2017-1224

United States Court of Appeals for the Federal Circuit

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

Plaintiff – Appellant,

v.

UNITED STATES,

Defendant – Appellee.

Appeal from the United States Court of Federal Claims in Case No. 1:16-Cv-00744-CFL, Judge Charles F. Lettow

CORRECTED BRIEF OF *AMICUS CURIAE* ALLIANCE OF COMMUNITY HEALTH PLANS IN SUPPORT OF PLAINTIFF-APPELLANT

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February 13, 2017

CERTIFICATE OF INTEREST

Pursuant to Federal Circuit Rule 47.4, counsel for *amicus curiae* Alliance of Community Health Plans certifies the following:

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

   Alliance of Community Health Plans

   Health Republic Insurance Company

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

   Not applicable

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

   None

4. The names of all law firms and the partners or associates that appeared for the party or *amicus* now represented by one or more of the undersigned counsel in the trial court or agency or are expected to appear in this court are:

Stephen A. Swedlow of Quinn Emanuel Urquhart & Sullivan, LLP

February 13, 2017

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INTEREST OF AMICUS CURIAE[1]

The Alliance of Community Health Plans ("ACHP") is a national leadership organization whose members are not-for-profit, community-based, and regional health plans or subsidiaries of not-for-profit health systems. Like Appellant Land of Lincoln Mutual Health Insurance Co. ("Land of Lincoln"), ACHP's members began offering qualified health plans ("QHPs") in 2014 in health exchanges established throughout the country by the Patient Protection and Affordable Care Act. ACHP's members are collectively owed hundreds of millions of dollars in unpaid risk corridors receivables for the 2014 and 2015 benefit years. Thus, ACHP members' interests may be affected by the outcome of this appeal. ACHP respectfully submits this *amicus* brief to provide real world examples demonstrating the harm caused to QHP issuers by the United States of America's failure to pay full annual risk corridors

[1] Pursuant to Fed. R. App. P. 29(a)(4)(E), counsel for *amicus* Alliance of Community Health Plans represents that it authored this brief in its entirety and that none of the parties or their counsel, nor any other person or entity other than *amicus* or its counsel, made a monetary contribution intended to fund the preparation or submission of this brief. Pursuant to Federal Rule of Appellate Procedure 29(a)(2), all parties have consented to the filing of this brief.

amounts and to urge the Court to reverse the dismissal of Land of Lincoln's claims in this action.

INTRODUCTION

Amicus curiae is the Alliance of Community Health Plans ("ACHP"),[2] a national leadership organization whose members are not-for-profit, community-based, and regional health plans or subsidiaries of not-for-profit health systems. These plans deliver affordable, high-quality coverage and care for more than 18 million Americans in 27 states and the District of Columbia. As mission-driven organizations, member plans have been a strong and stable presence in their communities and states, some for decades.

Like appellant, ACHP's members began offering qualified health plans ("QHPs") in 2014 in health exchanges that the Patient Protection

[2] ACHP's members include: AvMed (FL), Capital District Physicians' Health Plan (NY), Capital Health Plan (FL), CareOregon (OR), Dean Health Plan (WI), Geisinger Health Plan (PA), Group Health Cooperative of South Central Wisconsin (WI), HealthPartners (MN), Independent Health Plan (NY), Kaiser Foundation Health Plan, Martin's Point Health Care (ME), Presbyterian Health Plan (NM), Priority Health (MI), Rocky Mountain Health Plans (CO), Scott and White Health Plan (TX), Security Health Plan (WI), SelectHealth (UT), UCare (WI), and UPMC Health Plan (PA).

and Affordable Care Act ("ACA") established throughout the country. ACHP submits this *amicus* brief to provide real world examples demonstrating why the United States Court of Federal Claims' opinion in *Land of Lincoln Mutual Health Insurance Company v. United States* is fundamentally incorrect.

