2017-1994

In the

United States Court of Appeals for the Federal Circuit

MODA HEALTH PLAN, INC.,

Plaintiff-Appellee,

v.

UNITED STATES,

Defendant-Appellant.

Appeal from the United States Court of Federal Claims, Case No. 1:16-cv-00649, Judge Thomas C. Wheeler

BRIEF OF AMICUS CURIAE THE NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS IN SUPPORT OF PLAINTIFF-APPELLEE

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August 14, 2018

CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, counsel for *amicus curiae* the National Association of Insurance Commissioners certifies the following:

1. The full name of every party or *amicus* represented by one or more of the undersigned is:

- The National Association of Insurance Commissioners

2. The name of the real party in interest (if the party in the caption is not the real party in interest) represented by one or more of the undersigned counsel is:

- None

3. All parent corporations and publicly held companies that own 10% or more of stock in the party:

- None

4. The names of all law firms and the partners or associates that appeared for the party or amicus now represented by me in the trial court or agency or are expected to appear in this court (and who have not or will not enter an appearance in this case) are:

- Douglas J. Schmidt and Kirsten A. Byrd, Husch Blackwell LLP

5. The title and number of any case known to counsel to be pending in this or any other court or agency that will directly affect or be directly affected by this court's decision in the pending appeal:

Federal Circuit

Land of Lincoln Mutual Health Insurance Co. v. United States, No. 17-1224

Blue Cross and Blue Shield of North Carolina v. United States, No. 17-2154

Maine Cmty. Health Options v. United States, No. 17-2395

Court of Federal Claims

Affinity Health Plan, Inc. v. United States, No. 18-110C (Kaplan, J.)

Alliant Health Plans, Inc. v. United States, No. 16-1491C (Braden, J.)

BCBSM, Inc. v. United States, No. 16-1253C (Coster Williams, J.)

Blue Cross and Blue Shield of Alabama v. United States, No. 17-347C (Campbell-Smith, J.)

Blue Cross and Blue Shield of Kansas City v. United States, No. 17-95C (Braden, J.)

BlueCross BlueShield of Tennessee, Inc. v. United States, No. 17-348C (Horn, J.)

Blue Cross of Idaho Health Service, Inc. v. United States, No. 16-1384C (Lettow, J.)

Common Ground Healthcare Cooperative v. United States, No. 17-877C (Sweeney, J.)

Community Health Choice, Inc. v. United States, No. 18-5C (Sweeney, J.)

EmblemHealth, Inc., et al. v. United States, No. 17-703C (Wheeler, J.)

Farmer, et al. v. United States, No. 17-363C (Campbell-Smith, J.)

First Priority Life Ins. Co., Inc., et al. v. United States, No. 16-587C (Wolski, J.)

Health Alliance Medical Plans, Inc. v. United States, No. 17-653C (Campbell-Smith, J.)

Health Net, Inc. v. United States, No. 16-1722C (Wolski, J.)

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Molina Healthcare of Cal., et al. v. United States, No. 17-97C (Wheeler, J.)

Montana Health CO-OP v. United States, No. 16-1427C (Wolski, J.)

Neighborhood Health Plan, Inc. v. United States, No. 16-1659C (Smith, J.)

New Mexico Health Connections v. United States, No. 16-1199C (Bruggink, J.)

Ommen, et al. v. United States, No. 17-712C (Lettow, J.)

Sanford Health Plan v. United States, No. 17-357C (Bruggink, J.)

Sendero Health Plans, Inc. v. United States, No. 17-2048C (Griggsby, J.)

Dated: August 14, 2018

/s/ Steven A. Neeley
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I. IDENTITY AND INTEREST OF AMICUS CURIAE[1]

Founded in 1871, the National Association of Insurance Commissioners ("NAIC") is the U.S. standard-setting and regulatory support organization created and governed by the chief insurance regulators from the 50 states, the District of Columbia, and five U.S. territories. Through the NAIC, state insurance regulators establish standards and best practices, conduct peer review, and coordinate regulatory oversight. The NAIC represents the collective views of state regulators domestically and internationally. The NAIC members, together with the centralized resources of the NAIC, form the national system of state-based insurance regulation in the U.S.

