IN THE UNITED STATES COURT OF FEDERAL CLAIMS

BLUE CROSS AND BLUE SHIELD OF NORTH CAROLINA, Plaintiff, v. THE UNITED STATES OF AMERICA, Defendant.	)	No. 16-651 C Judge Griggsby

PLAINTIFF'S INITIAL SUPPLEMENTAL BRIEF

Pursuant to the Court's Scheduling Order of February 13, 2017 (ECF No. 25), Plaintiff Blue Cross and Blue Shield of North Carolina ("BCBSNC") respectfully submits its Initial Supplemental Brief, responding to the four issues raised by the Court, each of which are set forth below.

1. Whether the purpose of the risk corridor program may only be fulfilled by the full, annual payment of risk corridor payments?

Yes. The plain text of the risk corridors statute, its implementing regulations, HHS' repeated announcements and conduct, and the actual, devastating consequences of less than full, annual risk corridors payments, together demonstrate that only annual risk corridors payments can fulfill the purpose of the ACA's risk corridors program.

a. Statute

The plain text of the risk corridors statute, Section 1342, confirms Congress' intent that risk corridors payments must be made in full, annually. Congress explicitly mandated that the HHS Secretary "shall pay" qualifying QHPs risk corridors payments pursuant to a fixed statutory formula that is calculated on an annual, plan-year basis. *See* 42 U.S.C. § 18062(b)(1). If a

QHP's annual losses exceed the target amounts specified in the statute, the HHS Secretary "shall pay" the QHP the full risk corridors amounts pursuant to the statutorily prescribed formula. *Id.* Critically, there is no limitation on this requirement, and there is no provision in the statute allowing the Secretary to pay less than the full, prescribed amount. *See generally id.* Congress did not limit the mandatory "shall pay" requirement by the extent of any appropriations, nor is the risk corridors payment amount tied in any way to the amount of "payments in" through collections/charges from QHPs that exceeded certain specified annual profit targets. *See generally id.* Section 1342 does not give any discretion to the HHS Secretary in carrying out the "shall pay" risk corridors payment obligation. *See generally id.* Judge Wheeler, in his recent decision granting summary judgment to the insurer-plaintiff in the *Moda* case, agreed that the "shall pay" obligation in Section 1342 is "unambiguous and overrides any discretion the Secretary otherwise could have in making payments out under the program." *Moda Health Plan, Inc. v. United States*, No. 16-649C, --- Fed. Cl. ----, 2017 WL 527588, at *15-22 (Feb. 9, 2017) (Wheeler, J.). Therefore, Judge Wheeler concluded that "Section 1342 requires full annual payments to insurers." *Id*. at *22.

b. Implementing Regulations

In addition to the text of the statute itself, Section 1342's implementing regulations, which mirror the statute, also require full, annual risk corridors payments. Those regulations expressly state that QHPs "will receive payment from HHS," not at some indescript time or at the end of the three-year risk corridors program, but "[w]hen" the QHP's comparison of allowable costs to target amount "for any benefit year" triggers the statutory formula. 45 C.F.R. § 153.510(b). Moreover, when this occurs, the regulations require that "HHS will pay the QHP issuer." *Id.* Like Section 1342, there are no limitations on HHS' annual payment obligation, nor

any discretion by the Secretary to pay less than the full risk corridors amounts calculated under the prescribed statutory formula, which is repeated in the regulations. *See generally id.* For the same reasons that Judge Wheeler found "the unambiguous language of Section 1342 dispositive" that Section 1342 "is not budget-neutral on its face," it is clear that the implementing regulations are also not budget-neutral and thus require full, annual risk corridors payments. *Moda*, 2017 WL 527588, at *15. "Therefore, full payments out [t]he [HHS Secretary] must make" to qualified QHPs, including BCBSNC, each year. *Id.*[1]

c. *Land of Lincoln*

Judge Wheeler found it "puzzling" that Judge Lettow, in his *Land of Lincoln* opinion, "believed HHS's view to be that HHS would never owe money to lossmaking insurers beyond the amount of 'payments in' from profitable insurers." *Moda*, 2017 WL 527588, at *16 (citing *Land of Lincoln*, 129 Fed. Cl. 81, 106-07 (2016) (Lettow, J.)). The unique – and erroneous – procedural posture in which Judge Lettow decided *Land of Lincoln* was likely to blame. As explained in BCBSNC's Sur-Reply Brief (ECF No. 22), *Land of Lincoln* was decided on a limited Administrative Record that the Court had asked the Defendant to assemble despite there being no agency proceeding below, and applied an inapplicable Administrative Procedure Act standard of deference and review to an agency decision which had not actually been made with respect to Land of Lincoln. *See, e.g.*, Sur-Reply at 8-11.[2] Judge Wheeler, by contrast, considered the plain text of Section 1342, its context and purpose, and the entire history of HHS'

[1] Judge Wheeler concluded that "HHS has consistently recognized that Section 1342 is not budget-neutral." *Moda*, 2017 WL 527588, at *17. Judge Sweeney, in the *Health Republic* opinion, found the same. *Health Republic Ins. Co. v. United States*, No. 16-259C, 129 Fed. Cl. 757, 776 (2017) (Sweeney, J.) ("[T]here is no evidence that HHS understood that it could choose not to make annual risk corridors payments to insurers. Thus, there can be no dispute that HHS construes its regulations to require annual risk corridors payments.").

