of filing by stamping in and retaining an extra copy of the comments being filed.)

b. For delivery in Baltimore, MD: Centers for Medicare & Medicaid Services, Department of Health and Human Services, 7500 Security Boulevard, Baltimore, MD 21244–1850.

If you intend to deliver your comments to the Baltimore address, please call telephone number (410) 786–9994 in advance to schedule your arrival with one of our staff members.

Comments mailed to the addresses indicated as appropriate for hand or courier delivery may be delayed and received after the comment period.

Submission of comments on paperwork requirements. You may submit comments on this document's paperwork requirements by following the instructions at the end of the ''Collection of Information Requirements'' section in this document.

For information on viewing public comments, see the beginning of the **SUPPLEMENTARY INFORMATION** section.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold at (301) 492–4415 for general information.

Wakina Scott at (301) 492–4393 for matters related to reinsurance and risk corridors.

Kelly O'Brien at (301) 492–4399 for matters related to risk adjustment.

Grace Arnold at (301) 492–4272 for matters related to the collection of information requirements.

Brigid Russell at (301) 492–4421 for matters related to the summary of preliminary regulatory impact analysis.

Abbreviations:

Affordable Care Act—The collective term for the Patient Protection and Affordable Care Act (Pub. L. 111–148) and the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152)

CMS Centers for Medicare & Medicaid Services

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)

MLR Medical Loss Ratio

PHS Act Public Health Service Act (42 U.S.C. 201 *et seq.*)

QHP Qualified Health Plan

SUPPLEMENTARY INFORMATION:

Submitting Comments: We welcome comments from the public on all issues set forth in this proposed rule to assist us in fully considering issues and developing policies. Comments will be most useful if they are organized by the section of the proposed rule to which they apply. You can assist us by referencing the file code [CMS–9975–P] and the specific ''issue identifier'' that precedes the section on which you choose to comment.

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all electronic comments received before the close of the comment period on the following public Web site as soon as possible after they have been received: *http://www.regulations.gov.* Follow the search instructions on that Web site to view public comments. Comments received timely will be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at Room 445–G, Department of Health and Human Services, Hubert H. Humphrey Building, 200 Independence Avenue, SW., Washington, DC 20201, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, call 1–800–743–3951.

across which risk is distributed in risk adjustment.

2. Risk Adjustment Administration (§ 153.310)

Section 1343(a) of the Affordable Care Act establishes that States must assess risk adjustment charges and provide risk adjustment payments based on plan actuarial risk as compared to a State average. We interpret this provision to mean that risk pools must be aggregated at the State level, even if a State decides to utilize regional Exchanges. Furthermore, section 1343(c) indicates that risk adjustment applies to individual and small group market health insurance issuers of non-grandfathered plans within a State, both inside and outside of the Exchange. Accordingly, similar to our approach in reinsurance, if multiple States contract with a single entity to administer risk adjustment, risk may not be combined across State lines, but must be pooled at the individual State-level.

In this section, in paragraph (a)(1), we specify that any State electing to establish an Exchange is eligible to establish a risk adjustment program. Pursuant to section 1321(a)(1)(D) of the Affordable Care Act, we propose in paragraph (a)(2) that for States that do not operate an Exchange, HHS will establish a risk adjustment program. We also clarify in (a)(3) that HHS will administer all of the risk adjustment functions for any State that elects to establish an Exchange but does not elect to administer risk adjustment. In paragraph (b), we clarify that the State may elect to have an entity other than the Exchange perform the risk adjustment functions of this subpart provided that the selected entity meets the requirements for eligibility to serve as the Exchange proposed in § 155.110 of the notice of proposed rulemaking entitled, ''Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans.''

In paragraph (c), we propose timeframes for completion of the risk adjustment process. We propose that all payment calculations must commence with the 2014 benefit year. The Affordable Care Act does not explicitly set forth a timeframe by which risk adjustment programs must start. However, we believe risk adjustment must be coordinated with reinsurance and risk corridors to help stabilize the individual and small group markets and ensure the viability of the Exchanges, which begin in 2014. Timely completion of the risk adjustment process is important because risk adjustments affect calculations of both risk corridors and the rebates specified under section 2718 of the PHS Act. By law, HHS will be performing the risk corridors calculations for all qualified health plans (QHP) in all States. Therefore, we seek comment on the appropriate deadline by which risk adjustment must be completed. For example, HHS may require that States complete risk adjustment activities by June 30 of the year following the benefit year. This timing assumes at least a three-month lag from items and services furnished in a benefit year and the end of the data collection period. This approach is similar to the Medicare Advantage (Part C) risk adjustment data submission, in which the annual deadline for risk adjustment data submission is 2-months after the end of the 12-month benefit period, but may, at CMS's discretion, include a 6-month lag time.

Since risk adjustment is designed as a budget neutral activity, States would likely need to receive remittances from issuers of low actuarial risk plans before making payments to issuers of high actuarial risk plans. We seek comment on an appropriate timeframe for State commencement of payments.

To ensure the each State's risk adjustment program is functioning properly, we believe that States should provide HHS with a summary report of risk adjustment activities for each benefit year in the year following the calendar year covered in the report. The summary report should include the average actuarial risk score for each plan, corresponding charges or payments, and any additional information HHS deems necessary to support risk adjustment methodology determinations. We seek comment on the requirements for such reports, including data elements and timing.

3. Federally-Certified Risk Adjustment Methodology (§ 153.320)

Section 1343(b) of the Affordable Care Act requires HHS to establish criteria and methods for risk adjustment in coordination with the States. We interpret this provision to mean that HHS will establish a baseline methodology to be used by a State, or HHS on behalf of the State, in determining average actuarial risk. To fulfill the terms of that basic requirement, we propose in paragraph (a)(1) a Federally-certified risk adjustment methodology that will be developed and authorized by HHS. Section 1343 indicates that the Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act. We seek to minimize issuer burden and will leverage existing processes of part C and D wherever appropriate while recognizing the differences in market demographics in determining methodologies.

We considered proposing a requirement that all States utilize a Federally-certified risk adjustment methodology that was developed and promulgated by HHS. However, we recognize that States may have alternative methods that can achieve similar results. We also know that some States have already implemented risk adjustment models for programs such as Medicaid. We believe that the terms ''methods and criteria'' in the Affordable Care Act can be interpreted to allow certain levels of State variation provided that States meet basic Federal standards. Therefore, we propose in paragraph (a)(2) that a State-submitted alternative risk adjustment methodology may become a Federally-certified risk adjustment methodology through HHS certification. States that would like to use other methodologies should view the Federally-certified risk adjustment methodology as a comparative standard for their alternate risk adjustment methodologies. A State's alternate risk adjustment methodology should offer similar or better performance in that State than the Federally-certified risk adjustment methodology as determined based on the criteria set forth in § 153.330(a)(2). After HHS approves a State alternative risk adjustment methodology, that methodology is considered a Federally-certified risk adjustment methodology.

We propose in paragraph (b) of this section that a State that is operating a risk adjustment program must use one of the Federally-certified risk adjustment methodologies that HHS will publish in a forthcoming annual Federal notice of benefit and payment parameters or that has been published by the State in that State's annual notice, as described in § 153.110(b). These notices will include a full description of the risk adjustment model, including but not limited to: demographic factors, diagnostic factors, and utilization factors if any; the qualifying criteria for establishing that an individual is eligible for a specific factor; the weights assigned to each factor; the data required to support the model; and information regarding the deadlines for data submission and the schedule for risk adjustment factor determination. We seek comments on other information that should be included in this notice.

In paragraph (b)(2), we propose that the risk adjustment methodology will also describe any adjustments made to

DOCUMENT 2

FEDERAL REGISTER

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No. 57 March 23, 2012

Part IV

Department of Health and Human Services

45 CFR Part 153
Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment; Final Rule

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9975–F]

RIN 0938–AR07

Patient Protection and Affordable Care Act; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment

AGENCY: Department of Health and Human Services.

ACTION: Final rule.

SUMMARY: This final rule implements standards for States related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent with title I of the Patient Protection and Affordable Care Act as amended by the Health Care and Education Reconciliation Act of 2010, referred to collectively as the Affordable Care Act. These programs will mitigate the impact of potential adverse selection and stabilize premiums in the individual and small group markets as insurance reforms and the Affordable Insurance Exchanges (''Exchanges'') are implemented, starting in 2014. The transitional State-based reinsurance program serves to reduce uncertainty by sharing risk in the individual market through making payments for high claims costs for enrollees. The temporary Federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government. The permanent State-based risk adjustment program provides payments to health insurance issuers that disproportionately attract high-risk populations (such as individuals with chronic conditions).

DATES: *Effective Date:* These regulations are effective on May 22, 2012.

FOR FURTHER INFORMATION CONTACT:

Sharon Arnold at (301) 492–4415 or Laurie McWright at (301) 492–4372 for general information.

Wakina Scott at (301) 492–4393 for matters related to reinsurance.

Grace Arnold at (301) 492–4272 for matters related to risk adjustment.

Jeff Wu at (301) 492–4416 for matters related to risk corridors.