The NAIC's purpose is to provide its members with a national forum enabling them to work cooperatively on regulatory matters that transcend the boundaries of their own jurisdictions. This not only allows for consistency in regulating companies that do business in multiple states, but it provides a central point of communication and facilitation for joint initiatives with federal and international regulators. The NAIC also regularly assists federal regulators, federal agencies, members of Congress and the Government Accountability Office

[1] Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented to the filing of this brief. Pursuant to Federal Rule of Appellate Procedure 29(c)(5), amicus states that no counsel for a party authored this brief in whole or in part, and no person or entity other than amicus or its counsel made a monetary contribution intended to fund the preparation or submission of this brief.

("GAO") by providing information and data related to state insurance regulation, health insurance issues, terrorism insurance, annuities, insurance fraud and many other topics. Collectively, the state Insurance Commissioners work to develop model legislation, rules, regulations, handbooks, white papers and actuarial guidelines that promote and establish uniform regulatory policy. Their overriding objectives are to protect consumers, promote competitive markets, and maintain the financial solvency of insurance companies and the financial stability of the insurance industry as a whole.

Hundreds of state and federal laws, including the Patient Protection and Affordable Care Act ("ACA" or "PPACA"), Pub. L. No. 111-148, 124 Stat. 199 (2010), assign duties to the NAIC and incorporate NAIC standards, models and other publications. NAIC model laws, regulations and other standards, as implemented by the states, are a critical part of the robust regulatory structure in place to monitor the financial solvency of insurers.

The NAIC provided technical guidance and input to Congress as it drafted and debated the ACA. State Insurance Commissioners generally, and the NAIC specifically, are mentioned over 15 times in the Affordable Care Act. The NAIC was asked to develop standards for or provide expert advice to the Secretary of the Department of Health and Human Services ("HHS") on the Medical Loss Ratio, the Summary of Benefits and Coverage, Exchanges, age bands, the temporary

reinsurance program, external review standards, and more. The NAIC has also developed model laws and regulations to assist states in the implementation of the ACA and provided comments on federal regulations.

The interest of the NAIC in this case arises out of the adverse effect of unpaid risk corridor amounts on state Insurance Commissioners' ability to protect consumers. The essential functions through which insurance commissioners promote financial solvency and the fair treatment of policyholders have been impaired. Enormous risk corridor payments have been withheld, undermining competition and unduly burdening the insurers willing to market health plans to an unknown population with vast possible health needs. Just as the insurers who participated in the health marketplaces relied on the federal Government to "turn square corners"[2]and act as a "fair partner"[3]so did the state regulators charged both with protecting health care consumers and the solvency of insurance companies operating in their states.

BACKGROUND

The appellee, Moda Health Plan Inc. ("Moda") offers health insurance plans through American Health Benefit Exchanges ("Exchanges") established in each state for the purchase of insurance in the individual and small group markets.

[2] *United States v. Winstar Corp.*, 518 U.S. 839, 886 n. 31 (1996).

[3] *Moda Health Plan, Inc. v. U.S.*, 892 F.3d 1311, 1340 (Fed. Cl. 2018).

Through passage of the ACA, the United States Congress created the risk corridor system with the intent that insurers would pay the Government a percentage of their profits above a certain threshold of actual cost, from 2014 through 2016. 42 U.S.C. § 18062. The system also required the Government to cover insurers' losses during those years beyond a corresponding threshold. *Id.*

The GAO, in its analysis of the risk corridor system and its intent, noted it would be difficult to predict the proportion of high-cost enrollees and price the plans appropriately: "In order to minimize the possible negative effects of this uncertainty during the initial years of operation of the Exchanges, section 1342 of PPACA directs the Secretary of HHS to operate a temporary risk corridors program. This program is intended to protect against uncertainty in rates for qualified health plans ("QHPs") by limiting the extent of issuer losses and gains for calendar years 2014, 2015, and 2016." Letter from Susan A. Poling, General Counsel, U.S. Gov't Accountability Office, to Sen. Jeff Sessions and Rep. Fred Upton (Sept. 30, 2014)[4] (citing Pub. L. No. 111-148, § 1342(a) and 77 Fed. Reg. 17220, 17221 (Mar. 23, 2012)).

