No. 18-1028

IN THE
SUPREME COURT OF THE UNITED STATES

MODA HEALTH PLAN, INC.,,
Petitioner,

v.

UNITED STATES,
Respondent.

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA,
Petitioner,

v.

UNITED STATES,
Respondent.

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

BRIEF OF 18 STATES AND THE DISTRICT OF COLUMBIA AS AMICI CURIAE IN SUPPORT OF PETITIONERS

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QUESTION PRESENTED

Is the federal government required to make the "risk corridor" payments to insurers that Congress mandated in the Affordable Care Act?

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STATEMENT OF INTEREST OF AMICI

This case implicates the interests that Oregon and other states have as the primary regulators of the health insurance industry. *See* 15 U.S.C. § 1012(a) ("[t]he business of insurance * * * shall be subject to the laws of the several States"); 15 U.S.C. § 1011 ("the continued regulation and taxation by the several States of the business of insurance is in the public interest").

In the Affordable Care Act ("ACA"), Congress mandated "risk corridor" payments to insurance companies to mitigate risk and entice those companies into a marketplace that was untested in crucial respects. Many state regulators relied on that mandate when reviewing proposed rates to ensure that their citizens would receive access to affordable health insurance from financially stable companies. The court of appeals' ruling in this case, which held that Congress later eliminated the risk-corridor payments through a budget rider, has affected and will continue to affect the viability of insurance companies regulated by the amici states. The ruling will also have a practical impact in future cases in which Congress mandates risk-mitigating payments to attract participation in a state-regulated industry.

Because of their strong similar interests in the outcome of this case, several states and the District of Columbia participated as amici in support of petitioner before the court of appeals. The amici states now submit this brief in support of the petition for certiorari under Supreme Court Rule 37.4; counsel of record received timely notice of the intent to file the brief under Rule 37.2(a).

SUMMARY OF ARGUMENT

The court of appeals correctly held that, when enacting risk-corridor payments, Congress intended to create an enforceable obligation to pay insurance companies the full amount due under a statutory formula. But the court then relied on post-enactment appropriations riders to infer that Congress repealed that obligation, even though Congress at the same time failed to pass a substantive amendment that would have done so expressly.

If that opinion is allowed to stand, the federal government will be allowed to avoid making the promised payments that it used to entice petitioner and other companies into offering insurance under the ACA. That result compromises those companies' ability to continue providing health insurance coverage, transfers costs to consumers, places additional regulatory burdens on the states, and undermines Congress's stated goal in adopting the ACA—providing health insurance coverage for millions of Americans who previously were uninsured. The Court should grant certiorari to decide whether Congress intended to achieve such a substantive and far-reaching result by means of appropriations riders after expressly rejecting stand-alone legislation to the same effect.

ARGUMENT

The court of appeals correctly held that, in the statute creating the risk-corridors program, Congress "created an obligation of the government to pay" insurers "the full amount indicated by the statutory

formula for payments out under the risk corridors program." Pet. App. 20. But a divided panel also held that "riders in the appropriations bills for FY 2015 and FY 2016 repealed or suspended" that obligation to the extent that the relevant statutory formula called for outgoing payments in an amount exceeding incoming payments under the risk-corridors program. Pet. App. 21. The majority viewed those riders as supplying an "*implication* of Congress's intent to impose a new payment methodology for the time covered by the appropriations bills in question." Pet. App. 23 (emphasis added). But that "new payment methodology" amounts to nothing less than breaking a congressional promise on which a significant commercial market was built, consequently destabilizing that entire market. As explained below, that result is too significant for Congress to have effected it implicitly in an appropriations rider. And because the ruling will have far-reaching effects on the market for health insurance, it warrants review on a writ of certiorari.

A. Failing to honor the promise of risk-corridor payments will significantly and adversely affect the insurance markets in many states.

1. The ACA created a new insurance marketplace, one full of unknowns. Congress's stated goal was to "add millions of new consumers to the health insurance market * * * and increase the number and share of Americans who are insured." 42 U.S.C. § 18091(2)(C).

