United States Court of Appeals for the Federal Circuit

17-1224

LAND OF LINCOLN MUTUAL HEALTH INSURANCE CO., an Illinois Non-Profit Mutual Insurance Corporation,

Plaintiff-Appellant,

v.

UNITED STATES,

Defendant-Appellee.

Appeal from the United States Court of Federal Claims, in No. 16-744C

BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AS *AMICUS CURIAE* IN SUPPORT OF APPELLANT AND URGING REVERSAL

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CERTIFICATE OF INTEREST

As called for by Federal Circuit Rule 47.4, Counsel for *Amicus Curiae* America's Health Insurance Plans certifies the following:

1. The full name of every party or amicus represented by me is:

America's Health Insurance Plans.

2. The name of the real party-in-interest (if the party named in the caption is not the real party in interest) represented by me is:

America's Health Insurance Plans.

3. All parent corporations and any publicly held companies that own 10 percent or more of the stock of the party or amicus curiae represented by me are:

None. America's Health Insurance Plans is an unincorporated trade association whose members have no ownership interests.

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 are:

AKIN GUMP STRAUSS HAUER & FELD LLP: Leslie B. Kiernan and Robert K. Huffman.

DEUTSCH HUNT PLLC: Hyland Hunt and Ruthanne M. Deutsch.

Dated: February 7, 2017

By: /s/Leslie B. Kiernan
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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES:

STATUTES AND COURT RULES:

REGULATIONS AND FEDERAL REGISTER:

OTHER AUTHORITIES:

STATEMENT OF INTEREST OF *AMICUS CURIAE*[1]

America's Health Insurance Plans (AHIP) is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable healthcare coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 50 years of experience in the industry. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As a result, AHIP's members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other healthcare stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's healthcare and health insurance systems and a unique understanding of how those systems work.

Health insurance issuers are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148,

[1] No counsel for any party authored this brief in whole or in part, and no person or entity other than the *amicus*, its members, or its counsel made a monetary contribution intended to fund the brief's preparation or submission. All parties have consented to the filing of this brief. *See* Fed. R. App. P. 29(a)(2), (a)(4); Fed. Cir. R. 29(c).

124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA"). AHIP has participated as *amicus curiae* in other cases to explain the practical operation of health insurance markets and concerns arising from the implementation of ACA. *See, e.g.*, *King v. Burwell*, No. 14-114 (U.S.); *U.S. House of Representatives v. Burwell*, No. 16-5202 (D.C. Cir.). Likewise here, AHIP seeks to provide the Court with its unique expertise and experience regarding the operation of health insurance markets, the role of the risk corridors program in stabilizing premiums, and the foreseeable consequences to consumers as well as to insurers that would follow from declining to order the government to pay damages for its failure to make congressionally-mandated risk corridors payments. Because AHIP's membership includes many insurers that continue to participate in the health insurance exchanges, its perspective will provide the Court with a deeper and more comprehensive understanding of the practical consequences of the parties' dispute.

INTRODUCTION AND SUMMARY OF ARGUMENT

Insurers across the country made the decision to participate in the new, risky insurance exchanges on the basis of clear statutory terms, amplified by unambiguous agency statements. In the initial years of the exchanges—when uncertainty about the newly-insured population was at its height—the risk corridors program allowed insurers to share gains with the government if the

premium revenue they collected exceeds costs to cover enrollees' medical care by a certain amount, and to share the losses if their premiums did not cover those costs. Insurers that owe payments under the program have made full payments as the statute requires. But the government has not shared the losses and made the full payments the statute requires. Because it is black-letter law that the failure to appropriate the necessary funds does not eliminate the statutory obligation to pay, the Court of Federal Claims should have required the government to pay damages. Unless reversed, that court's failure to uphold the statute's plain command will have harmful consequences both within and beyond the health care exchanges.

The absence of full risk corridors payments has already damaged the exchanges, contributing to the exit of several insurers from the exchanges. It will continue to impair the offerings of the insurers that remain, as they must narrow the plans that they sell in light of unreimbursed losses. The ultimate effect will be felt not only by insurers, but by consumers, who will generally have fewer insurers and fewer plans to choose from, often resulting in less affordable premiums and more limited choices of doctors and other health care providers.

Beyond the exchanges, moreover, the holding of the Court of Federal Claims calls into question whether private companies—in health care or any other industry—can rely upon the federal government as a fair business partner. It has long been recognized in the federal contracting context that no entity would partner

with the government if it did not expect the government to adhere to its commitments. It is therefore in the government's long-term interest to be a reliable, fair partner. This interest is just as strong when the government's obligation is created by a statutory program as it is when the interest is created by contract. And reliably keeping its word is critical for the success of government health care programs and the consumers, patients, and beneficiaries they serve, which depend upon, and necessarily will continue to depend upon, the participation of private health care entities, including health insurers, hospitals, physicians, and other service providers.

