Health Reform WK-EDGE Wrap Up, STRATEGIC PERSPECTIVES: When will insurers receive risk corridor payments?, (Feb. 15, 2017)

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A number of insurers have filed lawsuits against the federal government seeking money owed under the temporary risk corridors program, created by the Patient Protection and Affordable Care Act (ACA) (P.L. 111-148) to protect against uncertainty in claims costs during the first three years of the health insurance marketplace. In one such case filed by Moda Health Plan, Inc., the court found on February 7, 2017, that the government was liable for annual risk corridor payments. In another case the court granted class certification and denied the government’s motion to dismiss on jurisdictional grounds, finding that HHS was required to make annual risk corridor payments to insurers. With no current appropriations for risk corridor payments and Congress’s attempts to repeal the ACA, however, it remains to be seen if, and how, HHS will pay.

Risk Corridors Program

Recognizing that there would be uncertainty in the early years of the marketplace as insurance companies attempted to set premiums for higher-risk people, Congress established programs—risk adjustment, reinsurance, and risk corridors, the "Three Rs"—to help insurers through the transition period and help create a stable market for health insurance. The temporary risk corridors program, created by Section 1342 of the ACA, permits the federal government and qualified health plans (QHPs) to share in gains or losses resulting from inaccurate rate setting from 2014 through 2016.

The regulation at 45 C.F.R. Sec. 153.510(b) provides that when a QHP’s allowable costs for a year are between 103 and 108 percent of the target amount, HHS will pay the issuer 50 percent of the allowable costs in excess of 103 percent of the target amount. If a QHP’s costs are more than 108 percent of the target amount, HHS will pay the issuer 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.

Under 45 C.F.R. Sec. 153.510(c), if a QHP’s allowable costs for a benefit year are less than 97 percent but not less than 92 percent of the target amount, the plan must pay the HHS Secretary 50 percent of the difference between 97 percent of the target amount and the allowable costs. If a plan’s allowable costs are less than 92 percent of the target amount, the plan is required to pay 2.5 percent of the target amount plus 80 percent of the difference between 92 percent of the target amount and the allowable costs.

"Allowable costs" include the costs (excluding administrative costs) incurred by the plan in providing covered benefits. The target amount is the total amount of premiums received under the plan, reduced by administrative costs. Under 45 C.F.R. Sec. 153.510(d), insurers must remit charges within 30 days.

Funding for Risk Corridors Program

Section 1342(b) provides that HHS "shall pay" insurers amounts due under the risk corridors program. The Government Accountability Office (GAO) concluded that the CMS program management appropriation for fiscal year (FY) 2014 would have been available to make risk corridor payments. For these funds to be available in 2015, the appropriations for FY 2015 would have to include language similar to what was in the appropriation for FY 2014. However, the Consolidated and Further Continuing Appropriations Act of 2015 (P.L. 113-235) and the Consolidated Appropriations Act, 2016 (P.L. 114-113) prohibited the government from paying risk corridor amounts from the funds appropriated for CMS and HHS.

In an October 1, 2015 memo, CMS said that for 2014, the first year of the program, insurers paid risk corridor charges of $362 million, and insurers requested $2.87 billion in risk corridor payments. As a result, CMS announced, insurers would be paid about 12.6 percent of their payment requests for 2014. CMS anticipated that risk corridor payments for 2014 would be paid in late 2015 and that the remaining 2014 risk corridor claims would
be paid out of 2015 and, if necessary, 2016, risk corridor collections (see Risk corridor payments will be made or become U.S. obligations, November 24, 2015).

Health Republic Insurance Co. v. United States

A number of other insurers have filed lawsuits in the Court of Federal Claims to recover unpaid risk corridor payments. In March 2016, Health Republic filed a one-count class action complaint against the U.S. government for failing to make risk corridor payments as required by the ACA and its implementing regulations (see $5B suit filed against the U.S. for promised risk corridor payments, March 2, 2016). Health Republic alleged that it was owed more than $7 million in risk corridor payments for 2014. A CMS memo of November 18, 2016, shows that Health Republic was entitled to more than $13 million in risk corridor payments for 2015 and that it could expect to receive $261,922 toward its 2014 risk corridors payment.