[2] As stated in BCBSNC's Sur-Reply Brief, there are significant differences between the RCFC 12, RCFC 52.1, and RCFC 56 procedures, particularly with the extent of the record considered and the presumptions that the Court must apply, which render Judge Lettow's merits analysis wholly inapplicable to BCBSNC's claims. *See, e.g.*, Sur-Reply at 10-11.

statements and actions regarding the ACA risk corridors program ("HHS has consistently recognized that Section 1342 is not budget-neutral … , it has never conflated its inability to pay with the lack of an obligation to pay") to arrive at the correct conclusion: full, annual risk corridors payments are required. *Moda*, 2017 WL 527588, at *15-17.

d. HHS' Statements

Judge Wheeler expressly rejected the Defendant's argument, repeated in this case, that "payments out" under Section 1342 are "contingent" on "payments in," with the Court emphasizing that HHS had explicitly said that "[r]egardless of the balance of payments and receipts, HHS will remit payments as required under section 1342." *Moda*, 2017 WL 527588, at *17 (citing 78 FR 15410, 15473 (Mar. 11, 2013)). Judge Wheeler also rejected Defendant's argument that lack of a specific appropriation in the statute eliminated the Government's "shall pay" obligation to pay the full risk corridors amounts owed each year. *Id*. at *16; *cf*. *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 874 (Fed. Cir. 2007) (Sur-Reply at 13) (affirming Court of Federal Claims decision to not enforce statutory payment obligation because the statute there, unlike Section 1342 here, contained a provision that "expressly conditioned" the Government's obligation to pay "on the availability of appropriations"); *Prairie Cnty., Mont. v. United States*, 782 F.3d 685, 688-90 (Fed. Cir. 2015) (describing *Greenlee Cnty.*). "It has long been established that the mere failure of Congress to appropriate funds, without further words modifying or repealing, expressly or by clear indication, the substantive law, does not in and of itself defeat a Government obligation created by a statute." *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966) (quoted in *Greenlee Cnty.*, 487 F.3d at 877, and *Prairie Cnty.*, 782 F.3d at 689); *accord Moda*, 2017 WL 527588, at *18-22 (finding that Congress' 2015 and 2016 Spending Bill riders did not amend Section 1342's requirement for full, annual risk

corridors payments).

HHS also has repeatedly admitted that it "recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." 79 FR 30240, 30260 (May 27, 2014) (Compl. Ex. 26); 80 FR 10750, 10779 (Feb. 27, 2015) (Compl. Ex. 15); Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 21, 2015) (Compl. Ex. 16); Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Compl. Ex. 17); Bulletin, CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) (Def.'s Mot. at App'x A248); *see also* 78 FR 15410, 15473 (Mar. 11, 2013) ("… HHS will remit payments as required under section 1342 of the [ACA]."); Compl. ¶¶ 89-105. Indeed, the Government actually recorded the full risk corridors amounts owed each year as an obligation of the United States, and then paid QHPs, including BCBSNC, a portion of the full amount it admittedly owed. *See, e.g.*, Compl. ¶¶ 138 & 151; Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015) (Compl. Ex. 17); Bulletin, CMS, "Risk Corridors Payments for 2015" (Sept. 9, 2016) (Def.'s Mot. at App'x A248).

e. Purposes of Risk Corridors Program

The ACA risk corridors program had multiple purposes that could only be fulfilled by the receipt of full, annual risk corridors payments. The Government undermined those purposes by failing to make *both* full *and* annual payments.

i. Inducing Insurer Voluntary Participation

First, risk corridors were included in the ACA to induce insurers to participate in the ACA Marketplace in each of its first three years. Insurers believed – and the Government repeatedly acknowledged – that risk corridors payments would be made promptly and in full after the requisite data was analyzed by CMS. *See, e.g.*, 77 FR 17220, 17238 (Mar. 23, 2012)

("QHP issuers who are owed these amounts will want prompt payments, and payment deadlines should be the same for HHS and QHP issuers."). The Government repeatedly and unequivocally stated that it would share in the annual risk with insurers.[3] This induced insurers to undertake the cost, burden, and risk of committing to the ACA Marketplace each year in CY 2014, CY 2015, and CY 2016.[4] *See* Compl. ¶¶ 47-52.