It has long been settled that failure to make an appropriation does not defeat a clear statutory entitlement to payment. The Court of Federal Claims' decision disrupts that settled understanding based on two fundamental errors: deferring to an agency interpretation that the agency itself does not hold and reading an at best ambiguous appropriations bill to trump an unambiguous organic law. The agency itself—as distinct from its litigation counsel—has not adhered to the supposed budget-neutrality interpretation to which the court deferred. On the contrary, it has often reiterated the same conclusion that it stated before the insurers made their final decision to participate in the exchanges in 2014: "The risk corridors program is not statutorily required to be budget neutral." 78 Fed. Reg. 15,410, 15,473 (Mar. 11, 2013). And Congress did not require budget neutrality when it prohibited the

use of specific funding sources to make risk corridors payments, much less amend the risk corridors statute clearly and unmistakably as the law requires. The Court of Federal Claims' deference to litigation counsel's position that the statute is budget neutral was thus misplaced. The result is failure to honor an unambiguous government commitment upon which insurers reasonably relied when making decisions about participating in this new and untested market.

ARGUMENT

I. SIGNIFICANT SHORTFALLS IN RISK CORRIDORS PAYMENTS HAVE HAD, AND WILL HAVE, A SUBSTANTIAL EFFECT ON HEALTH INSURERS, HEALTH INSURANCE AFFORDABILITY, AND INDIVIDUAL CONSUMERS

The risk corridors program is one of three premium stabilization programs established by ACA, and was intended to help create stable, affordable individual and small group insurance markets in the first three years of the new insurance exchanges. *See* 78 Fed. Reg. at 15,412-13. Appellant Land of Lincoln is a member-run non-profit insurer known as a "co-op," established under a new grant and loan program created by ACA, *see* ACA § 1322, and it has since ceased offering any health insurance coverage in the wake of, *inter alia*, the government's failure to make full risk corridors payments, *see* Opening Br. Appendix ("Appx") Appx19 (Court of Fed. Claims Op.). But the failure to make full payments under the risk corridors program is an issue for health insurers of all kinds—large and small, non-profit and for-

profit—all of which undertook significant risk to enter the exchanges in 2014 with the understanding that the government would assume some of that risk through the risk corridors program.

Moreover, although the risk corridors program is short-term and meant to be transitional, the effect of non-payment is not. The failure to make timely, full risk corridors payments has ongoing and future ramifications for insurers that continue to offer health coverage on the exchanges, as payment shortfalls yield reduced participation, more limited offerings, and less affordable premiums. These consequences affect consumers as well as insurers, and will disrupt the individual and small group markets as a whole.

A. A Broad Array Of Insurers Undertook Substantial Risk To Participate In The Exchanges

Co-ops like Land of Lincoln are not the only players in the individual and small group exchanges. A broad group of traditional insurers, both for-profit and non-profit, took on the substantial obligations and risks of exchange participation beginning in 2014. More than 250 insurers (counted separately for each state market in which they participated) offered coverage on the individual-market exchanges in 2014. Amy Burke, et al., ASPE Research Br., *Premium Affordability, Competition, and Choice in the Health Insurance Marketplace, 2014*,

at 10 (June 18, 2014).[2] Many of these—more than a quarter—were new participants in the individual market. *Id*.

All of the insurers, whether new entrants or not, faced unprecedented uncertainty in deciding whether to participate in the exchanges and in setting premiums for 2014. The population expected to obtain coverage through the exchanges was largely uninsured before ACA, and insurers thus had to make assumptions about the "demographics, health status, prior health insurance status, etc." of the new enrollees "and what their medical spending would be." Am. Acad. of Actuaries, Issue Br., *Drivers of 2015 Health Insurance Premium Changes*, at 2 (June 2014).[3] "There was much uncertainty regarding these assumptions because insurers had only limited experience data on individuals who would be newly insured in the post-reform market." *Id.* That uncertainty would ordinarily demand a higher premium due to a "risk margin"; under actuarial principles, "[g]reater levels of uncertainty typically result in higher risk margins and higher premiums." *Id.* at 5.

The risk corridors program, however, permitted insurers to reduce their risk margin and thereby to set lower premiums, by sharing the risk of insufficient premiums between the federal government and insurers for the first three years of

[2] *Available at* https://aspe.hhs.gov/sites/default/files/pdf/76896/2014MktPlacePremBrf.pdf.
[3] *Available at* http://www.actuary.org/files/2015_Premium_Drivers_Updated_060414.pdf.

the exchanges. *See id.* at 3; *see also* 78 Fed. Reg. at 15,412-13 (stating that the risk corridors program requires "the Federal government and [qualified health plan]s to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016," permitting "issuers to lower rates by not adding a risk premium to account for perceived uncertainties in the 2014 through 2016 markets").