Insurers planning to operate on the Exchanges were assured of full risk corridor payments. On March 11, 2013, the Center for Medicare and Medicaid Services ("CMS") released its rule governing the schedule of the risk corridor

[4] Available at: *http://www.gao.gov/assets/670/666299.pdf.*

program and stated that "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 [ACA]." *See Moda Health Plan, Inc., v. United States,* 130 Fed. Cl. 436, 444 (2017).

It was not until 2014, when coverage under these QHPs was effective, that insurers operating on the Exchanges began receiving conflicting guidance from the Government on the amount of funds available. In April of 2014, a memorandum issued by HHS announced possible pro rata payments depending on available funds. The memorandum indicated the goal of the program was budget neutrality. *See id.* at 445. By December of 2014, Congress had expressly prohibited the CMS Program Management appropriation from specifically funding risk corridor payments in 2015 and 2016. *See id.* at 447. As a result, the available offset funds to make insurers whole under the program represented only 12.6% of the amounts owed. *See id.* at 448.

II. ARGUMENT

The unpaid risk corridor funding impacts not only the insurance companies, but the insurance regulators and, most importantly, the consumers those regulators are charged with protecting. Insurance Commissioners continue to maximize the interests of consumers wherever possible, but their ability is limited in a defunded Exchange marketplace. This is most evident in the rate review process.

A. Calculation and approval of prospective insurance rates are skewed by large scale nonpayment of risk corridor amounts.

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

The ratemaking process is challenging even in a stable market, as insurers must predict health care costs. An unpaid bill in the hundreds of millions, such as various Exchange insurers have alleged in the Court of Federal Claims, greatly impacts regulators' ability to exercise the appropriate rate review and evaluate whether proposed rates are fair and adequate. As the Pennsylvania Insurance Department noted in support of four domestic insurers in their risk corridor lawsuit, the insurers were locked into market participation before learning of the shortfalls that undermined their ratemaking process:

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

Brief for Penn. Insur. Dep't as Amicus Curiae, *First Priority Life Insurance Co., Inc. et al. v. U.S.*, Case No. 16-587 at 5 (Fed. Cl. filed Oct. 14, 2016).

If this Court determines these massive deficits are indeed not owed by the Government, then state regulators will have to evaluate the fairness of rates in an environment where (1) insurers have tremendous financial exposure through no fault of their own and (2) the market is populated by these disadvantaged insurers, while other financially stronger insurers are deterred from participating. The sum of this equation is higher rates and a higher burden on consumers. As Maryland Insurance Commissioner Al Redmer testified with respect to risk corridor lawsuits, "[Carriers] would still be legally obligated to provide these more costly plans, but the courts could prohibit Treasury from reimbursing them without an appropriation. . . . Uncertain funding streams lead to higher premiums." *Rising Health Insurance Premiums Under the Patient Protection and Affordable Care Act*: Before the H. Oversight and Gov't Reform Subcomm., 114th Cong. p. 6 (Sept. 14, 2016) (testimony of Comm'r Al Redmer Jr., on behalf of the NAIC ("Redmer Testimony")).

In this respect, the NAIC's members navigate the rate approval process with tied hands. Similarly, regulators are not able to overcome the negative impact on the marketplace resulting from the Government's broken promises. The lack of

funding for insurers offering QHPs on the Exchanges has operated to stifle competition and leave fewer options at higher cost to consumers.

B. The Government's failure to make full risk corridor payments has suppressed competition in the Exchanges, burdening consumers and regulators.

Promoting competition stands alongside financial solvency and consumer protection as an essential part of the NAIC's mission. Approval of policy rates and forms, scrutiny of health plans for the inclusion of mandated benefits, and ongoing monitoring of reserves and investments to improve financial solvency are essential regulatory functions and serve the public well. But the infusion of competition is frequently beyond the regulator's control: "[m]arket competition can apply pressure that the Department cannot. Without this pressure, insurers may choose to eliminate certain plan offerings or attributes that consumers have enjoyed in the past." Brief of Penn. Insur. Dep't, *First Priority Life Ins.*, Case No. 16-587 at 10 (2016).