The United States filed a motion to dismiss Health Republic’s complaint pursuant to Fed. R. Civ. P. 12(b)(1), alleging lack of subject matter jurisdiction on the following bases: (1) Health Republic did not have a claim for presently due money damages; (2) the claim was not ripe; and (3) the court lacked jurisdiction to award certain requested relief.

The government did not dispute that Section 1342 ("shall pay") and 42 C.F.R. Sec. 153.510(b) ("will pay") mandate the payment of money to Health Republic and other similarly situated insurers; to do so, said the court, would be "folly." Because Section 1342 and the implementing regulation are money-mandating sources of law, the court had subject matter jurisdiction.

The U.S. argued that the claim for unpaid risk corridor payments was not ripe because neither ACA Sec. 1342 nor 45 C.F.R. Sec. 153.510(b) expressly includes a deadline for HHS to make risk corridor payments to insurers and, in the absence of an explicit deadline, it may defer payments to insurers until the conclusion of the program or whenever it has the funds available to make full payment. Since it was not under a present obligation to make payments, the government argued, the claim was premature.

Congressional intent. The court rejected the government’s argument and concluded that Congress intended for HHS to make annual risk corridor payments to eligible insurers (see Congress intended for HHS to make risk corridor payments each year to insurers, January 18, 2017). While the ACA does not contain an explicit deadline for HHS to make such payments, Congress contemplated that HHS would calculate risk corridor payments separately for each year of the program. For example, the ACA directed HHS to establish a risk corridors program "for calendar years 2014, 2015, and 2016," rather than a program for 2014 through 2016, and HHS was required to calculate payments in and payments out for each year of the program.

Further support lies in the requirement in Section 1342(a) that the risk corridors program "be based on the program for regional participating provider organizations under part D." Soc. Sec. Act Sec. 1860D-15(e)(3)(A) requires HHS to establish a risk corridor for each prescription drug plan for each year. Further, 42 C.F.R. Sec. 423.336(c) provides that CMS makes payments in the following year.

The court also cited the purpose of the three premium stabilization programs. The "common thread" among the three programs is a concern that insurers’ costs would detrimentally exceed the premiums collected. If these programs did not provide for prompt compensation to insurers after the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges—and if enough insurers left the exchanges, one of the goals of the ACA, the creation of effective health insurance markets, would be unattainable. It is "nonsensical to suggest that Congress, in enacting provisions meant to ensure the success of the Affordable Care Act, drafted those provisions to have the opposite effect."

HHS’s interpretation. The court’s conclusion would not change even if it found the ACA ambiguous as to whether HHS was required to make annual risk corridor payments because the agency construed its own regulations to require annual payments. In a proposed rule (76 FR 41866, 41943, July 15, 2011), HHS indicated that it was considering a deadline for making risk corridor payments and an April 11, 2014, HHS memo represented that the agency intended to make whatever payments it could after each of the three years of the program.
Request for other relief. The court, however, had no jurisdiction over Health Republic’s request for consequential, special, or other damages; declaratory and injunctive relief; and prejudgment and postjudgment interest.

Land of Lincoln Mutual Health Insurance Co. v. United States

Two months earlier, a second judge from the Court of Federal Claims dismissed a complaint filed by now-defunct insurer Land of Lincoln Mutual Health Insurance Co., also attempting to collect risk corridor payments from the federal government (see Illinois insurer has to wait for $72M in risk corridor payments, November 16, 2016). The insurer in that case alleged that it was entitled by statute and regulation to the full amount of payments due for 2014 and 2015 and that the government’s actions breached an express or implied-in-fact contract, breached the covenant of good faith and fair dealing, and contravened the Takings Clause of the Fifth Amendment. HHS moved to dismiss under Fed. R. Civ. P. 12(b)(6) and for judgment on the administrative record pursuant to Rule 52.1(c).