In addition to sharing the downside risk, the federal government also shared in any potential upside, taking a portion of the gains from insurers that collected more in premiums, over a certain threshold, than was required to cover the medical care received by their enrollees. 78 Fed. Reg. at 15,412. The statute sets forth a straightforward formula for determining when the government "shall pay" money to an insurer (and how much), and when an insurer "shall pay" money to the government, based on the ratio of the "target amount"—generally, premiums net of administrative costs—to "allowable costs"—generally, the cost of providing benefits. ACA § 1342(b)(1)-(2); *see generally* Appx4-6; *Health Republic Ins. Co. v. United States*, No. 16-259C, 2017 WL 83818, *2 (Fed. Cl. Jan. 10, 2017) (Sweeney, J.).

Based on the shared understanding reflected in a final rule issued in March 2013, *see* 78 Fed. Reg. at 15,473, a large number of insurers, of all kinds, submitted premiums to state regulators in the spring and summer of 2013, and

made final decisions to participate in the 2014 exchanges in September 2013.[4] That shared understanding included the agency's flat rejection of any notion that the risk corridors program was budget neutral: "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, [the Department of Health and Human Services ("HHS")] will remit payments as required under section 1342 of the Affordable Care Act." 78 Fed. Reg. at 15,473.

B. The Failure To Make Full Risk Corridors Payments Significantly Impairs The Offerings Of The Insurers That Continue To Participate In The Exchanges, To The Detriment Of Consumers

Notwithstanding its shared (pre-litigation) understanding that the statute required full risk corridors payments to be made regardless of the amount of risk corridors collections, HHS did not make full risk corridors payments for plan year 2014 because insufficient appropriated funds were available. *See* Appx11. It has also announced that the agency will not make any payments for plan year 2015 from 2015 risk corridors collections for the same reason; instead, all of the risk corridors collections from 2015 will go toward 2014 payments. *See* Ctrs. for

[4] Although the precise deadline varies by state, insurers generally must file premiums for approval in the spring or summer preceding the year in which they intend to offer the coverage. *See, e.g.*, Kristi Wick, AHIP, *2017 QHP Rate Filing—Key Dates* (Apr. 18, 2016), *available at* https://ahip.org/2017-qhp-rate-filing-key-dates. Final decisions regarding participation in the federal exchange must generally be made the September before the plan year starts. *Id.*

Medicare & Medicaid Servs., Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year (Nov. 18, 2016) ("Payment Memo for 2015").[5]

The resulting shortfall in risk corridors payments is massive: 2014 collections represented only about 12% of the $2.87 billion owed. Appx11. And expected 2015 collections—announced after the Court of Federal Claims' judgment—are only about $95.4 million, compared to about $5.9 billion in payments owed, a $5.8 billion shortfall. *See* Payment Memo for 2015. If this Court of Federal Claims' judgment is affirmed, and money damages are not awarded for the government's failure to pay, this shortfall will have devastating consequences for the individual and small group insurance markets long after the end of the risk corridors program.

One consequence already manifest is the exit of insurers from the exchanges. Several insurers have announced that they would exit or substantially reduce their exchange participation in 2017, and the lack of full risk corridors payments "has been cited as one of the primary reasons for exiting the market." Aaron S. Wright, et al., Milliman, *Ten potential drivers of ACA premium rates in 2017*, at 3, Dec. 2015.[6] Other exchange participants have closed their doors entirely. *See* Melissa Cassutt, *WINHealth ordered to liquidate*, JACKSON HOLE

[5] *Available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-RC-Issuer-level-Report-11-18-16-FINAL-v2.pdf.
[6] *Available at* http:// http://www.milliman.com/insight/2015/Ten-potential-drivers-of-ACA-premium-rates-in-2017/.

NEWS & GUIDE (Jan. 19, 2016); Becky Orr, *Judge orders liquidation of WINhealth Partners*, WYOMING TRIBUNE EAGLE, Jan. 15, 2016. The upshot is reduced competition—and consumer choice—in many exchange markets. For example, the number of insurers participating per state, on average, for the states using the federal exchange declined by about 28% in 2017, compared to 2016. *See* Cynthia Cox et al., Kaiser Family Found., *2017 Premium Changes and Insurer Participation in the Affordable Care Act's Health Insurance Marketplaces*, Nov. 1, 2016.[7] Nationwide, more than 20% of likely enrollees will have only one insurer option, compared to 2% in 2016. *Id.*

Still, many of the insurers affected by the failure to make risk corridors payments continue to operate in the individual and small group markets. But the failure of the government to honor its obligations harms their financial health, and limits their ability to offer a variety of plans going forward. *See* Helaine Olen, *What's Happening to Obamacare's PPOs?*, SLATE, Dec. 14, 2015 (reporting that many insurers state that they are losing money on preferred provider organization plans in the exchanges and will no longer offer them);[8] Anna W. Mathews, *Insurers Move to Limit Options in Health-Care Exchange Plans*, WALL ST. J., Aug.

