Nos. 18-1023, 18-1028, 18-1038

IN THE

Supreme Court of the United States

MAINE COMMUNITY HEALTH OPTIONS, *Petitioner*
v.
UNITED STATES, *Respondent.*

MODA HEALTH PLAN, INC. ET AL., *Petitioners,*
v.
UNITED STATES, *Respondent.*

LAND OF LINCOLN MUTUAL HEALTH INSURANCE COMPANY, AN ILLINOIS NONPROFIT MUTUAL INSURANCE CORPORATION, *Petitioners,*
v.
UNITED STATES, *Respondent.*

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

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

GAIL SCIACCHETANO
Deputy General Counsel
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
1100 Walnut Street
Kansas City, MO 64108

DEREK T. TEETER
Counsel of Record
DOUGLAS J. SCHMIDT
KIRSTEN A. BYRD
MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main St., Suite 1000
Kansas City, MO 64112
(816) 983-8000
derek.teeter@huschblackwell.com

Counsel for Amicus Curiae

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INTEREST OF AMICUS CURIAE[1]

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

The interest of the NAIC in this case relates to the federal government's unreliability as a business and regulatory partner in implementing the provisions of the Affordable Care Act ("ACA"). Just as the government relied upon state regulators to develop laws and standards in order to implement the ACA, regulators relied on the government to comply with the ACA, including the risk corridors mandate.

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[1] Pursuant to Supreme Court Rule 37.3(a), all parties have consented to the filing of this brief. Pursuant to Rule 37.6, amicus curiae certifies that no counsel for a party authored this brief in whole or in part, and no persons other than amicus curiae or its counsel made a monetary contribution to the brief's preparation or submission.

The NAIC regularly assists federal regulators, federal agencies, members of Congress, and the Government Accountability Office by providing information and data related to state insurance regulation of all lines of insurance. Their overriding objectives are to protect consumers, promote competitive markets, and maintain the financial stability of the insurance industry.

Hundreds of state and federal laws, including the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 199 (2010), assign duties to the NAIC and incorporate NAIC standards, models, and other publications.

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

The NAIC's members have a further interest in this action because of the adverse effect of statutorily required, unpaid risk corridor amounts on state insurance commissioners' ability to protect consumers through stable health insurance markets. The essential functions through which insurance

commissioners promote financial solvency and the fair treatment of policyholders have been impaired by the government's default on risk corridor payments. The government, through a reckless and retroactive appropriations rider, undercut competition and unfairly burdened insurers that sold health plans to a population with accumulated, unaddressed health care needs. Insurance commissioners, already walking a careful line between companies' financial health and consumer protection, must manage the impact of huge shortfalls due to the government's default.

SUMMARY OF ARGUMENT

A decision in favor of Petitioners is critical to ensure not only the integrity of the government's legislated financial commitments, but also the ability of state regulators to effectively manage their health insurance markets and protect consumers. The ACA recognized the essential regulatory functions of insurance commissioners and created a partnership. The risk corridor program was vital to keeping insurance markets, and this partnership, healthy. State insurance departments have virtually transformed—shifting limited resources, investing in innovation, and enacting new laws—in order to fulfill their obligations under the ACA. But, as to the risk corridor program, the government has not been a fair or reliable partner.

Through the ACA, the government induced insurers into the health insurance market only to directly compromise these companies' financial condition once they committed. The government's default derailed the orderly approval of health insurance rates, which are set prospectively at the

state level. Additionally, the government's default has deterred insurers from offering plans on the exchanges, dampening competition and hurting consumers by cutting off access to affordable healthcare coverage.

Holding the government accountable for its risk corridor obligations under the ACA is necessary to protect consumers, stabilize the market, promote competition, and boost financial solvency across the industry. The havoc imposed by the government's default will have repercussions beyond this litigation and for years to come. The government must be seen as a reliable business partner—and a reliable regulatory partner—in order for the insurance industry and its state regulators to function. Only this Court's favorable ruling can ensure that is so, by requiring the government to live up to the unambiguous promises Congress expressly made.

For these reasons, this Court should reverse the Federal Circuit's decisions.

ARGUMENT

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

away funding required by the ACA through an after-the-fact appropriations law.