SUPPLEMENTARY INFORMATION:

Abbreviations

CMS Centers for Medicare & Medicaid Services

HHS U.S. Department of Health and Human Services

HIPAA Health Insurance Portability and Accountability Act of 1996 (Pub. L. 104–191)

MLR Medical Loss Ratio

PCIP Pre-existing Condition Insurance Plan

PHS Act Public Health Service Act (42 U.S.C. 201 *et seq.*)

QHP Qualified Health Plan

Table of Contents

I. Background

A. Legislative Overview

Starting in 2014, individuals and small businesses will be able to purchase private health insurance through State-based competitive marketplaces called Affordable Insurance Exchanges, or ''Exchanges.'' Exchanges will offer Americans competition, choice, and clout. Insurance companies will compete for business on a level playing field, driving down costs. Consumers will have a choice of health plans to fit their needs. In addition, Exchanges will give individuals and small businesses the same purchasing power as big businesses. The Departments of Health and Human Services, Labor, and the Treasury are working in close coordination to release guidance related to Exchanges in several phases. A Request for Comment relating to Exchanges was published in the **Federal Register** on August 3, 2010. An Initial Guidance to States on Exchanges was issued on November 18, 2010. A proposed rule for the application, review, and reporting process for waivers for State innovation was published in the **Federal Register** on March 14, 2011. Two proposed rules, including the proposed form of this rule, were published in the **Federal Register** on July 15, 2011 to implement components of Exchanges and health insurance premium stabilization programs (that is, reinsurance, risk corridors, and risk adjustment) from the Affordable Care Act. A proposed rule regarding eligibility for Exchanges was published in the **Federal Register** on August 17, 2011. A proposed rule on the Health Insurance Premium Tax Credit was published in the **Federal Register** on August 17, 2011. A proposed rule making changes to eligibility for the Medicaid program was published in the **Federal Register** on August 17, 2011. The final versions of the Exchange Establishment and Eligibility rules were made available for public inspection at the Office of the Federal Register on March 12, 2012. A final version of the Medicaid rule is being made available for public inspection at the Office of the Federal Register on the same date as this rule.

Section 1341 of the Affordable Care Act provides that each State must establish a transitional reinsurance program to help stabilize premiums for coverage in the individual market during the first three years of Exchange operation (2014 through 2016). Section 1342 provides that HHS must establish a temporary risk corridors program that will apply to QHPs in the individual and small group markets for the first three years of Exchange operation (2014 through 2016). Section 1343 provides that each State must establish a permanent program of risk adjustment for all non-grandfathered plans in the individual and small group markets both inside and outside of the Exchanges. These risk-spreading mechanisms, which will be implemented by HHS and the States, are designed to mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets. If a State chooses not to establish a transitional reinsurance program or a risk adjustment program, this final rule provides that HHS will do so on its behalf.

Section 1321(a) also provides broad authority for HHS to establish standards and regulations to implement the statutory requirements related to reinsurance, risk adjustment, and the other components of title I of the Affordable Care Act. Section 1321(a)(2) requires, in issuing such regulations, HHS to engage in stakeholder consultation in a way that ensures balanced representation among interested parties. We describe the consultation activities HHS has undertaken later in this introduction. Section 1321(c)(1) authorizes HHS to establish and implement reinsurance,

care, but were not specific to the proposed rule.

Comments that were specific to the proposed rule represented a wide variety of stakeholders, including States and tribal organizations, health insurance issuers, consumer groups, healthcare providers, industry experts, and members of the public. Many commenters emphasized the importance of the premium stabilization programs as Exchanges and insurance reforms are implemented and addressed the balance between flexibility for States and standardization and predictability for consumers nationwide.

A. Subpart A—General Provisions

1. Basis and Scope (§ 153.10)

Section 153.10(a) of subpart A specified that the general statutory authority for the standards proposed in part 153 are based on the following sections of title I of the Affordable Care Act: sections 1321 and 1341–1343. Section 153.10(b) specified that this part establishes standards for the establishment and operation of a transitional reinsurance program, a temporary risk corridors program, and a permanent risk adjustment program. We received a number of supportive comments on these provisions and we are finalizing them without modification.

2. Definitions (§ 153.20)

In § 153.20, § 153.200, § 153.300, and § 153.600 of the proposed rule, we set forth definitions for terms that are critical to the reinsurance, risk adjustment, and risk corridors programs. Many of the definitions presented in § 153.20 were taken directly from the Affordable Care Act or from existing regulations. New definitions were created to carry out the regulations in part 153. When a term is defined in part 153 other than in subpart A, the definition of the term is applicable only to the relevant subpart or section. The application of the terms defined in § 153.20 is limited to part 153.

Considering the comments received, we are finalizing this section as proposed, with the following modifications:

We are moving a number of definitions that previously appeared in subparts C, D, and G of the proposed rule to subpart A of this final rule. We are revising the definition of ''attachment point'' to clarify that reinsurance payments will apply to claims costs accumulated on an incurred basis in a benefit year, and to specify that reinsurance payments are payable on all covered benefits. We are making conforming revisions to the definitions of ''coinsurance rate'' and ''reinsurance cap.'' We are revising the definition of ''contribution rate'' to be a per capita amount payable with respect to reinsurance contribution enrollees who reside in a State. We are adding a new defined term, ''reinsurance contribution enrollee,'' which means an individual covered by a plan for which reinsurance contributions must be made pursuant to § 153.400(b). We are removing the definition of ''percent of premium'' because this definition is no longer used.

We are modifying the definition of ''risk adjustment methodology'' to mean all parts of the risk adjustment process—the risk adjustment model, the calculation of plan average actuarial risk, the calculation of payments and charges, the risk adjustment data collection approach, and the schedule for the risk adjustment program. We are doing so to clarify the distinct parts of the risk adjustment process. The risk adjustment model calculates individual risk scores. The calculation of plan average actuarial risk adjusts those individual risk scores for rating variation, and calculates average actuarial risk at the plan level. The plan average actuarial risk is used for the calculation of payments and charges for risk adjustment covered plans. The risk adjustment data collection approach specifies how risk adjustment data will be stored, collected, accessed, transmitted, and validated, and the timeframes, data format, and privacy and security standards associated with each. The schedule for the risk adjustment program is the schedule for calculating payments and charges, invoicing issuers for charges, and disbursing payments. We are modifying the definition of ''risk adjustment data'' to mean all data that are used in a risk adjustment model, the calculation of plan average actuarial risk, or the calculation of payments and charges, or that are used for validation or audit of such data. We have added several new definitions—''individual risk score,'' ''calculation of plan average actuarial risk,'' ''calculation of payments and charges,'' and ''risk adjustment data collection approach.''

Finally, we are making a number of clarifying modifications throughout this section.

Comment: We received one comment suggesting that HHS define the benefit year as a calendar year and that the reinsurance program would be best operated on a calendar year basis.

Response: The benefit year was defined as the calendar year in the Exchange Establishment rule. We have cross-referenced this definition in this final rule.

Comment: Although a few commenters supported the proposal that reinsurance be payable only on essential health benefits, the majority of commenters urged that reinsurance be payable on all covered benefits, with several citing the administrative complexity of distinguishing between claims for essential health benefits and claims for other covered benefits.

Response: Because it would be administratively burdensome for issuers to distinguish claims for covered essential health benefits from other claims, we are revising the definitions so that reinsurance is payable on all covered benefits.

Comment: We received several comments disagreeing with the inconsistency in the proposed definition of percent of premium, which would include administrative costs for the fully insured market, but not the self-insured market.

Response: We believe that the statute intended for self-insured plans also to pay administrative costs. However, since we have modified the policy for the collection of contributions as discussed in the preamble to § 153.220, we are no longer proposing a definition for percent of premium.

Comment: We received a number of comments requesting clarification of the definition of a contributing entity for the reinsurance program. Several commenters suggested that HHS clarify that third-party administrators are not financially liable for contributions to be made by group health plans for which they administer benefits.

Response: The Affordable Care Act requires that health insurance issuers and third party administrators on behalf of group health plans make contributions. We are including text in § 153.400 that clarifies which issuers must make reinsurance contributions and which are exempt.

Comment: A few commenters expressed support for the differentiation between the defined terms ''risk adjustment model'' and ''risk adjustment methodology.'' Another commenter suggested an expanded set of definitions to capture more of the steps in the risk adjustment process, including a term to define the methodology for transferring money between plans, and a term to describe an individual enrollee's relative cost compared to that of an average enrollee.

Response: We are adding a definition of ''individual risk score'' to describe a relative measure of predicted health care costs for a particular enrollee. We are adding a definition of ''calculation

calculation take into account profits in a manner similar to the MLR rule. Some commenters requested that allowable administrative costs include profits, margin, or underwriting gain. This inclusion would be consistent with the MLR rule, which permits an issuer in certain circumstances to have administrative expenses and profits up to 20 percent of after-tax premium revenues before a rebate is due. Commenters also noted that section 1342(a) of the Affordable Care Act states that risk corridors calculations are to be based on a similar program under Medicare Part D, which includes return on investment, an analog to profits, in the definition of target amount.

Response: The proposed rule did not address profits in the risk corridors calculation. In the HHS notice of benefit and payment parameters, we intend to propose that profits be included within administrative costs for purposes of the risk corridors calculation, consistent with MLR.