The lower court concluded that Section 1342 of the ACA is ambiguous regarding when payments must occur under the risk corridors program. The lower court also concluded that the program was still effective, just "less" so, even if the United States of America (the "Government") paid only a small fraction of the full amounts it owed for the 2014 and 2015 benefit years in the following year. Each of these conclusions, however, ignores how health plan coverage works, how the novel "three-year payment framework" the Government propounded in its motion to dismiss is entirely counter to the purpose of a risk corridors program, and the harm done to qualified health plans and enrollees.

Put simply, ACHP's members—all of whom are longstanding, sophisticated health plans—each understood Section 1342 of the ACA and its subsequent implementing regulations would fully compensate

them annually, in accordance with the formulas set forth in the ACA for any unexpected losses stemming from the inability to predict what the risk pool would look like and therefore to accurately set premiums or fees in the new ACA markets. It was recognized that reliable data for setting premiums would not be available until the third year. The governmental commitment to risk corridors payments permitted ACHP's members to keep rates as low as possible, and as stable as possible, while they learned the new markets' demographics and health status. The risk corridors program assured ACHP member plans that they could enter the risky new ACA Exchanges knowing that health plans would neither inordinately gain nor disastrously lose from their ACA business. More broadly, this principle was fundamental to the underpinnings of the public exchange and to industry support for the original passage of the ACA.

It was only after the QHP issuers had committed to entering the ACA Exchange marketplace and set premiums that the Government unexpectedly announced it would not make full risk corridors payments on an annual basis. The Government's subsequent refusal to pay the full risk corridor amounts it calculated and owed for each of the 2014

and 2015 benefits years has caused enormous losses to ACHP members and their enrollees, which has, in turn, required ACHP members to raise premiums for many ACA enrollees. This *amicus* brief provides a few such examples so the Court can understand that any orders stemming from this case will have widespread ramifications for millions of Americans. The lower court completely discounted allegations of this sort from petitioner's complaint and did not permit it to offer such evidence on either its or the Government's competing motions. However, these types of results demonstrate why HHS's supposed "three-year payment framework" cannot be correct, because it directly contradicts and undermines the risk corridors program's central purpose of healthcare rate stabilization. As such, the lower court erred and this Court should remand for reconsideration of evidence such as that ACHP's members provide here.

ARGUMENT

I. ACHP MEMBERS DECIDING WHETHER TO OFFER QUALIFIED HEALTH PLANS UNDERSTOOD THE RISK CORRIDORS PROGRAM WOULD PROTECT AGAINST UNEXPECTED LOSSES FROM RATE-SETTING.

Before they ever decided to offer a QHP, each ACHP member had to decide whether they could enter the untested new ACA market at

reasonable financial risk. In order to maintain their financial stability, healthcare companies must actuarially predict how much an average patient will need in terms of medical expenditures. These predictions are used to price the health plan's rates or premiums (a process called "rate-setting").

The ACA Exchange market was a new and uncertain marketplace where insurers and health plans did not have a good picture of the likely cost of those enrolling in their plans. Many of the enrollees had preexisting medical conditions. Many had no previous medical insurance. Under the new law, health plans accepted all applicants and could not engage in medical underwriting (*i.e.*, evaluate and utilize the medical and health information of an applicant) before providing medical coverage. In other words, ACHP member plans did not have any data or effective methodology to accurately predict the number and cost of the additional individuals who would be enrolling in their plans starting in 2014. The resulting uncertainty caused by this lack of information dramatically increased the risk healthcare companies and insurers took in offering QHPs.

