

September 27, 2016

The Honorable Paul Ryan
Speaker
U.S. House of Representatives
Washington, D.C. 20515

The Honorable Nancy Pelosi
Minority Leader
U.S. House of Representatives
Washington, D.C. 20515

Dear Mr. Speaker and Madame Minority Leader:

The National Association of Insurance Commissioners (NAIC) asks Congress to take prompt action to ensure continued protection and priority of policyholder claims in the event of insurer insolvency. The Department of Justice (DOJ), on behalf of the Department of Health and Human Services (HHS), undermines policyholder protections long recognized under state and federal law by asserting that debts allegedly owed by failed Consumer Operated and Oriented Plans (CO-OPs), which were established under the Affordable Care Act (ACA), to the federal government – or to other insurers – should have precedence over the CO-OPs’ obligations on their insurance policies.

This conduct: (1) harms policyholders, healthcare providers, and taxpayers of the states where the CO-OPs operated; (2) lacks legal authority and violates the statutory priority of distribution of assets to creditors, as well as long standing Supreme Court precedent; and (3) threatens the fair, orderly, timely, and transparent administration of state liquidation proceedings.

- **States Exclusively Regulate Insurance Company Solvency and Developed Statutes to Protect Policyholders**

The states have long been the primary regulator of the insurance industry and the *exclusive* regulator of insurer financial health, rehabilitation, and liquidation. States developed specialized statutes addressing insurance company rehabilitation and liquidation, with the paramount purpose of protecting policyholders. Under state statutes, policy claims have first priority after administrative expenses, and are paid before all other creditor claims, including the so-called “super-priority” claims of the federal government. Federal claims not otherwise subordinated have the next priority of payment, ahead of all claims except policy claims and estate administration. In addition, the state process protects all creditors and maximizes estate assets by ensuring all claims are resolved in a single, transparent, and efficient process.

More than two decades ago, DOJ challenged the state priority scheme by claiming that federal law, which by its terms grants the highest priority to the federal government, preempted state liquidation laws. The Supreme Court rejected that challenge in 1993 in *U.S. Dept. of Treasury v. Fabe*, holding that state laws protecting policyholder priority regulate the business of insurance and therefore “reverse preempt” federal law under the McCarran-Ferguson Act (15 U.S.C. §§ 1011-1015). Congress implicitly concurred with state law distribution priority and policyholder protection above other creditors because it has not reversed the holding in *Fabe* despite ample time to do so.

- **Congress Did Not Intend to Usurp State Liquidation Law by Enacting the ACA**

DOJ asserts that because the ACA specifically relates to the business of insurance it is not subject to “reverse preemption” and therefore overrides state liquidation laws. While that would be true if the ACA enacted a conflicting priority scheme, it does nothing of the sort. *No provisions* in the ACA address insurer solvency

requirements or insurer rehabilitation or liquidation. To the contrary, the ACA includes an express anti-preemption clause, 42 U.S.C. §18041(d) (titled “No interference with State regulatory authority”) stating: “Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.” Thus, far from preempting state law protections for policyholders, the ACA expressly preserves them, and leaves liquidation within the exclusive purview of the states.

The ACA made no exception to this principle when it called for the federal government to become the CO-OPs’ founding investor by authorizing funding in the form of “start-up” and “solvency” loans. HHS approved and funded 23 CO-OPs, which began covering consumers on January 1, 2014. HHS reviewed the policyholder priority laws when formulating the ACA regulations and did not substitute any federal process or attempt to create any special priorities should a CO-OP experience financial distress or insolvency. HHS concluded that state regulation should exclusively govern solvency matters. As HHS explained: “In the potential case of insurer financial distress, a CO-OP follows the same process as traditional issuers and must comply with all applicable State laws and regulations.” (Final Rules, Responses and Comments, 45 C.F.R. 156, E.6 and F Dec. 13, 2011.) Additionally, under the express loan terms *drafted by HHS*, the start-up loans were subordinated to policyholder claims, and the solvency loans, because they serve as capital contributions, were further subordinated to all other creditor claims.

- **HHS/DOJ’s Reduction of Payments Owed to the CO-OPs to Recoup Claimed Federal Debts is Not Supported Under the Law or the CO-OP Loan Agreements**

Notwithstanding the Supreme Court’s precedent in *Fabe* and HHS’s affirmation that policyholder claims should receive the highest priority, DOJ now claims HHS may collect debts of the insolvent CO-OPs *before* policyholder level claims are paid by unilaterally reducing payments owed to the insolvent insurers. DOJ asserts ACA regulation 45 C.F.R. § 156.1215 (“netting regulation”) as its authority for this conduct. However, because the ACA does not preempt state liquidation laws, any regulation that purported to alter the priority of claims in liquidation would be void, because it would exceed the agency’s regulatory authority and would violate the McCarran-Ferguson Act. State liquidation laws expressly govern the extent to which a creditor may or may not use netting as self-help in collecting its claims against an insolvent insurer, and the ACA did not give HHS the authority to preempt those laws through rulemaking.

Furthermore, DOJ’s purported reliance on the netting regulation is belied by the fact that HHS has failed to follow the very mandate of that regulation. In particular, HHS fails to account for *all* debts and credits, including the millions HHS owes to carriers for Risk Corridors, of which HHS has only paid a small fraction (12.6%). The netting regulation expressly includes Risk Corridors in the list of payments subject to “netting”.

HHS claims that netting is essential to have sufficient funds to pay other carriers, and that if it is not allowed to net, this will harm other carriers and ultimately consumers. HHS ignores that a principal cause of CO-OP financial stress is the shortfall under the Risk Corridor program.