The ACA provided safeguards to incentivize insurers and state regulators to build a new infrastructure to give life to the ACA. [2] The Government Accountability Office, 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 the [ACA] 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 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)[3] (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

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[2] "The federal government has entered into a contract with insurers that provide coverage through the exchanges. That contract incorporates the federal laws and regulations governing the exchanges, including the risk corridor program. Insurers relied on the terms of the ACA, including the risk corridor program, in setting their premiums." *The Operation of the Affordable Care Act's Risk Corridor Program*, Testimony by Timothy Stolzfus Jost to House Committee on Oversight and Government Reform, Feb. 1, 2014.

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

Medicaid Services ("CMS") released its rule governing the schedule of payments from the risk corridor program and stated that "[t]he 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]." 78 Fed. Reg. 15410, 15473 (Mar. 11, 2013).

It was not until 2014, when coverage under plans offered on the exchanges—known as "Qualified Health Plans," or "QHPs"—was effective, that insurers operating on the exchanges began receiving conflicting guidance from the government on the amount of funds available. In March 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. HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13744, 13787 (Mar. 11, 2014). HHS acknowledged the possibility that there may not be sufficient funds coming in to the program to offset amounts owed to insurers. However, HHS indicated only that future guidance would be issued by rulemaking in that event. HHS, *Risk Corridors and Budget Neutrality* (Apr. 11, 2014).[4]

By December of 2014, Congress had prohibited the CMS Program Management appropriation from specifically funding risk corridor payments in 2015 and 2016. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, § 227, 128 Stat. 2130, 2491. As a result, the

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[4] Available at: https://www.cms.gov/CCIIO/Resources/Fact-Sheets-and-FAQs/Downloads/faq-risk-corridors-04-11-2014.pdf.

available offset funds to make insurers whole under the program represented only 12.6% of the amounts owed. CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015).[5]

Once the risk corridor payments were withheld, the core functions of the NAIC's members—monitoring solvency, promoting competitive markets, and protecting consumers—were seriously compromised.

I. The government's sudden default on risk corridor payments unraveled state regulators' painstaking work in prospective rate approval.

The bait and switch story at the center of this litigation quickly put regulators in a difficult position, particularly as to their ability to calculate and approve prospective insurance rates. Starting in 2014, neither insurers nor insurance commissioners had any idea whether risk corridor payments would be forthcoming. In a sense, all parties were flying blind into a process that already required balance, precision and calibration in order to comply with the law.

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

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[5] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

fractional risk corridor payments undermined both the regulator and the insurer for purposes of setting premium rates and assuring a stable market.

Since this work is prospective, the ACA's stabilization features were crucial in determining rates. "In all 50 states, insurance regulators normally approve premium rates in the year before an insurance policy will go into effect, and insurers then offer their policies in 'open enrollment' periods in the late fall of the year before the policy's coverage year. . . . As such, insurers sold policies at fixed and approved premium rates in 2013 for the 2014 year, and incurred the costs of providing benefits under those policies throughout 2014." Pet. Br. in 18-1028, at 31-32. As the Pennsylvania Insurance Department noted in support of four domestic insurers in their risk corridor lawsuit, the insurers were locked into market participation before learning of the risk corridors default that vitiated 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 Ins. Co. v. United States*, Case No. 16-587 at 5 (Fed. Cl. filed Oct. 14, 2016).

The fact that the government reneged on its promised payments, resulting in massive deficits, forced state regulators to re-evaluate the fairness of

rates in an environment where insurers incurred tremendous financial exposure through no fault of their own. The market was now populated by these disadvantaged insurers. Double-digit rate increases plagued the exchanges from 2014 to 2018, including a 28% increase in 2018.[6]

Although rates stabilized in 2019, the damage has been done to the once-promising exchange marketplace. Regulators' best efforts at supplying the exchanges with financially strong insurers could not truly succeed once the government gutted funding for the risk corridor program.

II. Delinquent risk corridor payments accelerated the financial problems of new insurers induced by the ACA to participate in state exchanges.