In order to assuage their fears, the law provided, and HHS/CMS told health plan issuers, that three premium stabilization programs (risk corridors, reinsurance, and risk adjustment – the "3R's") would help protect against losses.[3] HHS/CMS also repeatedly told insurers and health plans that it believed the risk corridors program required full annual payments, and that it would pay those amounts annually regardless of whether risk corridor payments to QHP issuers exceeded the amounts HHS/CMS received from other QHP issuers. *See*, *e.g.*, 78 Fed. Reg. 15410, 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 payments as required under section 1342 of the Affordable Care Act.***") (emphasis added).[4]

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[3] This was not a new concept in the ACA. Risk corridor payments have been made by the Government, *on an annual basis*, in the Medicare Part D program for prescription drug coverage under the Medicare Prescription Drug, Improvement and Modernization Act of 2003 (Pub. L. 108-173.)

[4] *See also* Exchange and Insurance Market Standards for 2015 and Beyond Final Rule, 79 Fed. Reg. 30,240, at 30,260 (May 27, 2014) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers"); HHS Notice of Benefit and Payment Parameters for 2016 Final Rule, 80 Fed. Reg. 10,750, at 10,779 (Feb. 27, 2015) ("HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers[.]").

Indeed, HHS stated that the ACA required "full payments to issuers" and that HHS would "record risk corridors payments due as an obligation of the United States Government for which full payment is required."[5] Accordingly, ACHP members and other health plans could commit to providing affordable coverage because the risks would be mitigated.

The 3R's targeted specific uncertainties in the new Exchange markets and, as CMS has explained, were designed "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance."[6] Discussing the risk corridors program specifically, CMS stated that "[d]ue to uncertainty about the population during the first years of Exchange operation, issuers may

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[5] CMS, *Risk Corridors Payments for 2015* (Sept. 9, 2016), *available at* https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Risk-Corridors-for-2015-FINAL.PDF#sthash.F6vymHRx.dpuf.

[6] CMS, *The Three Rs*, (Oct. 1, 2015), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html; *see also* CMS, *Regulatory Impact Analysis*, (Mar. 16, 2012) ("March 2012 Regulatory Impact Analysis"), at 38, *available at* https://www.cms.gov/CCIIO/Resources/Files/Downloads/hie3r-ria-032012.pdf.

not be able to predict their risk accurately, and their premiums may reflect costs that are ultimately lower or higher than predicted." March 2012 Regulatory Impact Analysis, at 44. The risk corridors program would thus "protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains." *Id.* at 43.

Health plans and insurers took actions in reliance on the risk corridors program and these statements from HHS and CMS. They set fees and premiums on an annual basis, and they based their rates on the belief they would receive full risk corridors payments on an annual basis as well. Insurers would normally account for an uncertain risk pool by setting premiums higher and/or purchasing reinsurance or holding additional financial reserves (both of which would be passed along to consumers in the form of higher premiums). Under ACA rating rules, insurers and health plans cannot set rates for future years to recoup for past years' losses. That made the risk corridors program even more important, as health plans could count on a "floor" established by the Government, allowing them to offer plans with more competitively priced premiums.

The rates offered by QHP issuers overall could not accurately reflect the health status of the enrollees, which were not known at the time. As experience later showed, the subscribers covered by QHP issuers—including ACHP member plans—were much sicker and had much higher costs than predicted. For example, when one ACHP member (referred to herein as "Plan 5"), a not-for-profit, community-based health plan operating in multiple states, entered the Exchanges in 2014, it anticipated that the illness burden would be significantly higher than its prior pool of "medically underwritten" individuals. Plan 5 expected 30-50% higher morbidity due to the requirement of guaranteed issue and the removal of underwriting. It priced its products accordingly. However, the actual increase in morbidity was over 100% due to significant "unmet needs," severe and complex medical conditions, and the fact that many healthy people stayed outside of the ACA risk pool when HHS/CMS allowed non-compliant or "grand-mothered" plans to continue. Plan 5 expected the risk corridors program would function as it was designed to do and reimburse insurers for unexpectedly high losses. However, the Government failed to pay full risk corridors amounts. If Plan 5 would have known that the

Government did not intend to honor its obligations under the ACA's risk corridors program, it would have priced its plans differently – or perhaps not taken on the risk of offering ACA coverage.