[7] *Available at* http://kff.org/health-reform/issue-brief/2017-premium-changes-and-insurer-participation-in-the-affordable-care-acts-health-insurance-marketplaces/.
[8] *Available at* http://www.slate.com/articles/business/moneybox/2015/12/ppos_are_disappearing_from_obamacare_why.html.

31, 2016 (reporting that some insurers are offering plans with narrower options in light of losses in the exchanges).[9]

This impairment of insurers' offerings in turn affects consumers, who not only have fewer choices among plans, but may pay increased premiums as a result. *See* Cox, Kaiser Family Found., *supra* (reporting that premiums "are expected to increase faster in 2017 than in previous years due to a combination of factors, including substantial losses experienced by many insurers in this [individual] market"). In sum, this case has significant implications not only for many insurers, but also for consumers and the individual and small group insurance markets as a whole.

II. IT IS ESSENTIAL TO THE VAST MAJORITY OF GOVERNMENT HEALTH CARE PROGRAMS THAT THE COURTS SAFEGUARD THE GOVERNMENT'S ROLE AS A FAIR BUSINESS PARTNER

The judgment of the Court of Federal Claims has damaging effects that reach beyond the significant harm to the insurance market, the ACA exchanges, and consumers. Courts have long recognized that entities doing business with the federal government—including but not limited to health insurers—must be able to rely upon the federal government as a fair partner in such business relationships. Such reliability protects not only the interests of those doing business with the federal government, but also the government's own long-term interest in finding

[9] *Available at* http://www.wsj.com/articles/insurers-move-to-limit-options-in-health-care-exchange-plans-1472664663.

willing partners. That governmental interest is paramount in health care, where it is indisputable that no matter its particular shape and scope, any health care program will depend upon the participation of private health care providers.

A. The Supreme Court And This Court Have Long Recognized The Government's Interest In Being A Reliable Business Partner

Government programs increasingly cannot operate without robust business relationships between the federal government and private partners. Whether delivered through standard government contracts or other forms of public-private partnership, government programs operated at least in part through business relationships with private entities are massive and growing. For instance, the Medicare Advantage program provides health coverage and serves over 18 million Medicare beneficiaries through private health plans that partner with the federal government. Ctrs. for Medicare & Medicaid Servs., Medicare Advantage, Cost, PACE, Demo and Prescription Drug Plan Contract Report, Monthly Summary Report (Jan. 2017). Similarly, states and private Medicaid health plans work in partnership to provide Medicaid coverage to over 55 million Medicaid beneficiaries. Kaiser Family Found., *Total Medicaid Managed Care Enrollment* (2014).[10]

[10] *Available at* http://kff.org/medicaid/state-indicator/total-medicaid-mc-enrollment/.

A 2015 analysis by the Congressional Budget Office based on a "not complete" database of government contracts concluded that the federal government spent more than $500 billion on contracted goods and services in 2012, representing 15% of all federal spending that year and an 87% increase in real terms (adjusted for inflation) from 2002. Letter from Douglas Elmendorf, Cong. Budget Office, to Hon. Chris Van Hollen (Mar. 11, 2015) at 1, 3-4.[11] That amount does not include services delivered through programs like Medicare, which involves payment by the government to participating private health care providers at rates set by statute or regulation. Medicare benefit spending in 2014 was $597 billion, or 14% of all federal spending that year. Kaiser Family Found., *The Facts on Medicare Spending and Financing* (July 24, 2015).[12] Considering other business relationships not encompassed by these two examples, government programs requiring the willing participation of private business partners are a third or more of the federal budget.

As this Court and the Supreme Court have long recognized, the federal government can operate through the participation of private parties only so long as it is perceived as a fair partner. If "the Government could be trusted to fulfill its promise to pay only when more pressing fiscal needs did not arise, would-be

[11] *Available at* https://www.cbo.gov/sites/default/files/114th-congress-2015-2016/reports/49931-FederalContracts.pdf.
[12] *Available at* http://kff.org/medicare/fact-sheet/medicare-spending-and-financing-fact-sheet/.

contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." *Salazar v. Ramah Navajo Chapter*, 132 S. Ct. 2181, 2190 (2012). Accordingly, the law "safeguards both the expectations of Government contractors and the long-term fiscal interests of the United States," *id.* at 2189, given the "Government's own long-run interest as a reliable contracting partner in the myriad workaday transaction of its agencies." *United States v. Winstar Corp.*, 518 U.S. 839, 883 (1996) (plurality op.). Were it otherwise, "contracting would become more cumbersome and expensive for the Government, and willing partners more scarce." *Salazar*, 132 S. Ct. at 2190.