Like the court in Health Republic, the Land of Lincoln court found that it had jurisdiction over most of the insurer’s claims and that the claims were ripe for judicial review; however, the court proceeded to dismiss the complaint on other grounds.

Statutory entitlement. Section 1342 does not specify when HHS must make risk corridor payments, and the only statutory source of funding for the program is subsection 1342(b)(2), which refers to "payments in" from qualified health plans. The court rejected Lincoln’s reliance on the risk corridors program being "based on" Part D, since Soc. Sec. Act Sec. 1860D-15(e)(3)(A) specifically requires the Secretary to establish a risk corridor "for each plan year," while the only mentioned of "any plan year" in Section 1342 is in reference to a plan’s reported costs. In addition, the Medicare program, unlike Section 1342, explicitly provides for the authorization of appropriations. Applying the two-step process established by Chevron U.S.A., Inc. v. National Resources Defense Council, Inc., 467 U.S. 837 (1984), the court found Section 1342 to be ambiguous in terms of the "payments in" and "payments out" arrangement because it does not contain an express authorization for appropriations to make up for any shortfall in the "payments in" to cover all of the "payments out" that may be due.

Under Chevron step two, the court must defer to HHS’s interpretation of Section 1342 as long as that interpretation is reasonable. HHS’s interpretation was reflected in a 2014 Final rule (79 FR 30240, May 27, 2014), when it stated that it intended to "administer risk corridors in a budget neutral way over the three-year life of the program, rather than annually." HHS’s interpretation was reasonable because Section 1342 did not obligate HHS to make annual payments or authorize the use of appropriated funds. The court rejected Lincoln’s argument that HHS’s failure to make full payments annually defeats the purpose of the risk corridors program, as "there is no deadline for HHS to make payments" to insurers.

Other counts. The court dismissed the remaining counts on the basis that: (1) an express contract did not exist between HHS and the insurer concerning the risk corridors program; (2) Lincoln failed to allege a valid implied-in-fact contract because mutuality of intent and offer and acceptance were lacking; and (3) because no valid contract existed, Lincoln failed to allege a breach of the covenant of good faith and fair dealing. The court also dismissed Lincoln’s Takings Clause claim because the insurer was not entitled to annual risk corridor payments.

Moda Health Plan Inc. v. United States

Most recently, a third judge in the Court of Claims found in favor of an insurer. Moda Health Plan Inc.’s lawsuit alleged that it was owed over $214 million in risk corridor payments for 2014 and 2015. Like the previous cases, the Moda court rejected the government’s Rule 12(b)(1) jurisdictional challenge. Ruling on the merits, the February 7, 2017 order denied the government’s Rule 12(b)(6) motion to dismiss and granted Moda’s motion for summary judgment, concluding that (1) the government unlawfully withheld risk corridor payments from Moda; (2) the ACA requires annual payments to insurers; (3) Congress did not design the risk corridors program to be budget neutral; and (4) in the alternative, the ACA constituted an offer for unilateral contract, which Moda accepted by offering QHPs on the exchanges.
The court disagreed with the *Land of Lincoln* court’s use of *Chevron* deference to HHS’s view that it would never owe money to lossmaking insurers beyond the "payments in" from profitable insurers. The court called this analysis was "puzzling" since the government only argued that deference was appropriate when considering the three-year payment framework, a ripeness issue.

The court concluded that the government made a promise in the risk corridors program that it has yet to fulfill and to say, "'The joke is on you. You should not have trusted us,’ is hardly worthy of our great government."

**Next Steps for Risk Corridor Cases**

David M. Kaufman, partner at Freeborn & Peters LLP in Chicago and a key member of the Healthcare Practice Group, said that the order in *Health Republic* "appears to be a reasonable interpretation" of the ACA. "The impact on the insurance market from the failure to make full risk corridors payments, with company failures and withdrawals from the market, shows that full payment of risk corridors amounts was an important component of the ACA’s structure," Kaufman explained.