Under the ACA, insurers would be offering federally shaped products to millions of citizens whose health histories or risks were largely unknown, and whose purchasing behavior under the new marketplace rules was difficult to predict. Further, the ACA required policies to be "guaranteed issue"—i.e., issued without regard to the applicant's health. Before the ACA, Oregon and virtually all other states had permitted individualized medical underwriting. *Compare* Or. Rev. Stat. § 743.766 (2009), *and* Or. Laws 2003, ch. 748, § 7 (pre-ACA version of statute allowing "carriers who offer individual health benefit plans" to "evaluate the health status of individuals for purposes of eligibility"), *with* Or. Rev. Stat. § 743.766 (2013), *and* Or. Laws 2011, ch. 500, § 24 (post-ACA version allowing such health status evaluation only for "grandfathered health plans," i.e., health plans in existence prior to enactment of the ACA); *see also* 42 U.S.C. § 18011 (defining "grandfathered health plan" as one in which such individual was enrolled on March 23, 2010).

Due to the new marketplace's uncertainties, many health insurance companies were reluctant to enter the market. The same uncertainties initially bedeviled state regulators as they tried to assess the rates that petitioner and others proposed for insuring the previously uninsured.

Congress understood all of this when it mandated risk-corridor payments, which it intended to help stabilize the ACA's new and unknown marketplace, and to diminish the risks of entering that marketplace. *See* Pet. App. 2 ("The ACA established three pro-

grams designed to mitigate that risk and discourage insurers from setting higher premiums to offset that risk: reinsurance, risk adjustment, and risk corridors."). For the statutory scheme to have the effect intended by Congress (in part, the providing of insurance to millions of previously uninsured citizens), the payment mandate needed to be understood as creating an enforceable obligation. Otherwise, insurance companies would be deterred by the risks they faced from entering that new market, and state regulators might be deterred from allowing carriers to shoulder those risks.

2. Consistent with Congress's understanding that the promise of risk-corridor payments was necessary to a well-functioning ACA marketplace, the government's failure to honor that promise has significantly and adversely affected the insurance markets in multiple states.

In Oregon, the government's failure to make the promised payments has had a significant adverse impact. As of September 30, 2015, petitioner Moda Health Plan, Inc. had enrolled roughly 244,000 Oregonians. Oregon Department of Consumer and Business Services, News release, *State places Oregon health insurer under supervision* (Jan. 28, 2016) ("DCBS news release"), *available at* http://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=947 (last visited Feb. 13, 2019). For 2014 and 2015, the government owed and failed to pay Moda more than $210 million in risk-corridor payments. Pet. 11. Those non-payments caused Moda to descend into hazardous operating conditions, which

in turn prompted the State of Oregon to assume supervision of Moda, meaning that it maintained a representative on site and controlled all financial decisions. DCBS news release, *supra*. The State of Oregon subsequently lifted the supervision order, based on Moda's commitment to raise $179 million in new capital—nearly the $214 million that Moda had failed to collect from the federal government under the risk-corridors program. *In the Matter of Moda Health Plan, Inc.*, No. INS 16-13-002, Consent Order (Or. Dep't of Consumer & Bus. Servs. Feb. 6, 2016).

Other states also were adversely affected by Congress's broken promise. To stabilize its Oregon operation, Moda also pulled out of the Washington market, thus weakening the health insurance market in that state. Washington State Health Care Authority, News release, *Moda Health pullout from Washington health insurance market doesn't affect its participation with PEBB Program in 2016* (Nov. 2, 2015), *available at* https://www.hca.wa.gov/about-hca/moda-health-pullout-washington-health-insurance-market-doesn-t-affect-its-participation (last visited Feb. 13, 2019) (noting that "Moda Health has notified the Office of the Insurance Commissioner that it will not participate in the Washington Health Benefit Exchange * * * for 2016 coverage").

The failure to make full risk-corridor payments has similarly undermined the ACA's goal of promoting stability in Pennsylvania's insurance market. After the federal government announced that it would not be making full payments for 2015, several insurance carriers there sought to raise their rates by more

than 40 percent. *See* Brief of Pennsylvania Insurance Department as Amicus Curiae Supporting Plaintiffs 13–14, *First Priority Life Ins. Co., et al. v. United States*, No. 16-587C (Ct. Fed. Cl. Oct. 14, 2016).