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

Insurance companies relied on financial inducement from the Government in deciding to market plans to an unknown demographic. Insurers' profit margins are under constant scrutiny from state regulators, meaning the companies do not have unfettered ability to raise prices in order to cover losses. Many companies simply could not afford to stay in the Exchanges, and the resulting lack of competition and risk of monopoly can be traced back to the Government's drastic miscalculation.

The risk corridor program was specifically developed to induce greater participation by insurers on the Exchanges.[5] When full payments under the program were not forthcoming and guidance was conflicting among HHS and Congress, it was inevitable that insurers were then deterred from participating: "Private companies cannot be expected to participate in a market where the rules and regulations are not made clear in advance and where there is no faith that the government will uphold its end of the bargain." Erin Trish, Loren Adler, and Paul

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

B. Ginsburg, *To Promote Stability in Health Insurance Exchanges, End the Uncertainty Around Cost-Sharing and Other Rules,* Brookings (April 20, 2017).[6]

It should be noted that in those cases where an Exchange insurer fails completely, it will be up to the Insurance Commissioner to continue the company's struggle in collecting unpaid risk corridor amounts.[7] Insurance Commissioners are concerned about the sheer dollar figures representing unpaid risk corridor amounts, as such funds could compensate policyholders following an insolvency. In this sense, the majority panel's decision jeopardizes the general insurance-buying public as well as insurers and regulators.

The states are not likely to see intervention from the Government to maintain basic standards of availability and competition. It falls immediately to the state insurance commissioner to conduct outreach and solicit participation by insurers. These efforts come at a cost – commissioners do not retain the same ability to restrain rates once competition is suppressed. Taken together, these conditions will

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

[7] An order to liquidate the business of an insurer shall appoint the commissioner and any successor in office as the liquidator and shall direct the liquidator to take possession of the property of the insurer and to administer it subject to this Act. The liquidator shall be vested by operation of law with the title to all of the property, contracts and rights of action, and all of the books and records of the insurer ordered liquidated, wherever located, as of the entry of the final order of liquidation. NAIC Model Laws, *Regulations and Guidelines*, Art. V, Sec. 501, 555-38, 20XX WL 8342898 (1936, amended 2007).

have the greatest impact on states' most vulnerable consumers who rely on the Exchange subsidies in order to obtain affordable health insurance.

III. CONCLUSION

The ACA recognized the essential regulatory functions of Insurance Commissioners and created a partnership allowing its terms to be implemented at both the state and federal level. The risk corridor program was vital to keeping insurance markets healthy. State Insurance Departments have virtually transformed—shifting limited resources, investing in innovation, and enacting new law—in order to fulfill their obligations. But the Government has not been a fair partner.

The failure to make full risk corridor payments to insurers operating on the Exchanges has interfered with state insurance commissioners' essential mission to protect insurance consumers. It has induced insurers into the market only to directly compromise these companies' financial condition once they committed. It has skewed rate review by introducing an additional level of uncertainty. Finally, it has deterred the insurance industry in general from marketing qualified plans on the Exchanges, dampening competition and hurting consumers.

The insurance market cannot function properly with the disruption caused by the Government's failed obligations. "As any actuary will tell you, insurance hates uncertainty." Redmer Testimony at 4. As insurance companies increasingly find

no advantage to participating in the Exchanges, it is the consumers who suffer from the lack of affordable health coverage.

The NAIC and its members request this Court accept review of the panel majority's ruling and order payment of full risk corridor amounts in order to protect consumers, stabilize the market, promote competition and boost financial solvency across the health insurance industry.

Dated: August 14, 2018

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CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with the type-volume limitation of Fed. R. App. P. 32 and Federal Circuit Rule 32 because this brief contains 2,581 words excluding the parts exempted Fed. R. App. P. 32(f) and Federal Circuit Rule 32(b).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and (a)(6) because it has been prepared in a proportionally spaced type-face using Microsoft Word in a 14-point Times New Roman font.

Dated: August 14, 2018

/s/ Steven A. Neeley
Steven A. Neeley

CERTIFICATE OF SERVICE

I certify that on August 14, 2018, I filed the foregoing document by the U.S. Court of Appeals for the Federal Circuit's CM/ECF System.

/s/ Steven A. Neeley
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