Comment: A number of commenters requested that the risk corridors calculation take into account taxes in a manner similar to the MLR rule. The MLR rule requires reporting of a broad range of taxes, and deduction of certain taxes from premiums in the MLR denominator. One commenter noted that taxes may either be subtracted from premiums or added to allowable administrative costs.

Response: The proposed rule did not address taxes in the risk corridors calculation. In the HHS notice of benefit and payment parameters, we intend to propose that taxes and other expenses be included within administrative costs for purposes of the risk corridors calculation, with those Federal and State taxes and licensing and regulatory fees described in § 158.161(a), § 158.162(a)(1), and § 158.162(b)(1) exempt from the 20 percent cap on allowable administrative expenses.

Comments: Several commenters sought clarification as to whether any of the risk corridors elements were projections. Various commenters suggested that premiums or administrative costs should reflect projections. One commenter requested a clarification to confirm the intent to use projected costs as the targeted amount.

Response: Section 1342 of the Affordable Care Act does not allow the use of projections. Furthermore, because the temporary risk corridors program is designed to limit the extent of actual issuer losses (and gains) with respect to QHPs, the program will use actual data, not projected data.

2. Risk Corridors Establishment and Payment Methodology (§ 153.510)

In § 153.510 of the proposed rule, we proposed to establish risk corridors by specifying risk percentages above and below the target amount. In § 153.510(a), we proposed to require a QHP issuer to adhere to the requirements set by HHS for the establishment and administration of a risk corridors program for calendar years 2014 through 2016. The preamble to the proposed rule stated that we would issue guidance in the annual HHS notice of benefit and payment parameters for QHPs regarding reporting and the administration of payments and charges. The preamble also stated that risk corridors guidance will be plan-specific, and not issuer-specific, as is the case with respect to the MLR rule, and that we interpreted the risk corridors provisions to apply to all QHPs offered in the Exchange.

In § 153.510, we also established the payment methodology for the risk corridors program, using the thresholds and risk-sharing levels specified in statute. In § 153.510(b), we described the method for determining payment amounts to QHP issuers. For a QHP with allowable costs in excess of 103 percent but not more than 108 percent of the target amount, HHS will pay the QHP issuer 50 percent of the amount in excess of 103 percent of the target amount. For a QHP with allowable costs that exceed 108 percent of the target amount, the Affordable Care Act directs HHS to pay the QHP issuer an amount equal to 2.5 percent of the target amount plus 80 percent of the amount in excess of 108 percent of the target amount.

In § 153.510(c), we described the circumstances under which QHP issuers will remit charges to HHS, as well as the means by which HHS will determine those charge amounts. We proposed that QHP issuers will begin to remit charges to HHS for the first dollar of allowable charges less than 97 percent of the target amount. For a QHP with allowable costs that are less than 97 percent of the target amount but greater than 92 percent of the target amount, HHS will charge the QHP issuer an amount equal to 50 percent of the difference between 97 percent of the target amount and the actual value of allowable costs. For a QHP with allowable costs below 92 percent of the target amount, the QHP issuer will remit charges to HHS in an amount equal to 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the actual value of allowable costs.

While we did not propose deadlines in the proposed rule, we discussed in the preamble timeframes for QHP issuers to remit charges to HHS. We suggested, for example, that a QHP issuer required to make a risk corridors payment may be required to remit charges within 30 days of receiving notice from HHS, and that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers. We sought comment on these proposed payment deadlines in the preamble to the proposed rule.

Considering the comments received, we are finalizing this section as proposed, with a few clarifying modifications.

Comments: We received a number of comments suggesting that the risk corridors calculation should be performed at a less granular level than the plan level. The most common suggestion was aggregation at the issuer level, although other alternatives were suggested. One commenter suggested aggregation at the carrier, State and business line level, while another recommended applying the risk corridors calculation separately to an issuer's aggregate non-group QHP business and aggregate small group QHP business. One reason advanced for these alternatives was consistency with the MLR rules, which apply at the issuer level. Commenters also noted that issuers do not currently accumulate data at the plan level. Some commenters stated that issuer-level data would be more credible and reliable.

Response: We have carefully considered the commenters' suggestions, but are not making the requested change. The statutory language governing risk corridors does not afford the necessary flexibility. The statutory provision that governs risk corridors at section 1342(a) of the Affordable Care Act describes the risk corridors program as one in which ''a qualified health plan offered in the individual or small group market shall participate * * *''. By contrast, section 2718 of the PHS Act, which governs the MLR program, requires the calculation of a ratio with respect to an issuer.

Comment: One commenter requested that the risk corridors program may be based on targeted medical costs (net premiums) in addition to the premium rates.

Response: We are not making the changes proposed by the commenter because section 1342 of the Affordable Care Act does not provide the flexibility necessary to do so. That section requires

that the risk corridors program be based upon the ratio of a plan's total costs, other than administrative costs, to its total premiums, reduced by the administrative costs. In codifying that section in regulation, we have sought to define the relevant terms in a manner consistent with those used in the MLR calculation.

Comments: A number of commenters addressed the risk corridors payment deadline. Three commenters agreed that 30 days was a reasonable timeframe for both payments and charges, and one commenter recommended that payments and charges be paid once per year. One commenter suggested requiring issuers of QHPs to submit risk corridors data within 30 days after submission of a request for payment to HHS or receipt of demand for payment from HHS.

Response: We plan to address the risk corridors payment deadline in the HHS notice of benefit and payment parameters.

3. Attribution and Allocation of Revenue and Expense Items (§ 153.520)

In § 153.520(a)(3) of the proposed rule (now § 153.530(d)), we proposed rules for accounting for reinsurance claims submitted on a date to be determined by HHS for a given reinsurance benefit year. Specifically, we proposed that a QHP issuer be required to attribute reinsurance payments to risk corridors based on the date on which the valid reinsurance claim was submitted. For example, if the QHP issuer were to submit a reinsurance claim on or before the deadline for a benefit year, that QHP issuer would attribute the claim payment to the risk corridors calculation for the benefit year in which the costs were accrued. Conversely, if the QHP issuer were to submit a claim after the deadline for a benefit year, that QHP issuer would attribute the claim payment to the risk corridors calculation for the following benefit year.

We are finalizing this provision as proposed, with the following modifications:

We are revising § 153.520(d) to clarify that an issuer must attribute not only reinsurance payments, but also reinsurance contributions and risk adjustment payments and charges to the benefit year for which the contributions, charges, or payments apply, not the year in which the claim was submitted.

In addition, we are including the new paragraphs § 153.520(a), § 153.520(b), § 153.520(c), and § 153.520(e) to clarify the attribution of items, such as quality improvement and health information technology expenditures, that are typically not plan-specific. Paragraph 153.520(a) requires that each item of revenue and expense in allowable costs and target amount for a QHP must be reasonably attributable to that QHP's operations. Paragraph 153.520(b) states that each item must be reasonably allocated across the issuer's plans (that is, QHPs and non-QHPs). Thus, § 153.520(a) and § 153.520(b) require an issuer to allocate shared revenue and expense items between its health plans and its other business lines, and then to attribute its shared items within its health plans to each plan. To the extent that the issuer is utilizing a method for allocating expenses for MLR purposes, the method used for risk corridors purposes under § 153.520 must be consistent. Paragraph 153.520(c) requires an issuer to disclose to HHS a detailed description of the methods and bases for the attribution and allocation. We plan to specify the timing and method of disclosure in future guidance. Finally, § 153.520(e) requires an issuer to maintain the supporting records for the attribution and allocation for 10 years, and to make the records available to HHS upon request.

Comments: We received a few comments to the proposed provision attributing reinsurance payments to the applicable benefit year. One commenter stated that the rule was inconsistent with issuers' pricing practices, the MLR calculation, and financial reporting practices. The commenter stated that issuers could manipulate risk corridors payments by delaying claims submissions, and that claims not submitted in time for the 2016 calculation would not be eligible for risk corridors, since the program would have terminated. Another commenter recommended that reinsurance amounts be on a ''basis other than a paid basis'' in order to be consistent with the MLR calculation. Another commenter recommended attribution of reinsurance claims to the year of submission, even if the claims were incurred in a prior benefit year.

Response: We are clarifying in the rule that reinsurance and risk adjustment payments, contributions, and charges are attributed to the benefit year with respect to which the reinsurance or risk adjustment amounts apply. For example, reinsurance payments received in 2015 for claims costs incurred in 2014 (even if the reinsurance claim was properly submitted in 2015) would be attributed to 2014 for purposes of risk corridors calculations.

4. Risk Corridors Data Requirements (§ 153.530)

To support the risk corridors program calculations, we proposed in § 153.520 of the proposed rule that all QHP issuers submit data needed to determine actual performance relative to their target amounts, to be collected in standard formats specified by HHS. We proposed in § 153.520(a) to require that QHP issuers submit data related to actual premium amounts collected, including premium amounts paid by parties other than the enrollee in a QHP, and specifically, advance premium tax credits paid by the government. We also proposed that risk adjustment and reinsurance be regarded as after-the-fact adjustments to premiums for purposes of determining risk corridors amounts. Therefore, § 153.520(a)(1) of the proposed rule required that the reported premium amounts be increased by the amounts paid to the QHP issuer for risk adjustment and reinsurance, and § 153.520(a)(2) required that reported premium amounts be reduced for any risk adjustment charges the QHP issuer pays on behalf of the plan, reinsurance contributions that the QHP issuer makes on behalf of the plan, and Exchange user fees that the QHP issuer pays on behalf of the plan. We sought comment on this issue in the preamble.