In addition, HHS’s own conduct negates any claim that netting is essential to pay carriers amounts owed under ACA programs. In at least one circumstance, HHS reduced a payment owed to an insolvent CO-OP to recover a \$15 million debt on a start-up loan, only to pay those funds to the U.S. Treasury rather than to carriers. Netting cannot be critical to the administration of ACA programs if the funds purportedly withheld to fund those programs are instead diverted to the U.S. Treasury.

In addition, the netting regulation provides no legal authority for HHS/DOJ to recoup on the start-up loan by netting. HHS did not reference debts under the start-up loans in the netting regulation, and the loan agreements stated that the loans were subordinated to policyholder claims. This means that if a CO-OP were to become insolvent, there was a contractual agreement that policyholder claims would be paid first, before all other creditors. This is consistent with Congressional intent and insurance industry practice – the company’s investors

typically may only collect after policyholder and other creditor claims are paid. Nevertheless, DOJ now seeks to renege on that agreement and collect on these investor claims ahead of policyholder claims.

- **The Federal Government Cannot Pick and Choose Which Policy Claims Deserve Priority**

In some CO-OP liquidations, DOJ argues that despite what Congress, the Supreme Court, and the State Legislatures have all said, state laws prioritizing policy benefit claims are not fully saved from preemption. DOJ's position seems to be that the priority of claims should be decided on a case-by-case basis rather than on the basis of a comprehensive legislative framework, so that benefit claims involving direct payment to healthcare providers receive less protection than benefit claims involving patient reimbursement. The result, if DOJ had its way, would be that out-of-network health benefit claims have privileged status, while federal "super-priority" would trump the payment of in-network benefit claims. The notion that only out-of-network claims qualify as "real" policy claims is exactly the opposite of the incentive system codified by the ACA.

The rationale appears to be that if providers commit to hold patients harmless from balance billing, then the policy benefit priority does nothing to protect patients and therefore should be preempted. This reasoning is deeply flawed for two reasons. First, the question is not whether the law protects policyholders, but whether it regulates the business of insurance. Insurance liquidation laws give priority to policy benefit claims, both first-party and third-party, because insurers' essential purpose is the payment of insurance benefits. Second, and even more important, providers' promise to their patients that their sole recourse will be against the insolvent insurer's estate rests on the state's promise to the provider that there *will* be recourse against the insolvent insurer's estate. The provider – except in the special case of provider-owned insurers – stands in the shoes of the patient with the same priority rights. The uniform priority under state law for policy benefit claims protects patients, even when payments are made to providers, because if providers could not receive payment, they would not agree to refrain from billing the patients.

- **If HHS/DOJ Abuses its "Super-Priority" Status, Policyholders, Healthcare Providers and Residents of Affected States will be Harmed**

If HHS/DOJ collects its claims ahead of policy claims, it will harm policyholders. For many years, the state priority scheme protected policyholders from risks associated with insurer insolvency.. Congress should not allow DOJ to ignore insolvency laws and harm consumers by rewriting the "super-priority" law to nullify claims for insurance benefits.

Some of the failed CO-OPs are located in states where state law provides guaranty association protection to policyholders. This means that the CO-OP participates in a system that assesses all health insurers to cover policyholder claims against an insolvent insurer. The guaranty association promptly pays policyholder claims in full unless they exceed the guaranty association's statutory limit, commonly \$500,000 per claimant. After a guaranty association pays the policyholder claims, it holds a claim against the estate at the policyholder level and the insurers that paid the assessments receive a dollar-for-dollar state tax credit. Thus, taxpayers of those states pay the price for the CO-OP collapse through revenue shortfall and higher taxes.

Due to the financial consequences of rapid market changes following ACA enactment, the health insurance market as a whole is still in flux. Several companies exited the marketplace, which decreased the pool of money from which guaranty associations can draw. While in some states these companies may realize a premium tax reduction, it may not be sufficient to offset the insurer's contribution to pay for a carrier insolvency. An increase in premiums across all segments of the market reflects those costs.

In other states, the CO-OP does not participate in the guaranty association. In those states, the impact of a CO-OP collapse falls directly on patients and health care providers, and every dollar of the insurer's estate that is diverted for other purposes is another dollar of unpaid medical bills.

- **Conclusion**

The ACA's purpose was to ensure "quality, affordable health care for all Americans." Instead of protecting policyholders, the HHS/DOJ abuse of the federal "super-priority" will have a significant financial impact on policyholders, providers, the states, and state taxpayers. It will also disrupt the orderly liquidation process established by the states, confirmed by Congress, and endorsed by HHS when it promulgated ACA regulations.

The NAIC urges your prompt attention and action to ensure continued protection and priority of policyholder claims. State insurance receivership laws are part of a comprehensive legislative scheme that regulates the business of insurance. The McCarran-Ferguson Act protects these laws in their entirety, subject only to a provision ensuring appropriate priority for federal claims not otherwise subordinated, behind policy benefit claims and ahead of general creditors. Insurance insolvency laws should have full parity with other financial institution resolution laws as a recognized alternative to bankruptcy proceedings. Federal claims can be filed and adjudicated in the same manner as all other claims against the estate of an insolvent insurer and all creditors will be fairly and efficiently protected.

Sincerely,



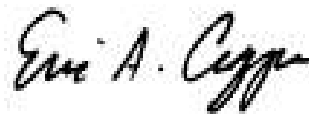
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