The very purpose of the ACA, to expand affordable health care coverage to additional millions of Americans, created an urgent demand for companies willing to offer QHPs to consumers who would otherwise face a financial penalty for declining to purchase health coverage. Many of these consumers were previously uninsured, with immediate need for health services. The proportion of healthy to unhealthy individuals in the new market dropped sharply when CMS allowed transitional non-ACA-compliant policies to continue in November 2013. *See* Pet. Br. in 18-1028, at 10-11. Again, well after 2014 rates were finalized, the government changed the rules in a manner that

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[6] Susan Morse, *Insurers' Collective Premium Rate Increases Are Less Than 1% for 2020 ACA Plans*, Healthcare Finance (Aug. 15, 2019), https://www.healthcarefinancenews.com/node/139067.

would inevitably hurt insurers' financial condition by keeping healthier participants out of the exchanges. *See ibid.*

A perfect storm was building. Not yet knowing the full impact of the transitional policy and having absolutely no indication that risk corridor payments would not be forthcoming, smaller insurance carriers entered the market. Many of these entities focused on care management, whether as Medicaid Managed Care Organizations or as "CO-OPs" under the ACA. The Consumer Operated and Oriented Plan ("CO-OP") program provided for federal loans to "foster the creation of qualified nonprofit health insurance issuers to offer [QHPs] in the individual and small group markets in the states in which the issuers are licensed to offer such plans." 42 U.S.C. § 18042. Across the country, new non-profit health cooperatives, such as Petitioner Land of Lincoln, applied for licenses to transact business on state exchanges.

The CO-OPs were largely unable to withstand the capital demands of issuing QHPs to a population significantly less healthy than price projections had indicated. There were 24 CO-OPs operating at peak participation in 2014, but only four are offering plans in 2019. The insolvencies impacted 18 states, pulling more resources away from successful ACA implementation and leaving fewer qualified health plans to cover consumers on the exchanges. Full risk corridor payments may have given some of these CO-OPs time to shore up capital and gain underwriting experience. Instead, the government's refusal to pay what it owed hastened the collapse of the CO-OP structure. The remaining insurers on the exchanges

were forced to carry even more of the burden to offer affordable coverage.

The NAIC's members remain bound by the terms of the ACA to provide QHPs to their consumers, but the government's refusal to fulfill its obligation to make risk corridor payments helped to drive companies out of the state exchanges and in some cases, out of business. What's more, the defunding of the risk corridor program seems to have emboldened the government to further disregard the law. Not satisfied with the 87.4% of risk corridor payments it unlawfully withheld, the government has also attempted to drain the few remaining resources of failed insurers—funds otherwise needed to pay policyholder claims—by claiming a fictional super priority.

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

The ACA reformed the health insurance arena in many ways, but one thing it did not change is the application of state law to adjudicate insurer insolvency proceedings.[7] When insurers ultimately

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[7] *See, e.g.*, 42 U.S.C. § 18041(d) (stating, in a section titled "No interference with State regulatory authority": "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title."); Proposed Rules, 45 C.F.R. Part 156, 76 Fed. Reg. 43237-01 (July 20, 2011) ("State law establishes a variety of required regulatory actions if an insurer's RBC [risk-based capital] falls below established levels or percent of RBC. These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State-regulated

become insolvent, it is up to the insurance commissioner to continue the company's struggle to collect unpaid debts, including risk corridor amounts.[8] The Court's decision in this case will dictate whether policyholders are treated fairly when companies fail due, in part, to the government's failure to fulfill its commitments.

Based on CO-OP insolvencies to date, regulators have reason to believe the government will jump at the chance to make a bad situation worse. As an example, on July 17, 2017, the Iowa Insurance Commissioner, in his capacity as receiver for a failed CO-OP, CoOportunity Health, Inc., filed suit in the Court of Federal Claims alleging the government refused to pay approximately $130 million owed that CO-OP under the risk corridor program. *See Ommen v. U.S.*, Case No. 17-957 (Fed. Cl. filed July 17, 2017), Pl.'s Compl. ¶ 104. The current status of the Iowa action is stayed, awaiting a decision by this Court in the present case.

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function."); Final Rules, Responses and Comments, 45 C.F.R. Part 156, 76 Fed. Reg. 77392-01 at E.6 and F, Dec. 13, 2011 ("In the potential case of insurer financial distress, a CO-OP follows the same process as traditional insurers and must comply with all applicable State laws and regulations.").

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

Although the government had identified $16.4 million as owing (12.6% of the $130 million figure), it placed this amount—along with reinsurance and risk adjustment payments—in an "administrative hold" to set off against debts from a start-up loan the government provided at the inception of the entity. *See id.* The complaint alleged:

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

Id. at ¶ 106.