We proposed in § 153.520(b) that QHP issuers be required to submit allowable cost data to calculate the risk corridors in a format to be specified by HHS, and that allowable costs be reduced for any direct and indirect remuneration received. Finally, we proposed that allowable costs be reduced by the amount of any cost-sharing reductions received from HHS.

Considering the comments received, we are finalizing this provision, with the following modifications:

In order to more clearly reflect section 1342(c)(1)(B) of the Affordable Care Act, we are revising this section so that the adjustments for reinsurance and risk adjustment are made to allowable costs. We are also making a number of clarifying modifications throughout this section.

Comments: Commenters generally agreed that reinsurance and risk adjustment payments and charges should be treated as after-the-fact adjustments to risk corridors. One commenter noted the inconsistency between the proposed rule's treatment of reinsurance and risk adjustment payments and charges as adjustments to premium revenue, and section 1342 of the Affordable Care Act, which requires that those adjustments be made to allowable costs. Another commenter

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Part II

Department of Health and Human Services

45 CFR Parts 153, 155, 156, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014 and Amendments to the HHS Notice of Benefit and Payment Parameters for 2014; Final Rules; Patient Protection and Affordable Care Act; Establishment of Exchanges and Qualified Health Plans; Small Business Health Options Program; Proposed Rule

programs when practicable so that similar concepts in the two programs are handled in a similar manner, and similar policy goals are reflected. Consequently, our treatment of taxes for risk corridors purposes follows the approach of the MLR program, as outlined in section 3C of the model MLR regulation published by the National Association of Insurance Commissioners (NAIC).[23] We note that, because of the way profits is defined for the risk corridors calculation, no such circularity will occur with profits.

Comment: One commenter asked whether reinsurance contributions could be considered as ''taxes and regulatory fees'' when determining ''allowable administrative costs'' in the denominator of the risk corridors calculation.

Response: We note that other provisions of this final rule amend the MLR calculation so that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in § 158.161(a), and are deducted from premiums for MLR purposes. Our proposed definition of ''taxes'' for purposes of the risk corridors program cross-referenced § 158.161(a) and similarly included reinsurance contributions. Thus, in response to these comments, and to maintain consistency with the MLR calculation and our proposed definition, which we are finalizing as proposed, we are making a conforming amendment to § 153.530(b)(1). In this final rule, we are deleting § 153.530(b)(1)(ii) and clarifying that reinsurance contributions are included in Federal and State licensing and regulatory fees paid with respect to the QHP as described in § 158.161(a), and thus are included in allowable administrative costs for risk corridors purposes. We are also making a conforming change to § 153.520(d) to remove the requirement that a QHP issuer must attribute reinsurance contributions to allowable costs for the benefit year. In addition, we are making a conforming modification to the proposed definition of ''taxes'' in § 153.500, by replacing the term ''taxes'' with ''taxes and regulatory fees.''

Comment: Nearly all those that commented on the risk corridors profit margin agreed with the 3 percent profit margin set in the proposed rule. One commenter suggested that a 2 percent profit margin would be more appropriate.

Response: Based on the comments received and the policy arguments outlined in our proposed rule, we are finalizing the definition of ''profits'' in § 153.500 as proposed.

Comment: One commenter expressed concern that an allowance for up to 3 percent profit could disrupt the budget neutrality of the risk corridors program, and asked for clarification on HHS's plans for funding risk corridors if payments exceed receipts.

Response: 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.

Comment: One commenter stated that the risk corridors calculation does not account for the credibility adjustment that is part of the MLR formula, and recommended setting maximum allowable administrative costs at 20 percent plus the allowed credibility adjustment for the carrier's block of business. The commenter believed that this change would be consistent with the MLR formula and make it more viable for carriers to maintain their smaller blocks of business, given the higher claims volatility that often characterizes these smaller blocks of business.

Response: Although we seek consistency with MLR where the risk corridors and MLR formulas contain similar parameters, we believe that the credibility adjustment is a unique parameter in the MLR formula. The MLR statute provides for a credibility adjustment through ''methodologies * * * designed to take into account the special circumstances of smaller plans, different types of plans, and newer plans'' at section 2718(c) of the Affordable Care Act. No similar reference appears in section 1342 of the Affordable Care Act.

Comment: One commenter requested clarification on whether community benefit expenses would be included in the taxes of non-profit entities for the purposes of calculating the risk corridors target amount.

Response: We believe that accounting for these expenses as taxes when calculating the target amount would appropriately align the risk corridors formula with the MLR calculation. Our proposed definition of ''taxes'' in § 153.500 includes Federal and State taxes defined in § 158.162(b), which describes payments made by a tax-exempt issuer for community benefit expenditures. Consequently, we are clarifying that non-profit entities may account for community benefit expenditures as ''taxes and regulatory fees'' in a manner consistent with the MLR reporting requirements set forth in § 158.162 for the purposes of calculating the risk corridors target amount.

2. Risk Corridors Establishment and Payment Methodology

We proposed to add paragraph (d) to § 153.510, which would specify the due date for QHP issuers to remit risk corridors charges to HHS. Under this provision, an issuer would be required to remit charges within 30 days after notification of the charges. By June 30 of the year following an applicable benefit year, under § 153.310(e), QHP issuers will have been notified of risk adjustment payments and charges for the applicable benefit year. By that same date, under § 153.240(b)(1), QHP issuers also will have been notified of all reinsurance payments to be made for the applicable benefit year. As such, we proposed in § 153.530(d) that the due date for QHP issuers to submit all information required under § 153.530 of the Premium Stabilization Rule is July 31 of the year following the applicable benefit year. We also proposed that the MLR reporting deadline be revised to align with this schedule. We are finalizing this provision as proposed.

Comment: We received several supportive comments on our proposal to require issuers to submit risk corridors information by July 31 of the year following the applicable benefit year.

Response: We are finalizing § 153.530(d) as proposed, so that the due date for QHP issuers to submit all risk corridors information is July 31 of the year following the applicable benefit year. In section III.I.1. of this final rule, we also finalize our proposal to align the MLR reporting deadline with this schedule.

Comment: One commenter asked how payments made under the State supplemental reinsurance payment parameters are taken into account in the risk corridors calculation. Another commenter requested that HHS clarify the treatment of State ''wrap-around'' reinsurance payments under the risk corridors calculation, and asked for information on the way in which HHS analyzed the impact of the administrative burden associated with removing these costs.

Response: Under section 1342(c)(1)(B) of the Affordable Care Act, allowable costs are to be reduced by any risk adjustment and reinsurance payments received under sections 1341 and 1343. Supplemental reinsurance payments

[23] Section 3C of the NAIC model regulation, available at *http://www.naic.org/documents/committees_ex_mlr_reg_asadopted.pdf* states, ''[a]ll terms defined in this Regulation, whether in this Section or elsewhere, shall be construed, and all calculations provided for by this Regulation shall be performed, as to exclude the financial impact of any of the rebates provided for in sections 8, 9, and 10 [rebate calculation sections].''

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Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2015; Final Rule

policy upon a plan with the following specified characteristics: allowable costs (including claims) equal to 80 percent of premiums, Federal income taxes equal to 35 percent of pre-tax profits, other tax liability equal to 7.5 percent of premiums, and other administrative costs equal to 8 percent of premiums. We proposed to estimate the effect of the transitional policy upon the model plan's claims costs by assuming that allowable costs (including claims) among the transitional plans are 80 percent of the allowable costs that would have resulted from the broad risk pool, in the absence of the transitional policy. HHS would analyze that data, and publish the State-specific adjustments that issuers would use in the risk corridors calculations for the 2014 benefit year.

Finally, in the proposed rule, we stated that we were considering modifying the MLR formula to ensure that the proposed adjustment to the risk corridors program does not distort the implementation of MLR requirements, so that the rebates that would be owed absent the transitional policy and this adjustment would not substantially change.

We are finalizing the risk corridors adjustment policy as proposed. Consistent with our proposal, we are adding a definition of ''adjustment percentage'' to § 153.500, and are amending the definitions of risk corridors ''profits'' and ''allowable administrative costs'' in § 153.500 to account for the adjustment percentage. We are also adding a definition of ''transitional State'' to § 153.500. Finally, we are adding paragraph (e) to § 153.530 to require health insurance issuers in the individual and small group markets to submit enrollment data for the risk corridors adjustment. We are making a conforming change to § 153.530(d) to clarify that the July 31st submission deadline for risk corridors data does not apply to the enrollment data specified in § 153.530(e). We project that these changes, in combination with the changes to the reinsurance program finalized in this rule, will result in net payments that are budget neutral in 2014. We intend to implement this program in a budget neutral manner, and may make future adjustments, either upward or downward to this program (for example, as discussed below, we may modify the ceiling on allowable administrative costs) to the extent necessary to achieve this goal.