Similarly, the loss of promised risk-corridor payments led to the failure of one health insurer in Colorado—the Colorado Health Insurance Cooperative, Inc.—and its associated liquidation created a substantial burden borne by Colorado consumers and regulators. *See* Colorado Dep't of Reg. Agencies, *Division of Insurance moves to protect Colorado consumers, takes action against HealthOP*, Oct. 16, 2015, *available at* https://www.colorado.gov/pacific/dora/Division-of-Insurance-action-HealthOP (last visited Feb. 28, 2019). That failure also has forced Colorado insurance regulators to take significant additional actions to protect policyholders, creditors, and the public. Nat Stein, *Here's what happened to Colorado HealthOP*, Colorado Independent, Oct. 23, 2015, *available at* https://www.coloradoindependent.com/2015/10/23/heres-what-happened-to-colorados-health-co-op/ (last visited Feb. 28, 2019).

Alaska was especially hard-hit by the failure to make risk-corridor payments. On the same day that Oregon announced its supervision order, the State of Alaska issued an order requiring Moda, due to inadequate capital, to withdraw from Alaska's individual market. Tegan Hanlon, *Alaska kicks Moda Health out of individual insurance market*, Anchorage Daily News, Jan. 28, 2016, *available at* https://www.adn.com/health/article/alaska-kicks-moda-health-out-individual-insurance-market-leaving-only-

premera/2016/1/28 (last visited Feb. 13, 2019). Moda had been one of only two insurance companies offering plans in Alaska's individual health insurance market and had occupied more than 50 percent of that market. *Id.*; Alaska Division of Insurance, *Presentation to Alaska Sen. Health & Social Servs. Comm.* 6 (Feb. 17, 2016), *available at* http://www.legis.state.ak.us/basis/get_documents.asp?session=29&docid=40775 (last accessed Feb. 25, 2019). With Moda's exit, Alaskans had no option but to choose a plan from the remaining insurance provider, leaving less choice in coverage options and provider networks. And with the possibility that Moda's exit would exacerbate the spiral in Alaskans' health insurance premiums—already the highest in the nation, Tegan Hanlon, *Alaska's already high health insurance rates set to get even higher in 2016*, Anchorage Daily News, Nov. 3, 2015, *available at* https://www.adn.com/health/article/xg-0/2015/11/04/ (last visited Feb. 25, 2019)—the State of Alaska adopted an emergency reinsurance program, spending $55 million to slow the rate of premium increases. H.R. 374, 29th Leg., 4th Spec. Sess. (Alaska 2016); Alaska Div. of Ins., Presentation to Alaska Sen. Fin. Comm.: H.B. 374 – Reinsurance Program; Health Insurance Waivers 12 (May 31, 2016), *available at* http://www.akleg.gov/basis/get_documents.asp?session=29&docid=66685 (last visited Feb. 25, 2019). Although this backstop has stabilized the rate of premium increase,[1] there is still only one company offering

[1] The federal government has provided the bulk of funding for the reinsurance program in 2018 and

insurance plans on Alaska's individual market, to the detriment of consumers. Alaska Dep't of Comm., 2019 Individual Health Insurance Plan Information 1 (Oct. 8, 2018), *available at* https://www.commerce.alaska.gov/web/portals/11/pub/INS_2019_Enrollment_Information_Individual%20Market.pdf (last visited Feb. 25, 2019).

Finally, the federal government's unfulfilled promises have caused the failure and state supervision of another Oregon company—Health Republic Insurance Company (HRIC), which insured more than 10,000 members and who was owed roughly $20 million in promised risk-corridor payments for 2014–15. Nick Budnick, *Oregon insurer Health Republic to shut down in 2016, cites $20 million federal hit*, The Oregonian, Oct. 16, 2015, *available at* https://www.oregonlive.com/health/2015/10/oregon_insurer_health_republic.html (last visited Feb. 13, 2019). HRIC, which is the lead plaintiff in a class action contesting the governmental non-payments, was a co-op formed with federal start-up loans totaling more than $50 million. *Id.*; *see also Health Republic Ins. Co. v. United States*, No. 16-259C (Fed. Cl.). In licensing such

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2019, but the $55 million spent in 2017 were entirely State of Alaska funds. See Erica Martinson, *Premera expects big cut in health insurance premiums on Alaska's individual market*, Anchorage Daily News, Aug. 1, 2017, *available at* https://www.adn.com/alaska-news/health/2017/08/01/premera-expects-a-21-6-percent-decrease-in-individual-market-premiums-for-2018/ (last visited Feb. 25, 2019).

companies, Oregon had relied on pro forma financial statements that included substantial risk-corridor payments in addition to loan funds under the ACA.