This reliability interest must be safeguarded whether the particular health care program involves a government contract or a program established by statute, particularly given the paramount role of private partners in the delivery of health care in the United States. It is immaterial that the government lacks sufficient appropriated funds to make all the payments it is obligated to make. The Tucker Act enables the courts to safeguard that interest through payments from the Judgment Fund. *See* 28 U.S.C. § 1491(a) (Tucker Act permitting the Court of Federal Claims to hear certain claims against the United States); 31 U.S.C. § 1304(a)(3)(A) (permanent appropriation to pay judgments of the Court of Federal Claims). "Although the agency itself cannot disburse funds beyond those

appropriated to it, the Government's valid obligations will remain enforceable in the courts." *Salazar*, 132 S. Ct. at 2189 (internal quotation marks omitted).

This is true for obligations created by statute as well as contract. "It has long been established that the mere failure of Congress to appropriate funds … does not in and of itself defeat a Government obligation created by statute." *Greenlee Cty. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007). The Tucker Act, and the Judgment Fund, exist as a last-resort guarantor of the government's reliability, permitting payments of money damages for the government's failure to fulfill its obligations. *See Salazar*, 132 S. Ct. at 2193-94. The Court of Federal Claims' judgment declining to hold the government to its clear statutory obligations puts at risk the government's long-term interest in being perceived as—and acting as—a reliable business partner.

B. The Reliable-Partner Interest Is Paramount In The Health Care Context

Aside from a few, specialized examples such as military treatment facilities, the federal government rarely delivers health care services itself. Rather, of $918.5 billion dollars spent by the federal government on health care in 2015, across all programs, more than $724.9 billion (79%) involved services delivered through partnerships with doctors, hospitals, insurers, and other entities through programs

such as Medicare, Medicaid, and the ACA health insurance exchanges.[13] In light of this heavy dependence upon private entities, it is critical that the courts safeguard the government's long-term interest in being perceived as a fair business partner within the health care industry in particular.

Undermining that perception, as the judgment below does, will make it more difficult for the federal government to administer health care programs. These programs rely on agreements between the federal government and other entities (insurers, hospitals, physicians, suppliers). If it is perceived that the federal government will walk away from promises made to encourage private sector participation in new programs—and the courts will not secure those obligations through the Judgment Fund—the unique public-private nature of government health care programs will necessarily be undermined. Following the enactment of ACA, health insurers in particular undertook great obligations at substantial risk by participating in the untested markets of new health insurance exchanges.[14] Failure

[13] *See* Ctrs. for Medicare & Medicaid Servs., Nat'l Health Expenditure Data, Table 05-3 & n.2 (Fed. Gov't Sponsor Expenditures), downloadable from https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NHE-Fact-Sheet.html. The table reports $193.6 billion of spending on "Other Federal Health Insurance and Programs" that could have included health care services delivered directly by the government. *Id.*

[14] Indeed, the risk was compounded by the government's decision to alter (unfavorably) the risk pool faced by insurers on the exchanges after they had set their rates for 2014 by announcing a transitional policy that allowed renewal of plans that did not comply with ACA. The government pointed to the risk corridors program itself as a means of remedying the harm: "Though this transitional policy

to enforce the government's corresponding obligations will necessarily cause some health care providers to question whether it is a sound business decision to partner with the federal government in health care programs.

III. THE STATUTE'S CLEAR, MANDATORY PARAMETERS FOR THE BUSINESS RELATIONSHIP WITH INSURERS MUST BE HONORED

The statute imposes—and the government's contemporaneous statements reflect—clear, mandatory payment obligations on the government that this Court can, and should, honor.

A. Insurers Reasonably Relied Upon The Statute's Plain Terms And The Agency's Statements That Full Payments Would Be Made

Insurers expected, based on the unambiguous terms of the statute and clear agency statements, that the amounts owed under the risk corridors program would be paid to them "[r]egardless of the balance of [risk corridors] payments and receipts." 78 Fed. Reg. at 15,473. Their participation in the exchanges was based upon this reasonable—and correct—expectation.

Insurers were required to make final decisions on 2014 exchange participation in September 2013 (after setting premiums in the spring and summer). At that time—as now—the statute, regulation, and related agency

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was not anticipated by health insurers when setting rates for 2014, the risk corridor program should help ameliorate unanticipated changes in premium revenue." Letter from Gary Cohen, Ctrs. for Medicare & Medicaid Servs., to Insurance Commissioners (Nov. 14, 2013), *available at* https://www.cms.gov/cciio/resources/letters/downloads/commissioner-letter-11-14-2013.pdf.

pronouncements all reflected the statute's unambiguous command that the government make full risk corridor payments, according to the statutory formula, regardless of the amount of risk corridor collections. *See* Appellant Opening Br. 26-34.

First, the statute—which has not been amended—provided then and now that if an insurer's "allowable costs" are more than 103 percent of the "target amount," "the Secretary shall pay to the plan an amount equal to" a percentage formula specified by the statute. ACA § 1342(b)(1). The amount that the Secretary "shall pay" is dictated by a formula that depends entirely upon the ratio of allowable costs to the target amount, *id.*, and the payment obligation is neither qualified nor capped by the amount collected from insurers under the program. *Id.* That text thus creates a money-mandating statute that "leaves the government no discretion over payment of claimed funds." *Samish Indian Nation v. United States*, 419 F.3d 1355, 1364 (Fed. Cir. 2005).