Comment: Several commenters recommended that HHS implement a risk corridors adjustment based on a national calculation instead of State-level calculations, as we proposed. One commenter noted that the effect of the transitional policy on the State risk pool could vary by factors that we did not propose to account for, such as whether or not the State had a guaranteed issue law prior to 2014, and suggested that a national adjustment would help to mitigate the effect of these differences. Alternatively, the commenter suggested that HHS could provide an adjustment for different categories of States. A few commenters suggested that a national adjustment would reduce administrative burden on issuers and would be simpler to implement. However, several other commenters supported our approach of implementing a State-level adjustment, including the proposed approach of applying the adjustment based on enrollment in non-compliant plans within a State.

Response: We are finalizing our proposed approach to determine the risk corridors adjustment on a State-by-State basis. We believe that a State-based approach provides an appropriate means of accounting for differences in market composition, enrollment in transitional plans, and adoption of the transitional policy between States. Because a national approach would still require issuers to submit enrollment information to HHS in order to determine an accurate national risk corridors adjustment, we do not believe that a State-based approach would prove more burdensome for issuers.

Comment: One commenter recommended that the adjustment be extended through all three years of the temporary risk corridors program. However, another commenter believed that the adjustment should apply for the 2014 benefit year only, since issuers will be able to reflect the effect of the transitional policy in their pricing for subsequent benefit years.

Response: We agree with the comment that issuers will be able to reflect the effect of the transitional policy in their pricing for benefit years following 2014, and thus this specific risk corridors adjustment is needed for the 2014 benefit year only. Therefore, we are finalizing the risk corridors adjustment policy to apply the adjustment to eligible QHP issuers in transitional States for the 2014 benefit year only. However, as we discuss below, we are considering further changes to the risk corridors program.

Comment: Several commenters recommended that we apply the risk corridors transitional adjustment to all plans compliant with the Affordable Care Act, not just QHPs that are subject to the risk corridors program. Some commenters requested that any changes to the risk corridors formula be applied uniformly to all issuers, including issuers of plans that are not compliant with Affordable Care Act requirements, rather than limited to issuers offering transitional policies. One commenter supported defining ''transitional plans'' to include ''early renewal'' plans that have been renewed in late 2013 and that will not be required to comply with the Affordable Care Act until the end of 2014.

Response: Because, as described above, the risk corridors program is intended to share risk and stabilize premiums for QHPs and substantially similar off-Exchange plans that differ only due to legal requirements, we decline to expand the participation criteria for the risk corridors transitional adjustment. Consistent with our existing regulations set forth in subpart F of part 153, any risk corridors payment or charge amount, including any adjusted payment or charge amount resulting from this transitional policy, will be calculated for a QHP issuer in proportion to the premium revenue that the issuer receives from its QHPs, as defined in § 153.500. Plans that do not comply with the Affordable Care Act market reforms will not participate in the risk corridors program, and data from these plans will not be included in a QHP issuer's risk corridors calculation, or the calculation of its risk corridors adjustment percentage.

We are also finalizing our proposal that a QHP issuer in a transitional State will receive the risk corridors adjustment only if its allowable costs are above 80 percent of after-tax premiums, and will receive that adjustment irrespective of whether the issuer offers transitional policies. Because the transitional policy may affect the overall risk pool in a transitional State, we believe that it is appropriate to provide the adjustment to a QHP issuer in that State even if the issuer does not offer a transitional policy.

Comment: Some commenters recommended that HHS completely remove the administrative costs ceiling for risk corridors. One of these commenters agreed with HHS's proposal that the allowable costs must be at least 80 percent of after-tax premiums, and another agreed with setting the profit floor according to the methodology outlined in the proposed rule. Another commenter recommended that the risk corridors formula be changed to reflect a standard ceiling of 22 percent for allowable administrative costs.

Response: As we discussed in the proposed rule, the adjustment to the risk

DOCUMENT 5

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: **April 11, 2014**

Subject: **Risk Corridors and Budget Neutrality**

Q1: In the HHS Notice of Benefit and Payment Parameters for 2015 final rule (79 FR 13744) and the Exchange and Insurance Market Standards for 2015 and Beyond NPRM (79 FR 15808), HHS indicated that it intends to implement the risk corridors program in a budget neutral manner. What risk corridors payments will HHS make if risk corridors collections for a year are insufficient to fund risk corridors payments for the year, as calculated under the risk corridors formula?

A1: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. However, if risk corridors collections are insufficient to make risk corridors payments for a year, all risk corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and will then be used to fund current year payments. If, after obligations for the previous year have been met, the total amount of collections available in the current year is insufficient to make payments in that year, the current year payments will be reduced pro rata to the extent of any shortfall. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

Example 1: For 2014, HHS collects $800 million in risk corridors charges, and QHP issuers seek $600 million risk corridors payments under the risk corridors formula. HHS would make the $600 million in risk corridors payments for 2014 and would retain the remaining $200 million for use in 2015 and potentially 2016 in case of a shortfall.

Example 2: For 2015, HHS collects $700 million in risk corridors charges, but QHP issuers seek $1 billion in risk corridors payments under the risk corridors formula. With the $200 million in excess charges collected for 2014, HHS would have a total of $900 million available to make risk corridors payments in 2015. Each QHP issuer would receive a risk corridors payment equal to 90 percent of the calculated amount of the risk corridors payment, leaving an aggregate risk corridors shortfall of $100 million for benefit year 2015. This $100 million shortfall would be paid for from risk corridors

charges collected for 2016 before any risk corridors payments are made for the 2016 benefit year.

Q2: What happens if risk corridors collections do not match risk corridors payments in the final year of risk corridors?

A2: We anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments over the life of the three-year program. However, we will establish in future guidance or rulemaking how we will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from previous years) do not match risk corridors payments as calculated under the risk corridors formula for the final year of the program.

Q3: If HHS reduces risk corridors payments for a particular year because risk corridors collections are insufficient to make those payments, how should an issuer's medical loss ratio (MLR) calculation account for that reduction?

A3: Under 45 CFR 153.710(g)(1)(iv), an issuer should reflect in its MLR report the risk corridors payment to be made by HHS as reflected in the notification provided under §153.510(d). Because issuers will submit their risk corridors and MLR data simultaneously, issuers will not know the extent of any reduction in risk corridors payments when submitting their MLR calculations. As detailed in 45 CFR 153.710(g)(2), that reduction should be reflected in the next following MLR report. Although it is possible that not accounting for the reduction could affect an issuer's rebate obligations, that effect will be mitigated in the initial year because the MLR ratio is calculated based on three years of data, and will be eliminated by the second year because the reduction will be reflected. We intend to provide more guidance on this reporting in the future.

Q4: In the 2015 Payment Notice, HHS stated that it might adjust risk corridors parameters up or down in order to ensure budget neutrality. Will there be further adjustments to risk corridors in addition to those indicated in this FAQ?

A4: HHS believes that the approach outlined in this FAQ is the most equitable and efficient approach to implement risk corridors in a budget neutral manner. However, we may also make adjustments to the program for benefit year 2016 as appropriate.

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Department of Health and Human Services

45 CFR Parts 144, 146, 147, *et al.*
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adjustment percentage, of after-tax premiums) by 2 percentage points. We also proposed to increase the profit margin floor in the risk corridors formula (currently set at 3 percent, plus the adjustment percentage, of after-tax premiums) by 2 percentage points. These increases to the profit floor and administrative cost ceiling in the risk corridors formula would increase a QHP issuer's risk corridors ratio if claims costs are unexpectedly high, thereby increasing risk corridors payments or decreasing risk corridors charges.

We proposed these increases for 2015 for QHP issuers in every State because we believed that many of these additional administrative costs and risk pool uncertainties will be faced by issuers in all States, not just States adopting the transitional policy. Finally, under our authority under section 2718(c) of the PHS Act, we proposed that the MLR formula not take into account any additional risk corridors payments resulting from this adjustment. We requested comment on all aspects of this proposal.

Comment: Several commenters supported our proposal to implement the proposed adjustment on a nationwide basis so that it would apply equally to QHP issuers in all States. No commenters suggested a regional or State-level approach.

Response: We are finalizing the adjustment as proposed, and will apply the adjustment on a nationwide basis.

Comment: One commenter stated its support of the proposed adjustment to raise the ceiling on administrative costs, but questioned the necessity of the proposed adjustment to profits.

Response: We believe that an upward adjustment to the profit floor is necessary to account for unanticipated risk pool effects related to State decisions to adopt the transitional policy, the phase-out of high risk pools, and the six-month initial enrollment period, which would not be reflected in an issuer's administrative costs.