As discussed below, the Government's failure to pay the full risk corridors amounts caused QHP issuers like ACHP member plans to shoulder the burden of billions of dollars of losses, harming QHP issuers, consumers, and the entire ACA Exchange market.

II. THE GOVERNMENT'S FAILURE TO PAY FULL ANNUAL RISK CORRIDORS AMOUNTS HARMED ACHP'S MEMBERS.

A. ACHP Member Plans Are Owed Hundreds of Millions of Dollars in Unpaid Risk Corridors Amounts.

Because QHP subscribers had higher costs than anticipated, QHP issuers lost billions of dollars. And because the Government's current unpaid risk corridors shortfall for 2014 and 2015 totals approximately $8.3 billion, QHP issuers have been forced to absorb unacceptable losses without offsetting assistance.

ACHP member plans are no exception. According to HHS/CMS calculations, ACHP plans taken together were owed a total of nearly $248 million in risk corridor payments for 2014. HHS/CMS announced they would pay ACHP plans only about $31 million for the year, leaving

an unpaid total balance of almost $217 million. For 2015, ACHP plans taken together were owed a total of nearly $565 million in risk corridor payments. HHS/CMS announced they would pay ACHP plans only $8.25 million that year (and then only for the amounts still remaining for the 2014 benefit year), leaving an unpaid total balance of about $557 million.[7] For the 2014 and 2015 benefit plan years, the Government's unpaid obligation to ACHP member plans is more than three quarters of a billion dollars.

B. The Government's Failure to Pay Full Annual Risk Corridors Amounts Has Harmed ACHP Member Plans in Several Ways.

The following examples demonstrate the harms suffered by ACHP member plans:

- ***Plan 1.*** One relatively small ACHP member plan (referred to herein as "Plan 1") was owed millions of dollars in risk corridor payments but received only 2.2 percent of the obligation. Plan 1 estimates that premiums were higher by as much as 20 percent because risk corridor payments fell

[7] These totals include two plans that were ACHP members in 2014 and 2015 but are not currently members.

far short of what was owed. In addition, had full payments been made, Plan 1 would have considered offering individual market products in a broader service area. That broader service offering, however, has been taken off the table because of HHS/CMS's nonpayment.

- ***Plan 2.*** For another ACHP member plan (referred to herein as "Plan 2"), risk corridor payments of less than one half of one percent (0.5%) on obligations of tens of millions of dollars for 2014-2015 have contributed to sizable losses in operating margins. This in turn required substantial increases in funds needed to maintain required "risk-based capital" (RBC) levels and led to additional scrutiny by state regulatory bodies. Due to HHS/CMS's nonpayment of risk corridor amounts, Plan 2 had to eliminate a number of value-added benefit options for enrollees. Facing large additional losses in risk corridor payments for 2016 (currently estimated between $60-80 million), and without any indication the Government would meet its risk corridor obligations, Plan 2 was forced to withdraw from the public

exchanges for 2017, diminishing choices for consumers in that area.

- ***Plan 3.*** Risk corridor obligations for another ACHP member plan (referred to herein as "Plan 3") totaled tens of millions of dollars for 2014-2015, but the Government paid only about 5 percent of the amounts owed. The shortfall accounted for approximately 70 percent of the losses experienced by Plan 3 in the individual market for the two-year period. Enrollees had to absorb a premium increase of more than 15 percent for 2016, approved by the state, to partially offset the shortfall.
- ***Plan 4.*** In 2014 and 2015, this regional insurer (referred to herein as "Plan 4") targeted an approximate 2 percent operating margin on its ACA enrolled population. In actuality, Plan 4 experienced a negative operating margin of 4.8 percent in 2014 and an even greater loss in 2015 of 16.2 percent, primarily due to unexpected costs that it was unable to predict (and which the risk corridors program is designed to mitigate, exactly because the demographics in

the ACA Exchanges were largely unknown in those two benefit years). These losses resulted in an expected receivable of tens of millions of dollars for the risk corridor program in 2014 and 2015 combined. If risk corridor payments had been made in full, Plan 4 would have experienced margins of negative 4.3 percent in 2014 and positive 3.2 percent in 2015. Due to ACA rating rules, carriers cannot set premiums for future years to recoup for the previous year's losses; Plan 4 has therefore sustained sizeable reductions in capital reserves used to ensure continued operating strength.