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

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

The Iowa case demonstrates an alarming capacity for the government to take multiple shots at the

same target: first as a debtor causing or exacerbating an insurer's insolvency by over $100 million, and then as a creditor who seeks to push ahead of policyholders' valid claims.

More fundamentally, the government's strategy in the CoOportunity liquidation reveals an inconsistent approach to contractual obligations. In 2014, the Government felt free to breach the risk corridor obligations of the ACA. But a CO-OP that has struggled and failed to survive in the marketplace, *even in liquidation*, is expected to make the government whole for a 2013 start-up loan made pursuant to the same statutory scheme. Such tactics are inconceivable when employed by the government against their regulatory partners in sweeping health reform.

In this hostile landscape, regulators' desire to foster innovation and vital markets had to take a backseat to their biggest challenge: simply keeping a qualified plan in each county.

IV. Following defunding of the risk corridor program, state regulators' resources were consumed with maintaining the barest of coverage on the exchanges.

Promoting competition stands alongside financial solvency and consumer protection as an essential mission of the NAIC and its members, but 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, outweighed the potential benefits for many insurers to participate on the exchanges.

Congress intended the risk corridor program to provide full reimbursement for the years 2014 through 2016. The consequences of the withheld payments were clear by 2017, when consumers in approximately one third of all U.S. counties had access to only one insurer's plan through the exchanges. Olga Khazan, *Why so Many Insurers are Leaving Obamacare, how rejecting Medicaid and other Government Decisions Have Hurt Insurance Markets,* The Atlantic (May 11, 2017). [9] State insurance commissioners fought this threat county by county, customizing solutions to keep QHPs alive.

Projections for completely bare counties in 2018 spurred insurance commissioners to collaborate with companies and provide at least one QHP in underserved parts of Nevada, Wisconsin, Iowa, Missouri, and Ohio. Reversing this course was described as "a triumph for state regulators around the country, who have fought hard to fill potential bare patches in their coverage maps after insurers announced pullbacks over the past several months amid uncertainty about the law's future." [10] Regulators' creativity, forward thinking, and flexibility should be credited for sustaining the exchanges regardless of the government's neglect.[11]

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

[10] Anna Wilde Mathews, *All U.S. Counties to Have an ACA Plan After Ohio Plugs Last Gap*, Wall St. J. (Aug. 24, 2017), https://www.wsj.com/articles/ohio-county-gets-affordable-care-act-coverage-ending-risk-of-marketplace-gap-1503591859.

[11] "States also employed various regulatory levers to encourage insurer participation, such as clarifying regulatory standards regarding network adequacy, allowing flexibility in plan offerings, and sharing data on claims history. Some states

Despite these hard-won victories, it is clear even in 2019, how little the government has learned about the importance of competition in the individual health market. It was only one year ago that CMS Administrator Seema Verma warned the government about the negative impacts of three potential proposals: ending the practice of "silver loading,"[12] terminating automatic ACA exchange re-enrollment,

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

[12] The NAIC supports the option of silver loading and explained its effectiveness in a letter to CMS: "The Department of Health and Human Services (HHS) discontinued cost-sharing reduction (CSR) reimbursements in 2017 after a finding that Congress had not appropriated funds for them. Nonetheless, the requirement that issuers reduce cost-sharing for lower-income enrollees remains in place even though the issuers are no longer reimbursed for the cost-sharing reductions they provide. In response to the termination of CSR reimbursements, many state regulators directed insurers to use actuarial loading, also referred to as 'silver loading,' and in other states issuers themselves chose to employ actuarial loading. Under this method, issuers increase premiums on silver level plans (often only within the exchange) to compensate for the increased actuarial value they provide to eligible exchange enrollees." Letter from National Association of Insurance Commissioners to Centers for Medicare & Medicaid Services, at 1 (Feb. 15, 2019), *available at* https://www.naic.org/documents/index_health_comments_190215_ben_pay_params.pdf.

and revising the premium indexing methodology. Verma predicted these policies could disrupt the market, "potentially resulting in bare counties or states with no subsidized coverage available in 2019 and future plan years." Memorandum from Seema Verma, Administrator, Centers for Medicare & Medicaid Services to Secretary Alex Azar, Department of Health & Human Services (Aug. 29, 2018).[13] Despite these serious warnings, in April of 2019 the government finalized a rule to proceed with the revised premium indexing.[14] It is discouraging, to say the least, that the government continues to disregard CMS guidance and risk future bare counties despite regulators' strenuous efforts to protect consumers from this outcome. This pattern only highlights the dire need for this Court to set limits on the damage the government is allowed to inflict.