Comment: A few commenters urged HHS to increase the magnitude of the proposed adjustment, and to extend the duration of the adjustment so that it would apply beyond the 2015 benefit year. One commenter believed that issuers could face significant operations and risk pool challenges for the 2015 benefit year, and recommended that HHS raise the ceiling on allowable administrative costs by 5 percentage points, instead of 2 percentage points, as proposed in the proposed rule. The commenters did not specifically indicate or estimate any additional or greater administrative costs or pricing uncertainties that would necessitate an increase beyond the proposed 2 percentage point increase. Several other commenters supported our proposal, stating that the 2 percentage point increase is reasonable to address additional administrative costs and operational uncertainties in the 2015 benefit year. One commenter noted that the proposed adjustment would suitably help smaller issuers forced to amortize fixed additional administrative costs over a smaller operational base.

Response: We are finalizing the proposed 2 percentage point increase to the risk corridors allowable administrative cost ceiling and profit floor for benefit year 2015. Based on our internal estimates and the methodology used to determine the administrative cost adjustment to the MLR formula discussed elsewhere in this final rule, we believe that this 2 percentage point increase will suitably account for additional administrative costs and pricing uncertainties that QHP issuers will experience in benefit year 2015.

Comment: One commenter requested that we modify the risk corridors formula so that reinsurance payments are not deducted from allowable costs, in order to enhance the protections of the risk corridors program.

Response: Section 1342(c)(1)(B) of the Affordable Care Act states that allowable costs in the risk corridors calculation are to be reduced by risk adjustment and reinsurance payments received under sections 1341 and 1343. Therefore, we are maintaining the current definition of ''allowable costs'' for the risk corridors program.

Comment: A number of commenters expressed concern with HHS's intention to implement the risk corridors program in a budget neutral manner, as described in the preamble to the proposed rule. These commenters were concerned that an approach that makes risk corridors payments only when sufficient risk corridors charges are received could result in reduced risk corridors payments to issuers. The commenters questioned how much the payment formula specified in the final rules for 2014 and 2015 may be relied upon in setting premiums, if payments might be reduced. Several commenters believed that an approach implementing the risk corridors program in a budget neutral manner was counter to the intent of Section 1342 of the Affordable Care Act, which states that the Secretary of HHS will establish a risk corridors program that is similar to the Medicare Part D risk corridors program, which is not budget neutral. One commenter believed that implementing the risk corridors program in a budget neutral manner would result in issuers sharing in the gains and losses of other issuers, would unintentionally affect market dynamics, and could result in solvency problems for some issuers if risk corridors receipts are insufficient to fully fund risk corridors payments.

Response: We recognize the commenters' concerns. To provide greater clarity on how 2014 and 2015 payments will be made, we issued a bulletin on April 11, 2014, titled ''Risk Corridors and Budget Neutrality,'' describing how we intend to administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually. Specifically, if risk corridors collections in the first or second year are insufficient to make risk corridors payments as prescribed by the regulations, risk corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous year, and remaining funds will then be used to fund current year payments. If any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year.

As we stated in the bulletin, we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. That said, we appreciate that some commenters believe that there are uncertainties associated with rate setting, given their concerns that risk corridors collections may not be sufficient to fully fund risk corridors payments. In the unlikely event of a shortfall for the 2015 program year, HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In that event, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

Comment: One commenter asked that HHS apply this adjustment to all States for benefit year 2014. The commenter believed that this adjustment was necessary for the 2014 benefit year because of changes in the composition of the risk pools that were not anticipated when rates for the 2014 benefit year were developed.

Response: In the 2015 Payment Notice, we implemented an adjustment to the risk corridors formula for the 2014 benefit year that would help to further mitigate any unexpected losses for issuers of plans subject to risk corridors attributable to the effects of the transitional policy. In States that adopt the transitional policy, this

DOCUMENT 7

FEDERAL REGISTER

Vol. 80 Friday,
No. 39 February 27, 2015

Part II

Department of Health and Human Services

45 CFR Parts 144, 147, 153, et al.
Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2016; Final Rule

Response: We are maintaining the policy finalized in the 2015 Payment Notice under § 153.500 and § 153.530, which provides, for 2014, that the effect of the transitional adjustment will vary according to the member-month enrollment in a State, such that the 3 percent profit floor and 20 percent allowable administrative cost ceiling will apply in States that did not adopt the Federal transitional policy (QHP issuers in these States will receive a risk corridors transitional adjustment equal to zero). We believe that issuers in States that did not adopt the Federal transitional policy will not require the transitional adjustment to help mitigate mispricing that may have occurred due to unexpected changes in the risk pool resulting from the Federal transitional policy. We note that the adjustment will account for the effect of the Federal transitional policy in the entire market within a State that adopted the transitional policy, such that a QHP issuer in a transitional State will be eligible to receive an adjustment to its risk corridors calculation even if the issuer has not issued transitional policies.

b. Risk Corridors Payments for 2016

On April 11, 2014, we issued a bulletin titled ''Risk Corridors and Budget Neutrality,'' which described how we intend to administer risk corridors over the 3-year life of the program.[26] Specifically, we stated that if any risk corridors funds remain after prior and current year payment obligations have been met, they will be held to offset potential insufficiencies in risk corridors collections in the next year. We also stated that we would establish in future guidance how we would calculate risk corridors payments in the event that cumulative risk corridors collections do not equal cumulative risk corridors payment requests.

In the proposed 2016 Payment Notice, we proposed that if, for the 2016 benefit year, cumulative risk corridors collections exceed cumulative risk corridors payment requests, we would make an adjustment to our administrative expense definitions (that is, the profit margin floor and the ceiling for allowable administrative costs) to account for the excess funds. That is, if, when the risk corridors program concludes, cumulative risk corridors collections exceed both 2016 payment requests under the risk corridors formula and any unpaid risk corridors amounts from previous years, we would increase the administrative cost ceiling and the profit floor in the risk corridors formula by a percentage calculated to pay out all collections to QHP issuers. The administrative cost ceiling and the profit floor would be adjusted by the same percentage.

We proposed to determine the percentage adjustment to the administrative cost ceiling and profit margin floor by evaluating the amount of excess risk corridors collections (if any) available after risk corridors payments for benefit year 2016 have been calculated. As stated in our bulletin on risk corridors and budget neutrality, after receiving charges from issuers for the 2016 benefit year, we would first prioritize payments to any unpaid risk corridors payments remaining from the 2015 benefit year. We would then calculate benefit year 2016 risk corridors payments for eligible issuers based on the 3 percent profit floor and 20 percent allowable administrative cost ceiling, as required by regulation. If, after making 2015 payments and calculating (but not paying) risk corridors payments for benefit year 2016, we determine that the aggregate amount of collections (including any amounts collected for 2016 and any amounts remaining from benefit years 2014 and 2015) exceed what is needed to make 2016 risk corridors payments, we would implement an adjustment to the profit floor and administrative cost ceiling to increase risk corridors payments for eligible issuers for benefit year 2016. We would examine data that issuers have submitted for calculation of their 2016 risk corridors ratios (that is, allowable costs and target amount) and determine, based on the amount of collections available, what percentage increase to the administrative cost ceiling and profit floor could be implemented for eligible issuers while maintaining budget neutrality for the program overall. Although all eligible issuers would receive the same percentage adjustment, we proposed that the amount of additional payment made to each issuer would vary based on the issuer's allowable costs and target amount. We proposed that, once HHS calculated the adjustment and applied it to eligible issuers' risk corridors formulas, it would make a single risk corridors payment for benefit year 2016 that would include any additional, adjusted payment amount.

Because risk corridors collections are a user fee to be used to fund premium stabilization under risk corridors and no other programs, we proposed to limit this adjustment to excess amounts collected. We also proposed to apply this adjustment to allowable administrative costs and profits for the 2016 benefit year only to plans whose allowable costs (as defined at § 153.500) are at least 80 percent of their after-tax premiums, because issuers under this threshold would generally be required to pay out MLR rebates to consumers.[27] For plans whose ratio of allowable costs to after-tax premium is below 80 percent, we proposed that the 3 percent risk corridors profit margin and 20 percent allowable administrative cost ceiling would continue to apply. Furthermore, we proposed that, to the extent that applying the proposed adjustment to a plan could increase its risk corridors payment and affect its MLR calculation, the MLR calculation would ignore these adjustments.

As previously stated, we anticipate that risk corridors collections will be sufficient to pay for all risk corridors payments. HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. In the unlikely event that risk corridors collections, including any potential carryover from the prior years, are insufficient to make risk corridors payments for the 2016 program year, HHS will use other sources of funding for the risk corridors payments, subject to the availability of appropriations.

We are finalizing this policy as proposed.

Comment: We received one comment on the proposed approach for allocating excess risk corridors collections at the end of the program. The commenter supported our approach. Another commenter supported language in the proposed Payment Notice that reaffirmed HHS's commitment to make full risk corridors payments if collections are insufficient to fund payments.

Response: We are finalizing the policy regarding allocation of excess risk corridors collections for 2016 as proposed.

[26] The Centers for Medicare and Medicaid Services, Center for Consumer Information and Insurance Oversight. ''Risk Corridors and Budget Neutrality,'' April 11, 2014. Available at: *https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.*

[27] Because of some differences in the MLR numerator and the definition of allowable costs that applies with respect to the risk corridors formula, in a small number of cases, an issuer with allowable costs that are at least 80 percent of after-tax premium, may be required to pay MLR rebates to consumers.