The lack of an appropriation within the substantive statute is a legislative commonplace. *See* 1 GEN. ACCOUNTING OFFICE, PRINCIPLES OF FED. APPROPRIATIONS LAW, at 2-40 (3d ed. 2004) ("While the organic legislation may provide the necessary authority to conduct the program or activity, it, with relatively rare exceptions, does not provide any money."). Contrary to the Court of Federal Claims' reasoning, Appx25, the fact that the risk corridors statute, like

most, contains no appropriation creates no ambiguity as to whether the payment obligation is limited to risk corridors receipts. Rather, the rule is that a money-mandating statute limits payments to the amount of appropriated funds only if "the statute creating the right to compensation … restrict[s] the government's liability … to the amount appropriated by Congress." *Greenlee Cty*., 487 F.3d at 878. Unlike other premium stabilization programs, the risk corridors statute includes no such limitation. *See* Appellant Opening Br. 26-27.

Second, at the time the insurers took the plunge into this new, risky market—and for years thereafter—the agency interpreted the statute the same way. At the outset, the agency made clear its interpretation that the statute imposed a mandatory payment obligation for the full amount under the statutory formula regardless of the amount collected under the program. The regulation provided then and now that "[w]hen [an issuer's] allowable costs for any benefit year are more than" a set percentage of the target amount, "HHS will pay the … issuer an amount equal to" the same formula specified by the statute—with no limitation based on the amount collected. 45 C.F.R. § 153.510(b). Lest there be any doubt that the statute does not cap payments by the amount of receipts, HHS dispelled it in 2013. 78 Fed. Reg. at 15,473 ("The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts,

HHS will remit payment as required under section 1342 of the Affordable Care Act.").

Moreover, even after issuance of the Federal Register preamble and "FAQ" that the Court of Federal Claims relied upon (erroneously) as implementing a budget-neutral interpretation of the risk corridors statute, *see* Appx6; pp. 26-28, *infra*, the agency itself—as distinct from its litigation counsel—repeatedly and recently reiterated its understanding that the statute *requires* full payments to insurers. In the final Notice of Benefit and Payment Parameters for 2016, HHS expressly "recognize[d] that the Affordable Care Act requires the Secretary to make full payments to issuers," stating that the agency "will use other sources of funding for the risk corridors payments" in the event of a shortfall in collections. 80 Fed. Reg. 10,750, 10,779 (Feb. 27, 2015). The agency recognized that its *ability* to make those payments was "subject to the availability of appropriations," *id.*, not that the *obligation* was so subject. And in the summer of 2015, HHS reassured state insurance commissioners that the agency "remains committed to the risk corridor program" and reiterated that ACA "requires the Secretary to make full payments to issuers" when it urged those state regulators to hold the line against premium increases and to take risk corridor "payments … into account before

decisions are made on final rates" for 2016. Letter from Kevin J. Counihan, Ctrs. for Medicare & Medicaid Servs., to Insurance Commissioners (July 21, 2015).[15]

The agency has adhered to this interpretation of the statute repeatedly, in the context of issuing guidance regarding the amounts of risk corridors payments, including as recently as September 2016—after this case (and several others) commenced. In November 2015, when announcing the reduced payments for 2014, and again in September 2016, HHS reiterated that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Ctrs. for Medicare & Medicaid Servs., Risk Corridors Payments for the 2014 Benefit Year (Nov. 19, 2015) ("Payment Memo for 2014")[16]; Ctrs. for Medicare & Medicaid Servs., Risk Corridors Payments for 2015 (Sept. 9, 2016).[17] Tellingly, the agency stated that it was "recording those amounts that remain unpaid … as … obligation[s] of the United States Government for which full payment is required." Payment Memo for 2014. Insurers reasonably relied upon these many official agency pronouncements acknowledging that the statute required full payments, which squarely repudiate the statutory interpretation the agency's litigation counsel now proffers in this case.

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[15] *Available at* https://www.cms.gov/CCIIO/Resources/Letters/Downloads/DOI-Commissioner-Letter-7-20-15.pdf.
[16] *Available at* https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf.
[17] *Available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF

B. The Agency's *Post Hoc* Litigation Positioning Cannot Negate The Obligation To Pay Damages For Non-Payment Under The Tucker Act

Neither of the two events relied upon by the agency's litigation counsel and the Court of Federal Claims—the enactment of an appropriations rider or the issuance of a Federal Register preamble and FAQ addressing so-called "budget neutrality" over the three years of the program—altered, much less repealed, the statute's clear command that the government make full payments to qualifying insurers regardless of risk corridors collections.