A number of risk corridor cases are still pending; Lincoln is appealing the dismissal of its complaint and the government will almost certainly appeal the court’s decision in *Moda*. While the *Lincoln* and *Health Republic* cases were decided on different grounds—*Health Republic* determined jurisdiction only pursuant to Rule 12(b)(1) and *Lincoln* reached the merits of the complaint pursuant to Rules 12(b)(6) and 52.1(c)—the courts reached contrary conclusions as to whether HHS had an obligation to make annual payments. The *Health Republic* court, in the context of the jurisdiction discussion, specifically found that HHS was required to make annual risk corridor payments to insurers. The *Moda* court, however, essentially broke the tie by disagreeing with *Lincoln* and specifically finding the government liable to Moda.

After the government files its answer in *Health Republic*, the parties will be able to ascertain whether any facts are in dispute, including the amount Health Republic is owed in risk corridor payments. If not, said Kaufman, the parties will likely file motions for summary judgment, which will allow the judge to decide the case based on the law. Kaufman noted that the government, arguing that the *Lincoln* court’s reading of the law is the correct one, might decide to appeal the order in *Health Republic* and seek a stay of judgment.

**Effects on insurers.** Kaufman remarked that the damage from the failure to make full risk corridors payments in some senses, has already been done. "Certain insurers, such as the insolvent consumer operated and coordinated plans (CO-OPs), are unlikely to be revitalized if full payments are made at this time." However, the additional funds in an insolvency proceeding may allow for additional payments to be made to providers, such as doctors and hospitals that have not received payments for health care services they provided. He also noted that in their recent rate filings, insurers have likely factored in the likelihood of receiving risk corridors payments by raising rates. Ultimately, he said, since the risk corridors program expired at the end of 2016, insureds are unlikely to see a significant impact from these cases.

**Future of Risk Corridor Payments**

Billions of dollars are currently owed to insurers under the risk corridor program, but without current appropriations to make risk corridor payments, which then-CMS Acting Administrator Andy Slavitt characterized as an obligation of the U.S. government, the government is between a rock and a hard place. There was much ado about a September 9, 2016 memo saying that HHS was "open to discussing resolution of those claims. We are willing to begin discussions at any time," which led the House Republicans to seek to file an amicus curiae brief (later denied) in *Health Republic* (see *House Republicans file brief in $5B risk corridor suit*, October 19, 2016, and *House’s amicus brief rejected in risk corridor case DOJ keeps reins*, November 9, 2016). Settling could save the government money, particularly since some experts say that insurers are likely to prevail, eventually.

Settlement, however, would likely rely on the Judgment Fund, which, according to the Treasury, was created to pay court judgments and Justice Department compromise settlements of actual or imminent lawsuits against the government. The use of the Judgment Fund to make risk corridors payments is, said Kaufman, controversial. For example, in November Sen. Ben Sasse (R-Neb.) introduced the HHS Slush Fund Elimination Act (S. 3481)
(see also H.R. 6339 and H.R. 6074), which would prohibit HHS from paying claims or settlements through the Settlement Fund to insurers for the risk corridors program (see Bill would bar HHS from using Judgment Fund for illegal bailouts, November 30, 2016). The Moda court did, however, specifically cite the Judgment Fund as an "appropriation," “the only path that Congress has left open."

Future appropriations to cover risk corridor payments are unlikely in light of President Donald Trump’s promises to repeal, or at least chip away at, the ACA (see House Republicans narrow aim to specific provisions in health reform battle and Patient Freedom Act introduced to repeal and replace ACA, February 1, 2017). As Kaufman noted, "The future of health reform under the Trump administration is uncertain with different repeal and replace timeframes and various alternatives to the ACA being proposed on a weekly or even daily basis." It is possible, he said, that legislation to replace the ACA will include some measure to address market stabilization, but it is unlikely that such a measure would be named or look like risk corridors.

But will the government have a legal obligation to pay even if the ACA is repealed? Stakeholders will be watching and waiting for further decisions and legislation affecting the risk corridors program.

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