These ongoing and self-serving machinations illustrate why the present case demands more than a breach-of-contract analysis. Any attempt to cast this controversy as a simple business risk that didn't pay off for the Petitioners ignores the entirety of the

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[13] Available at: https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/August%202018%20Verma%20Azar%20Memo.pdf.

[14] "The August memo, sent to Azar eight months before the regulation was finalized, found these changes would result in consumers receiving less in advance payments of the premium tax credits by $980 million in 2020 and over $1 billion for each of the following three years." Rebecca Pifer, *CMS Warned Trump Policies Would Hike Taxes, Cause ACA Disruption, Internal Memo Says*, Healthcare Dive (June 14, 2019), https://www.healthcaredive.com/news/cms-warned-trump-policies-would-hike-taxes-cause-aca-disruption-internal/556908/.

insurance market. The ACA's legal requirements for risk mitigation were intended to provide large-scale stability. As the NAIC can attest in countless ways, financial solvency of companies always impacts the policyholders. The government's dismissive stance toward the insurers doesn't begin and end with those companies' balance sheets. It weakens the entire system and breeds distrust that may last for decades.

The NAIC and its members urge the Court to consider the consequences to the government's reputation as a reliable regulatory partner should the Court uphold the Federal Circuit's ruling. The judicial branch must exercise a check on the government's conduct in this case if state regulators are to have confidence in the federal assignment of regulatory responsibilities.

There is every indication that major policy initiatives in the United States will continue to proceed through a federal, state, and private partnership.[15] The ACA was intended to function in all these respects, and the NAIC's members appreciate the deference shown in the past to its effective and longstanding regulation of the

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[15] "[T]he fundamental issue of the Government's credibility extends uncertainty to all areas of public-private partnership. If the Government can induce detrimental reliance by private parties and then simply cancel its financial commitments on political grounds, it will find fewer willing partners and will have created incentives for counterparties to demand high 'risk premiums.' The impact on the quality and character of prospective private partners, if not sectors of the economy, could be severe." Jason A. Levine, *"Risk Corridors" Litigation Shows The U.S. Government Is A Risky Business Partner,* The Federalist Society (Apr. 25, 2019) https://fedsoc.org/commentary/blog-posts/risk-corridors-litigation-shows-the-u-s-government-is-a-risky-business-partner.

insurance industry. The combined expertise of the federal government, state regulators, and insurance companies is essential to tackling the complexity of health insurance. But all of that talent and knowledge is wasted without reliable partners. Simply put, it is impossible for state regulators to effectively execute the role prescribed to them by Congress when the government refuses to play by its own rules.

As Judge Wallach noted below in his dissent in *Moda*: "To hold that the Government can abrogate its obligation to pay through appropriations riders, after it has induced reliance on its promise to pay, severely undermines the Government's credibility as a reliable business partner." *Moda Health Plan, Inc. v. United States*, 908 F.3d 738, 748 (Fed. Cir. 2018) (Wallach, J., dissenting). This Court has also recognized the importance of holding the government to its obligations, warning against "undermining the Government's credibility at the bargaining table and increasing the cost of its engagements." *United States v. Winstar Corp.*, 518 U.S. 839, 884 (1996). In finding the government breached a contractual and statutory duty to provide cost sharing reduction payments under the ACA, the Court of Federal Claims ruled that insurers "should not be left 'holding the bag' for taking our Government at its word." *Local Initiative Health Auth. for L.A. Cty. v. United States*, 142 Fed. Cl. 1, 21 (2019).

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

protection of consumers, demands fair dealing on all sides.

CONCLUSION

This Court should reverse the judgments of the Federal Circuit.

Respectfully submitted,

GAIL SCIACCHETANO
Deputy General Counsel
NATIONAL ASSOCIATION OF INSURANCE COMMISSIONERS
1100 Walnut Street
Kansas City, MO 64108

DEREK T. TEETER
Counsel of Record
DOUGLAS J. SCHMIDT
KIRSTEN A. BYRD
MICHAEL T. RAUPP
HUSCH BLACKWELL LLP
4801 Main St., Suite 1000
Kansas City, MO 64112
(816) 983-8000
derek.teeter@huschblackwell.com
Counsel for Amicus Curiae