1. In December 2014—after the 2014 plan year had nearly concluded, and more than a year after insurers had made final decisions on whether to participate in 2014—Congress ruled out three specific sources of funds for risk corridors payments: the Federal Hospital Insurance Trust Fund, the Federal Supplemental Medical Insurance Trust Fund, and funds transferred from other accounts funded by the appropriations act to the agency's program management account. Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227, 128 Stat. 2130, 2491 (2014).[18] Nothing in the text of this enactment altered or capped the substantive obligation to make payments according to the statutory formula, regardless of collections. *See* Appellant Opening Br. 39-41.

[18] Materially identical language was enacted in 2015 for fiscal year 2016. Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225, 129 Stat. 2242, 2624 (2015).

Indeed, it did far less than that. Contrary to the conclusion of the Court of Federal Claims, *see* Appx9, this appropriations rider did not prohibit HHS from using any of its program-management appropriation for risk corridors payments, nor did it even limit HHS to using only risk corridors collections to make payments, as the government argues, *see* Mot. for J. on Admin. Record at 12 (Fed. Cl. Sep. 23, 2016).

The Court of Federal Claims erred by giving the appropriations rider an effect—capping payments at collections, Appx26—that is found nowhere in its text. By its terms, Section 227 does not cap risk corridors payments at the amount of risk corridors receipts; all it does is rule out three possible sources of funding: the two Medicare trust funds or amounts transferred into the program management account. But those three sources prohibited by Section 227 are not the only funds appropriated to "carry[] out … responsibilities of the Centers for Medicare and Medicaid Services," which includes the risk corridors program. Consolidated and Further Continuing Appropriations Act, 2015, Div. G., Title II, 128 Stat. at 2477. Rather, those funds are appropriated "together with" other funds, including "such sums as may be collected from authorized user fees …, which shall be credited to this account and remain available until September 30, 2020." *Id*. The risk corridors collections are one set of user fees, but they are not the only such fees. The agency also collects user fees from participants on the federal exchange, which

the agency has chosen to use to further exchange-related ACA programs. *See* 78 Fed. Reg. 39,870, 39,882 (July 2, 2013) (permitting user fee to offset certain contraception-related costs because it "support[s] many of the goals of the Affordable Care Act, including ... ensuring access to affordable qualified health plans (QHPs) via efficiently operated Exchanges"). The appropriations rider left the agency free to use any available user fees for risk corridors payments, although those fees have since been exhausted and are now unavailable. *See* Appx8 n.9.

Because it does not cap risk corridors payments by risk corridors receipts as an *appropriations* matter, the appropriations rider *a fortiori* does not implicitly amend the substantive statute to make the risk corridors program budget neutral. For Congress to alter the substantive law through an appropriations act, it must speak particularly clearly, and it did not do so here. Congress can add "further words modifying or repealing, expressly or by clear implication, the substantive law" in an appropriations act. *Greenlee Cty.*, 487 F.3d at 877. As a general rule, however, "'repeals by implication are not favored,'" and this "rule 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) (citation omitted). Because repeals by implication are "strongly disfavored," "a later statute will not be held to have implicitly repealed an earlier one unless there is a clear repugnancy between the two." *United States v. Fausto*, 484 U.S. 439,

452-53 (1988); *see also Calloway v. District of Columbia*, 216 F.3d 1, 9 (D.C. Cir. 2000) (holding that appropriations bill providing that "[n]one of the funds contained in this Act may be made available to pay" attorneys' fees restricted only the District of Columbia's ability to pay fees from its appropriation, not the court's authority to award fees under the substantive statute, because "when appropriations measures arguably conflict with the underlying authorizing legislation, their effect must be construed narrowly").

There is no such clear repugnancy here. Yet rather than properly analyze whether Congress plainly expressed its intent, in the appropriations bill, to alter the clear statutory terms of the substantive law, the Court of Federal Claims instead deferred to the government's litigating position that the appropriations bill resolved some latent ambiguity in the statute regarding whether payments were capped by collections. *See* Appx23. But there is no latent ambiguity; the statute commands that the agency "shall" pay according to an express formula when specific conditions are met—none of which include any particular receipts from the program. ACA § 1342(b)(1). The appropriations bill simply prohibited the use of three specific funding sources for making risk corridors payments, but neither imposed an overall monetary cap nor provided that "no funds" could be used to make risk corridor payments other than risk corridors collections. Without such indicia of intent to amend the original command to pay, the mere placing of three

accounts off limits does not clearly and unambiguously alter the plain, mandatory terms of the risk corridors statute.

2. Besides its erroneous interpretation of the appropriations acts, the Court of Federal Claims deferred to a purported interpretation by the agency that the statute permitted it to "administer risk corridors in a budget neutral way," Appx26-28. The agency itself never adopted that interpretation of the statute, and the Court of Federal Claims erred by deferring to it. *See* Appellant Opening Br. 42-44.