The refusal to make risk-corridor payments frustrates the ACA's goal of diversifying the health insurance marketplace and results in defaults on federal loans. If insurance companies fail, it reduces the availability of potential insurers who are willing to provide insurance in a manner that furthers the ACA's overall goals.

3. Those effects are likely just the beginning. If the Federal Circuit's opinion stands, regulators and insurers will have to address the permanent loss of the promised risk-corridor payments on which they had relied. In some instances, the federal government's unpaid risk-corridor obligations will be passed on to ratepayers, thus shifting costs of the federal default to the consumers themselves. In other instances, unpaid risk-corridor obligations, by increasing the costs and risks of doing business in the individual health insurance markets, will reduce the number of carriers willing to cover those markets, particularly in rural areas. *See* Oregon Department of Consumer and Business Services, News release, *DCBS to place Oregon's Health CO-OP in receivership* (July 8, 2016), *available at* https://www.oregon.gov/newsroom/Pages/NewsDetail.aspx?newsid=1211 (last visited Feb. 13, 2019) (noting the state's "concern about limited options for consumers, particularly in rural areas of the state," and noting that "several insurers are discontinuing coverage in certain counties for 2017").

Like many states, Oregon has struggled to maintain statewide coverage in the face of federal headwinds.

None of this is surprising. Indeed, as set forth above, Congress was well aware that, in the absence of an enforceable promise of payments under the risk-corridor program, these effects were entirely predictable.

B. The court of appeals erred in concluding that Congress reneged on its promise of risk-corridor payments through appropriations riders.

Because Congress understood how fundamental the promise of risk-corridor payments would be to the ACA and to state insurance marketplaces, Congress is unlikely to have reneged on that promise implicitly by burying a "new payment methodology" in appropriations riders. Indeed, Congress expressly considered and rejected stand-alone legislation to implement precisely the same "new payment methodology" that the court of appeals' majority inferred from the appropriations riders. *See* Pet. App. 49–50 & n.3 (dissenting opinion discussing Obamacare Taxpayer Bailout Protection Act, S. 2214, 113th Cong. (2014)).

In contrast to that rejected bill, the appropriations riders at issue did not purport to change the payment methodology or impose a new requirement of budget neutrality. To the contrary, their text did nothing more than prevent certain appropriations or funds from being diverted to pay for the risk-corridor pro-

gram. *See* Pet. App. 12–13 (quoting the relevant appropriations rider).

It is dangerous for a court to interpret an appropriation rider as implicitly enacting an amendment that Congress rejected under the normal legislative process. To do so undermines the transparency of the legislative process, encouraging legislators to enact important and controversial legislation through the appropriations process rather than through the open debate and proper deliberation required for normal legislation. Such prudential concerns about the legislative process have given rise to the "cardinal rule that repeals by implication are not favored" and that "the intention of the legislature to repeal must be clear and manifest." *Tennessee Valley Auth. v. Hill*, 437 U.S. 153, 189 (1978) (quotations omitted; discussing similar prudential concerns about the legislative process). That rule applies with even greater force here, where the purportedly implicit amendment was rejected as substantive legislation, would not just amend but significantly impair the ACA, and would renege on a promise that Congress invited insurers and regulators to rely upon.

This case merits certiorari review to determine whether Congress intended the appropriations riders at issue to implicitly amend the ACA in such a far-reaching and self-defeating way. Because the answer to that question could significantly destabilize state health insurance markets, it warrants this Court's attention.

CONCLUSION

The Court should grant a writ of certiorari.

Respectfully submitted,

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