DOCUMENT 8

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: October 1, 2015

Subject: Risk Corridors Payment Proration Rate for 2014

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS issued a bulletin titled ''Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing proration results for 2014 risk corridors payments. Based on current data from QHP issuers' risk corridors submissions, issuers will pay $362 million in risk corridors charges, and have submitted for $2.87 billion in risk corridors payments for 2014. **At this time, assuming full collections of risk corridors charges, this will result in a proration rate of 12.6 percent.**

HHS will begin collection of risk corridors charges in November, 2015, and will begin remitting risk corridors payments to issuers starting December, 2015.[1]

We thank QHP issuers for their hard work and timely responses to our data validation requests. We note that all QHP issuers submitted certifications or explanations and just over 50 percent of QHP issuers resubmitted their MLR/risk corridors filings on short notice as part of this important process.

[1] We note that the risk corridor payment and charge amounts reflected in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015, or the effect of subsequent appeals. Neither these amounts nor the proration rates reflected in this bulletin constitute specific obligations of federal funds to any particular issuer or plan.

DOCUMENT 9

Department of Health & Human Services

Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

Subject: Risk Corridors Payment and Charge Amounts for Benefit Year 2014

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. The program, which was modeled after a similar program implemented as part of the Medicare Part D prescription drug benefit program, encourages issuers to keep their rates stable as they adjust to the new health insurance reforms in the early years of the Marketplaces.

HHS has previously stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.[1] On October 1, 2015, HHS announced the payment proration rate for 2014 will be approximately 12.6 percent, reflecting risk corridors charges of $362 million and payments of $2.87 billion requested by issuers.[2] This proration rate was based on the most current risk corridors data submitted by issuers and assumes full collection of charges from issuers.

Today, HHS is releasing issuer-level risk corridors payments and charges based on the most current risk corridors data submitted by issuers and assuming full collection of charges from issuers, by market and state, for the 2014 benefit year. The tables below include the risk corridors payment or charge amounts for the individual and small group markets, respectively, and the prorated risk corridors payment, if applicable. **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.** HHS will begin collection of risk corridors charges in November 2015 and will begin remitting risk corridors payments to issuers starting in December 2015.[3]

[1] "Risk Corridors and Budget Neutrality", published April 11, 2014 and posted at https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf

[2] The exact proration rate for 2014 is 12.6178665287897%.

[3] We note that the risk corridor payment and charge amounts published in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 15, 2015 or any amount held back for appeals.

NM	93091	New Mexico Health Connections	$ 4,211,650.62	$ -	$ 531,420.45	$ -

Table 33 – New York

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	PRORATED AMOUNT (INDIVIDUAL MARKET)	PRORATED AMOUNT (SMALL GROUP MARKET)
NY	11177	MetroPlus Health Plan	$ 8,754,733.06	$ -	$ 1,104,660.53	$ -
NY	18029	Independent Health Benefits Corporation	$ (2,870,470.22)	$ (530,639.45)	$ (2,870,470.22)	$ (530,639.45)
NY	25303	New York State Catholic Health Plan, Inc.	$ (3,499,761.14)	$ -	$ (3,499,761.14)	$ -
NY	31808	American Progressive Life & Health Insurance Company of New York	$ (344,586.33)	$ -	$ (344,586.33)	$ -
NY	40064	HealthNow New York	$ (4,020,217.24)	$ (1,216,594.18)	$ (4,020,217.24)	$ (1,216,594.18)
NY	54235	UnitedHealthcare of New York, Inc.	$ (626,658.79)	$ -	$ (626,658.79)	$ -
NY	56184	MVP Health Plan, Inc.	$ (3,547,343.87)	$ 1,550,702.41	$ (3,547,343.87)	$ 195,665.56
NY	57165	Affinity Health Plan, Inc.	$ 1,179,368.76	$ -	$ 148,811.18	$ -
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$ 89,568,960.58	$ 59,765,898.72	$ 11,301,691.90	$ 7,541,181.33
NY	74289	Oscar Insurance Corporation	$ 9,342,723.93	$ -	$ 1,178,852.44	$ -
NY	78124	Excellus Health Plan, Inc.	$ (5,505,909.10)	$ 7,526,489.35	$ (5,505,909.10)	$ 949,682.38
NY	80519	Empire HealthChoice HMO, Inc.	$	$ -	$ -	$ -

DOCUMENT 10

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Date: November 19, 2015

From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)

Subject: **Risk Corridors Payments for the 2014 Benefit Year**

On October 1, 2015, the Centers for Medicare & Medicaid Services (CMS) announced that for the first year of the three year risk corridors program, qualified health plan (QHP) issuers will pay charges of approximately $362 million, and QHP issuers have requested $2.87 billion of 2014 payments, based on current data for the 2014 benefit year.[1] Consistent with prior guidance, assuming full collections of risk corridors charges for the 2014 benefit year, insurers will be paid an amount that reflects a proration rate of 12.6% of their 2014 benefit year risk corridors payment requests.[2] The remaining 2014 risk corridors payments will be made from 2015 risk corridors collections, and if necessary, 2016 collections.

In the event of a shortfall for the 2016 program year, the Department of Health and Human Services (HHS) will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments.

HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers, and HHS is recording those amounts that remain unpaid following our 12.6% payment this winter as fiscal year 2015 obligation of the United States Government for which full payment is required.

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[1] "*Risk Corridors Payment Proration Rate for 2014*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

[2] "*Risk Corridors and Budget Neutrality*." April 11, 2014. https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf. "*Risk Corridors Payment Proration Rate*." October 1, 2015. https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf

DOCUMENT 11

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: September 9, 2016

Subject: Risk Corridors Payments for 2015

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace. This program, which was modeled after a similar program used in the Medicare prescription drug benefit, encouraged issuers to keep their rates stable as they adjusted to the new health insurance reforms in the early years of the Marketplaces.

Under the risk corridors program, the federal government shares risk with QHP issuers – collecting charges from the issuer if the issuer's QHP premiums exceed claims costs of QHP enrollees by a certain amount, and making payments to the issuer if the issuer's premiums fall short by a certain amount, subject to certain adjustments for taxes, administrative expenses, and other costs and payments. On April 11, 2014, HHS issued a bulletin titled "Risk Corridors and Budget Neutrality," which described how we intend to administer risk corridors over the three-year life of the program. We stated that if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall.

Today, HHS is announcing preliminary information about risk corridors for the 2015 benefit year. Risk corridors submissions are still undergoing review and complete information on payments and charges for the 2015 benefit year is not available at this time. However, based on our preliminary analysis, HHS anticipates that all 2015 benefit year collections will be used towards remaining 2014 benefit year risk corridors payments, and no funds will be available at this time for 2015 benefit year risk corridors payments. HHS expects to begin collection of risk corridors charges and remittance of risk corridors payments on the same schedule as last year. Collections from the 2016 benefit year will be used first for remaining 2014 benefit year risk corridors payments, then for 2015 benefit year risk corridors payments, then for 2016 benefit year risk corridors payments.

As we have said previously, in the event of a shortfall for the 2016 benefit year, HHS will explore other sources of funding for risk corridors payments, subject to the availability of appropriations. This includes working with Congress on the necessary funding for outstanding risk corridors payments. 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.

We know that a number of issuers have sued in federal court seeking to obtain the risk corridors amounts that have not been paid to date. As in any lawsuit, the Department of Justice is vigorously defending those claims on behalf of the United States. However, as in all cases where there is litigation risk, we are open to discussing resolution of those claims. We are willing to begin such discussions at any time.

DOCUMENT 12

Department of Health & Human Services
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight 200
Independence Avenue SW
Washington, DC 20201

Date: November 18, 2016

Subject: Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year

Background:

Section 1342 of the Affordable Care Act directs the Secretary of the Department of Health and Human Services (HHS) to establish a temporary risk corridors program that provides issuers of qualified health plans (QHPs) in the individual and small group markets additional protection against uncertainty in claims costs during the first three years of the Marketplace.

HHS established a three-year payment framework for the risk corridors program and outlined the details of this payment framework in our April 11, 2014 guidance on *Risk Corridors and Budget Neutrality*.[1] As set forth in that guidance, if risk corridors collections for a particular year are insufficient to make full risk corridors payments for that year, risk corridors payments for the year will be reduced pro rata to the extent of any shortfall. Because risk corridors payments for the 2014 benefit year exceeded risk corridors collections for that benefit year, risk corridors collections for the 2015 benefit year will be used first towards remaining balances on 2014 benefit year risk corridors payments.

On September 9, 2016, HHS published guidance on *Risk Corridors Payments for 2015*, stating that we anticipated that all 2015 benefit year collections would be used toward remaining 2014 benefit year risk corridors payments, and that no funds would be available at this time for 2015 benefit year risk corridors payments.[2] Today, we are confirming that all 2015 benefit year risk corridors collections will be used to pay a portion of balances on 2014 benefit year risk corridors payments.

We are also announcing issuer-level risk corridors payments and charges for the 2015 benefit year. The tables below show risk corridors payments and charges calculated for the 2015 benefit year, by State and issuer, and the additional amount based on anticipated 2015 risk corridors collections that HHS expects to pay towards the calculated 2014 benefit year payments.[3] Pursuant to 45 CFR

[1] *Risk Corridors and Budget Neutrality*, available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf
[2] *Risk Corridors Payments for 2015*, available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF
[3] Risk corridor payment and charge amounts published in this bulletin do not reflect any payment or charge adjustments due to resubmissions after September 30, 2016 or any amount held back for appeals.