ii. Stabilizing Premiums

Another stated purpose of the risk corridors program was to stabilize affordable premiums for citizens insured on the ACA Exchanges, with premiums established and approved annually. *See* 77 FR 17220, 17243 (Mar. 23, 2012) (stating that the 3Rs, including risk corridors, "will mitigate the impacts of potential adverse selection and stabilize the individual and small group markets as insurance reforms and the Exchanges are implemented, starting in 2014"). Because, as originally intended by Congress and HHS, the risk corridors program was designed to make full, annual risk corridors payments, insurers reduced or eliminated a "risk premium" from their ACA rates that they otherwise would have priced into their ACA rates due to the prevalence of adverse selection in the ACA Exchanges, *i.e.*, customers having more knowledge of their poor health than the insurers. *See, e.g.*, 76 FR 41929, 41948 (July 15, 2011) ("Insurers charge premiums for expected costs plus a risk premium, in order to build up reserve funds in case medical costs are higher than expected. Reinsurance, risk adjustment and risk

[3] *See* HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" (July 11, 2011) ("Risk corridors create a mechanism for sharing risk for allowable costs between the Federal government and qualified health plan issuers."); 76 FR 41929, 41942 (July 15, 2011) (same); 77 FR 17219, 17220 (Mar. 23, 2012) ("The temporary Federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans sharing risk in losses and gains with the Federal government."); 77 FR 73118, 73121 (Dec. 7, 2012) ("The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016."); 78 FR 72322, 72379 (Dec. 2, 2013) ("The risk corridors program creates a mechanism for sharing risk for allowable costs between the Federal government and QHP issuers."); 79 FR 13743, 13829 (Mar. 11, 2014) (same).

[4] Note that CMS did not announce the massive risk corridors shortfall until after it had secured insurers' commitment to the CY 2016 ACA Exchanges, and until that time the Government assured insurers that full, annual payments would be made.

corridors payments reduce the risk to the issuer and the issuer can pass on a reduced risk premium to beneficiaries."). The risk corridors program was undisputedly designed to *reduce* insurers' risk of inaccurate rate-setting due to the lack of adequate information on the health of customers in in each of the three earliest years of the ACA Marketplace, not *increase* that risk.[5]

Had insurers known that the Government would not pay the full risk corridors payments due annually, then insurers certainly would not have agreed to set their ACA premiums as low as they did because they would have had to factor in uncertainty in receiving the full, annual risk corridors payments to which they were entitled if their annual losses exceeded the statutory targets during the first three years of the program. This would have resulted in fewer ACA market participants and less affordable ACA premiums offered by participating plans, defeating the purpose of the risk corridors program and the ACA.

iii. Complimenting Other 3Rs

The risk corridors program was designed to work in concert with the other 3Rs – risk adjustment and reinsurance – which are calculated and paid annually and in full, and are considered in calculating risk corridors payments. The 3Rs have always been considered together, working collectively to stabilize annual premiums on the ACA Exchanges. *See, e.g.*, 76 FR 41929, 41938 (July 15, 2011) ("[W]e believe risk adjustment must be coordinated with reinsurance and risk corridors to help stabilize the individual and small group markets and ensure the viability of the Exchanges, which begin in 2014."). Only full and annual risk corridors payments fulfill the intended purpose in this integrated design. Risk corridors payments not

[5] *See, e.g.*, 77 FR 17220, 17221 (Mar. 23, 2012) ("The risk corridors program, which is a Federally administered program, will protect against uncertainty in rates for QHPs by limiting the extent of issuer losses (and gains)."); 77 FR 73118, 73121 (Dec. 7, 2012) ("The temporary risk corridors program permits the Federal government and QHPs to share in profits or losses resulting from inaccurate rate setting from 2014 to 2016."); 78 FR 72322, 72379 (Dec. 2, 2013) ("The risk corridors program will help protect against inaccurate rate setting in the early years of the Exchanges by limiting the extent of issuer losses and gains."); 79 FR 13743, 13829 (Mar. 11, 2014) (same).

being made annually and in full would disrupt the congruence between the 3Rs, destabilizing annual premiums rather than stabilizing them. *See Health Republic*, 129 Fed. Cl. at 776 ("Reinsurance and risk adjustment payments are to be made on an annual basis. And, the risk corridors payment that HHS owes an eligible insurer for a particular year depends upon the amount of reinsurance and risk adjustment payments that insurer received for that same year. It seems probable, therefore, that Congress intended for risk corridors payments, like the reinsurance and risk corridors payments upon which they depend, to be paid annually.").