- ***Plan 5.*** A regional health plan (referred to herein as "Plan 5") offered QHPs in several states in 2014 and 2015. According to CMS and HHS calculations, Plan 5 was owed tens of millions of dollars in risk corridors amounts in 2014 for individual and small group coverage. However, HHS/CMS announced they would be paying Plan 5 only a fraction of that amount, leaving the vast bulk of the balance unpaid. Plan 5's 2015 losses for individual and small group

> business were even greater, but, in 2016, HHS/CMS announced they would pay even less than in the previous year, and the amounts paid would only go toward unpaid 2014 amounts. These catastrophic losses—and the Government's unanticipated refusal to pay its share—have caused severe harm to Plan 5's overall business.

These examples offer just a glimpse into the serious and varied harms suffered by ACHP member plans and QHP issuers around the country. These health plans made the commitment to enter a new and uncertain market with assurances by the Government (via the text of Section 1342 and its implementing regulations and by statements from HHS and CMS) that the risk of catastrophic losses would be mitigated by the risk corridors program and the other premium stabilization programs. Relying on the availability of risk corridors payments, health plans attempted to accurately set premiums that would cover expected costs but would be competitive in the marketplace.

Due to no fault of QHP issuers, individuals and families purchasing healthcare coverage for the first time on the ACA Exchange markets had far higher costs than anticipated, leading to devastating

losses for insurers and health plans. This was the exact risk that the risk corridors program was designed to avoid. It was only after the QHP issuers had committed to entering the ACA Exchange marketplace and set fees or premiums that the Government unexpectedly announced it would not be making full risk corridors payments on an annual basis.

Regardless of the motivations or politics behind this change in course, the reality facing QHP issuers like the ACHP member plans was that the Exchange plans had suffered huge losses, which the Government was now refusing to pay. This led to serious problems with cash flow, risk-based capital, and state-regulated reserve requirements. It also caused many health plans and insurers to raise their fees or premiums, scale back their QHP offerings, and even leave the ACA Exchange market entirely. This cannot have been the intended result of the ACA's risk corridors program and demonstrates that the Government's interpretation, as adopted by the Court of Federal Claims in *Land of Lincoln*, is incorrect.

CONCLUSION

For all these reasons, the Court should vacate the judgment for the Government.

Dated: February 13, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on February 13, 2017:

1. I presented the Brief of *Amicus Curiae* Alliance of Community Health Plans in Support of Plaintiff-Appellant to the Clerk of the Court for filing and uploading to the CM/ECF system, which will send notification of such filing to all counsel of record, which constitutes service pursuant to Fed. R. App. P. 25(c)(2), Fed. Cir. R. 25(a), and the Court's Administrative Order regarding Electronic Case Filing 6(A).

/s/ *Stephen A. Swedlow*
Stephen A. Swedlow

CERTIFICATE OF COMPLIANCE

In accordance with Federal Rule of Appellate Procedure 32(a)(7)(C), the undersigned certifies that this brief complies with the applicable type-volume limitations. Exclusive of the portions exempted by Federal Rule of Appellate Procedure 29(d) and 32(a)(7)(B), this brief contains 3192 words. This certificate was prepared in reliance on the word count of the word-processing system used to prepare this brief.

The undersigned further certifies that this brief complies with the typeface and type style requirements of Federal Rule of Appellate Procedure 32(a)(5) and (a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Office Word 2014 in 14-point Century Schoolbook font.

Dated: February 13, 2017

/s/ *Stephen A. Swedlow*
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