STATE	HIOS ID	HIOS INPUTTED INSURANCE COMPANY NAME	HHS 2015 RISK CORRIDOR AMOUNT (INDIVIDUAL MARKET)	HHS 2015 RISK CORRIDOR AMOUNT (SMALL GROUP MARKET)	EXPECTED PAYMENT TOWARD 2014 AMOUNTS
NJ	10191	Freelancers CO-OP of New Jersey, Inc.	$21,700,609.51	$1,475,511.90	$4,988.21
NJ	77606	AmeriHealth HMO, Inc.	$5,486,703.07	$1,333,811.00	$116,232.27
NJ	91661	Horizon Healthcare Services, Inc.	-$3,703,866.20	$0.00	$105,814.71
NJ	91762	AmeriHealth Ins Company of New Jersey	$12,445,206.11	$2,462,716.68	$38,455.14
NJ	48834	Oxford Health Plans (NJ), Inc.	$1,357,526.59	$0.00	N/A
NJ	50221	Oscar Insurance Corporation of New Jersey	$2,132,615.32	$0.00	N/A
NM	19722	Molina Healthcare of New Mexico, Inc.	-$107,005.94	$0.00	$0.00
NM	52744	Presbyterian Insurance Company, Inc.	$0.00	$0.00	$0.00
NM	57173	Presbyterian Health Plan, Inc.	-$499,336.69	-$60,281.72	$82,341.14
NM	75605	Blue Cross Blue Shield of New Mexico	$18,627,474.95	$0.00	$218,141.39
NM	93091	New Mexico Health Connections	$14,280,094.79	$4,706,916.14	$139,903.95
NM	72034	CHRISTUS Health Plan	$134,369.02	$0.00	N/A
NV	16698	Prominence HealthFirst	$501,439.74	$0.00	$0.00
NV	34996	Nevada Health CO-OP	$29,901,096.25	$3,753,264.74	$355,443.99
NV	60156	HMO Colorado, Inc., dba HMO Nevada	$3,155,927.89	$0.00	$90.21
NV	95865	Health Plan of Nevada, Inc.	$643,589.93	$0.00	$0.00
NV	29211	Time Insurance Company	$7,321,151.53	$0.00	N/A
NY	11177	MetroPlus Health Plan	$8,797,440.70	$338,440.65	$290,817.51
NY	18029	Independent Health Benefits Corporation	$0.00	$868,523.25	$0.00
NY	25303	New York State Catholic Health Plan, Inc.	$0.00	$0.00	$0.00
NY	31808	American Progressive Life & Health Insurance Company of New York	$0.00	$0.00	$0.00
NY	40064	HealthNow New York	$1,448,976.32	$8,170,408.69	$0.00
NY	54235	UnitedHealthcare of New York, Inc.	$909,112.89	$0.00	$0.00
NY	56184	MVP Health Plan, Inc.	-$2,414,553.41	$1,447,961.39	$51,511.72
NY	57165	Affinity Health Plan, Inc.	$0.00	$0.00	$39,176.64
NY	71644	Freelancers Health Service Corporation d/b/a Health Republic Insurance of New York	$180,865,046.61	$133,175,392.41	$4,960,652.92
NY	74289	Oscar Insurance Corporation	$50,645,914.29	$0.00	$310,349.58
NY	78124	Excellus Health Plan, Inc.	$1,024,558.12	$23,738,013.87	$250,017.32
NY	80519	Empire HealthChoice HMO, Inc.	-$297,726.69	$0.00	$0.00
NY	82483	North Shore-LIJ Insurance Company Inc	$10,162,882.20	$4,911,774.19	$116,826.04
NY	85629	Oxford Health Insurance, Inc.	$0.00	$0.00	$0.00
NY	88582	Health Insurance Plan of Greater New York	$3,645,672.92	$17,504,832.79	$0.00
NY	91237	Healthfirst PHSP, Inc.	$697,039.60	$0.00	$2,508.78

DOCUMENT 13

THE ENERGY AND COMMERCE COMMITTEE

E&C Leaders Press Administration on White House's Obamacare Insurance Bailout Scheme

Sep 20, 2016 Press Release

Letter Follows CMS Chief's Reinforcement in Sworn Testimony Last Week of Willingness to Settle Lawsuits Regarding Risk Corridors

WASHINGTON, DC – Republican committee leaders are urging HHS Secretary Sylvia Burwell to provide details about the Risk Corridors program and answers to questions concerning statements made by CMS Acting Administrator Andy Slavitt, who testified under oath last week that the administration is willing to settle lawsuits with taxpayer dollars. Congress has acted twice on a strong, bipartisan basis to ensure that the Risk Corridors program is budget neutral, and no taxpayer dollars are used to cover losses by plans. But the Obama administration has since signaled that they may circumvent Congress through a sue-and-settle scheme.

"During the joint hearing, U.S. Rep. Morgan Griffith asked Mr. Slavitt if CMS takes the position that insurance plans are entitled to be made whole on risk corridors payments, even if there is no congressional appropriation to do so. Mr. Slavitt responded under oath: 'Yes, it is an obligation of the federal government.' Mr. Slavitt also testified that the DOJ had reviewed the September 9, 2016, CMS memorandum that invited insurance companies to settle with CMS," **wrote the leaders**. "Since Congress acted twice to protect taxpayer dollars by prohibiting the use of federal funds to make up for any shortfall in risk corridors payments, the Committee is concerned about the Administration's intent to use *any* federal funds to settle the suits brought by the insurance companies. It appears that any such settlements would come from the permanent appropriations for judgments ('Judgment Fund')."

During Rep. Griffith's exchange, he asked CMS to provide the committee with information by the end of the week about insurers who have sued the government over these payments as well as those who have indicated their intent to sue. The lawmakers also requested the names of individuals who have been involved in inter-agency discussions about the lawsuits. To date, the committee has only received publicly available information about carriers that have sued the federal government.

“Further, the Administration’s explicit offer to settle these lawsuits appears to be a direct circumvention of the clear Congressional intent to prohibit the expenditure of federal dollars on this program,” explain the leaders, who requested more detailed information by October 4, 2016.

The letter was signed by Energy and Commerce Committee Chairman Fred Upton (R-MI), Health Subcommittee Chairman Joseph Pitts (R-PA), Oversight and Investigations Subcommittee Chairman Tim Murphy (R-PA), Rep. Leonard Lance (R-NJ), and Rep. Morgan Griffith (R-VA).

Read a full copy of the letter, HERE.

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Subcommittees:

Health (114th Congress)

Oversight and Investigations (114th Congress)

Subcommittees

ADDENDUM B

DOCUMENT 1

SELECTED CONGRESSIONAL ATTEMPTS TO REPEAL OR MODIFY THE ACA OR RCP

Congress has sought to repeal the Affordable Care Act at least 29 times.

H.R. 132, 114th Cong. (2015); H.R. 2829, 114th Cong. (2015); S. 336, 114th Cong. (2015); H.R. 596, 114th Cong. (2015); H.R. 370, 114th Cong. (2015); S. 339, 114th Cong. (2015); H.R. 138, 114th Cong. (2015); H.R. 2900, 113th Cong. (2013); H.R. 132, 113th Cong. (2013); S. 177, 113th Cong. (2013); H.R. 3165, 113th Cong. (2013); H.R. 45, 113th Cong. (2013); H.R. 779, 113th Cong. (2013); H.R. 6079, 112th Cong. (2012); H.R. 141, 112th Cong. (2011); H.R. 145, 112th Cong. (2011); H.R. 105, 112th Cong. (2011); H.R. 6053, 112th Cong. (2012); H.R. 429, 112th Cong. (2011); H.R. 4224, 112th Cong. (2012); H.R. 397, 112th Cong. (2011); S. 192, 112th Cong. (2011); H.R. 364, 112th Cong. (2011); H.R. 299, 112th Cong. (2011); H.R. 215, 112th Cong. (2011); H.R. 655, 111th Cong. (2010); H.R. 5421, 111th Cong. (2010); H.R. 5073, 111th Cong. (2010); H.R. 5424, 111th Cong. (2010).

Congress has attempted to render the risk corridors provision budget neutral at least 6 times.

H.R. 724, 114th Cong. (2015); S. 359, 114th Cong. (2015); S. 123, 114th Cong. (2015); H.R. 221, 114th Cong. (2015); H.R. 5175, 113th Cong. (2014); H.R. 4406, 113th Cong. (2014).

Congress has attempted to repeal the risk corridors provision entirely at least 8 times.

H.R. 3762, 114th Cong. (2015); H.R. 3985, 113th Cong. (2014); H.R. 3812, 113th Cong. (2014); H.R. 3851, 113th Cong. (2014); H.R. 3541, 113th Cong. (2013); S. 1726, 113th Cong. (2013); S. 2214, 113th Cong. (2014); H.R. 4354, 113th Cong. (2014).