In the preamble to the final Notice of Benefit and Payment Parameters for 2015, the agency stated—without prior notice or opportunity for comment—that the agency intended to "implement [the risk corridors] program in a budget neutral manner," but the agency never amended its previously-adopted regulation. 79 Fed. Reg. 13,744, 13,787 (Mar. 11, 2014). Shortly thereafter, the agency explained in a FAQ that "budget neutral" meant only that payments and collections would be assessed over the three-year life of the program, with subsequent years' collections making up for any shortfall in a prior year. Ctrs. for Medicare & Medicaid Servs., Risk Corridors and Budget Neutrality, A1 (Apr. 11, 2014).[19] With respect to budget neutrality at the *end* of the three-year period, however, the agency stated that it would issue future guidance to address "how [it] will calculate risk corridors payments if risk corridors collections (plus any excess collections held over from

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

previous years) do not match risk corridors payments as calculated under the risk corridors formula." *Id.* at A2. And, as described above, that "future guidance" (in 2015) resulted in the Secretary's reiterated conclusion that the statute "requires the Secretary to make full payments to issuers," 80 Fed. Reg. at 10,779—regardless of the amounts collected under the program. In other words, the agency (if not its litigation counsel) has always recognized its obligation to pay what Section 1342 requires, in full.

The whole of the agency's rulemaking and guidance thus contradict the Court of Federal Claims' conclusion that the agency itself interprets the statute to require payments only "to the extent funds are available from 'payments in' without resort to appropriated funds." Appx26-27. Rather, this contention is nothing more than a *post hoc* rationalization by counsel, to which no deference is owed. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 212 (1988). It is also flatly wrong under the plain terms of the statute. *See* pp. 18-20, *supra.*

3. The Court of Federal Claims' dismissal of Appellant's claims rested in part on its deference to the government's argument that full risk corridors payments need not be made annually, but may be made at the end of the three-year program. *See* Appx22. That deference, too, was in error. *Health Republic*, 2017 WL 83818, at *16 ("[C]ongressional intent [is] apparent: HHS is required to make annual risk corridors payments to eligible qualified health plans."); *see also*

Appellant Opening Br. 34-38. But as a practical matter, given the litigation schedule, the timing issue has to some extent been overcome by events. The three-year risk corridors program has now concluded, and full data has been published for 2014 and 2015 indicating an $8.3 billion shortfall through the first two years of the program. The government cannot, and does not, seriously contend that collections in 2016 will cover both the $8.3 billion shortfall for 2014 and 2015 *and* payments due for 2016. Accordingly, whether the statute requires that full payments for 2014 and 2015 be made annually or at the end of the three-year program, there is no reasonable likelihood that risk corridors collections from 2016 will be sufficient to cover the full payments required under the statute.

That brings to the fore the issue of whether, at the end of the day, the statute permits the government to limit payments by the total amount of collections. It does not. The Court of Federal Claims erred by deferring to an agency interpretation that never existed before this litigation. For years, the agency reiterated that the statute requires full risk corridors payments, inducing insurers to participate on the exchanges and encouraging them to offer premiums below what they might otherwise charge. The government did not meet its full annual payment obligations, due to insufficient appropriated funds. But that lack of appropriations is no bar to this Court's vindication of the government's statutory payment obligations. *See Greenlee Cty.*, 487 F.3d at 877 (A failure "to appropriate funds to

meet statutory obligations prevents the accounting officers of the Government from making disbursements, but such rights [remain] enforceable in the Court of Claims.") (internal quotation marks omitted; alteration in original).

The dismissal of any claim for damages here will harm not only the health insurance markets along with the consumers, patients, and beneficiaries they serve, but also the government's long-term reputation as a fair business partner. The plain terms of the statute require payment, and must be honored in this last-resort proceeding for insurers.

CONCLUSION

The judgment of the Court of Federal Claims should be reversed.

Dated: February 7, 2017 Respectfully submitted,

By: */s/ Leslie B. Kiernan*

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CERTIFICATE OF COMPLIANCE

Pursuant to Federal Rule of Appellate Procedure 32(a)(7)(C) and Federal Circuit Rule 32(b), the undersigned hereby certifies that this brief complies with the type-volume limitation of Federal Rule of Appellate Procedure 29(d).

1. Exclusive of the exempted portions of the brief, as provided in Federal Rule of Appellate Procedure 32(a)(7)(B)(iii) and Federal Circuit Rule 32(b), the brief contains 6,771 words.

2. This brief has been prepared in proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman font. As permitted by Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned has relied on the word count feature of this Microsoft Word in preparing this certificate.

Dated: February 7, 2017

/s/ Leslie B. Kiernan
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CERTIFICATE OF SERVICE

I hereby certify that I filed the foregoing Brief for Appellant with the Clerk of the United States Court of Appeals for the Federal Circuit via the CM/ECF system this 7th day of February, 2017, and served a copy on counsel of record by the CM/ECF system.

Dated: February 7, 2017

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