iv. Helping ACA Succeed

Ultimately, Congress included the risk corridors program in the ACA to help the new ACA Exchanges succeed. This could only be fulfilled with full, annual risk corridors payments. By failing to make full, annual risk corridors payments, the Government has caused co-ops to collapse, insurers to leave the ACA Marketplace, and remaining insurers to raise premiums – all of which defeats the stated purposes of the risk corridors program. As Judge Sweeney concluded, "[i]t is … nonsensical to suggest that Congress, in enacting provisions meant to ensure the success of the Affordable Care Act, drafted those provisions to cause the opposite effect." *Health Republic*, 129 Fed. Cl. at 776 (citing *King v. Burwell*, 135 S. Ct. 2480, 2496 (2015) ("Congress passed the Affordable Care Act to improve health insurance markets, not to destroy them.")); *accord Moda*, 2017 WL 527588, at *13 (quoting *N.Y. State Dep't of Soc. Servs. v. Dublino*, 413 U.S. 405, 419-20 (1973), for the proposition that courts do not "interpret federal statutes to negate their own stated purposes").[6]

[6] That full, annual risk corridors payments must be made is also consistent with the Medicare Part D risk corridors program that Congress expressly stated Section 1342 "shall be based upon." 42 U.S.C. § 18062(a). Medicare Part D requires full, annual payments, which Congress knew when it passed the ACA and required the ACA risk corridors program to be "based on" the Medicare Part D program. *See* 42 C.F.R. § 423.336(c) (2009); *Health Republic*, 129 Fed. Cl. at 774-75; *Moda*, 2017 WL 527588, at *12, *15.

f. Consequences of Not Making Full, Annual Payments

Further demonstrating that only full, annual risk corridors payments can fulfill the purpose of the ACA's risk corridors program, we know the actual consequences of the Government's failure to make full, annual payments. First, as has been widely reported, without full, annual risk corridors payments, the risk corridors program has failed, contributing to "the very 'death spirals' that Congress designed the [Affordable Care] Act to avoid." *King*, 135 S. Ct. at 2484. Of the 23 co-ops in operation when the ACA Marketplace opened in 2014, only seven remain open – Land of Lincoln was among the casualties.[7] As Judges Sweeney and Wheeler observed, if HHS "did not provide for prompt compensation to insurers upon the calculation of amounts due, insurers might lack the resources to continue offering plans on the exchanges." *Moda*, 2017 WL 527588, at *13 (quoting *Health Republic*, 129 Fed. Cl. at 776). Second and similarly, a number of major nationwide health insurers withdrew from the ACA Exchanges, including in North Carolina, where BCBSNC no longer competes with UnitedHealth and Aetna, leaving BCBSNC as the sole ACA Exchange participant in 95 of North Carolina's 100 counties. *See* Katherine Restrepo, *Most in N.C. will have one Obamacare option in 2017*, Carolina Journal, Sept. 8, 2016, *available at* https://www.carolinajournal.com/opinion-article/most-in-n-c-will-have-one-obamacare-option-in-2017/.

[7] *See* Phil Galewitz, *Seven Remaining Obamacare Co-Ops Prepare Survival Strategies*, Kaiser Health News, July 13, 2016, *available at* http://khn.org/news/seven-remaining-obamacare-co-ops-prepare-survival-strategies/ ("Shortfalls in anticipated levels of federal funding contributed, too. At the end of 2014, for example, insurers got blindsided when money they had counted on to offset losses was cut sharply from the ACA's risk corridor program. … The move disproportionately hurt small insurers, according to the nonpartisan Commonwealth Fund."); Sabrina Corlette, et al., *Why Are Many CO-OPs Failing?*, The Commonwealth Fund, Dec. 2015, *available at* http://www.commonwealthfund.org/~/media/files/publications/fund-report/2015/dec/1847_corlette_why_are_many_coops_failing.pdf ("The risk corridor program in particular, which is designed to help carriers recover significant losses, gave the CO-OPs and other insurers some license to price their plans lower than they otherwise would have. However, after these pricing decisions had been made, Congress changed the program to make it budget neutral. … Because more insurers experienced losses than gains, insurers received only 12.6 percent of the risk corridor payments they had originally been led to expect for 2014. In the wake of this news, several CO-OPs announced they will close their doors by the end of the year.").

Third, annual premiums have risen dramatically.[8] Fourth, to date, nineteen QHP issuers that suffered billions of dollars in risk corridors losses have sued the United States in this Court to recover immediate payment of the risk corridors amounts due and owing to them.[9] The "temporary" risk corridors program's undisputed purpose was negated by the Government's failure to comply with its unequivocal obligation to make full, annual risk corridors payments in each of the program's three years.

2. Whether the United States Department of Health and Human Service's ("HHS") proposed rule dated March 23, 2012, at 77 Fed. Reg. 17220-01, 17238, 2012 WL 959270 (Mar. 23, 2012), requires that HHS provide full, annual payment of the risk corridor payments?

Yes, the March 23, 2012 rule published by HHS in the Federal Register requires that HHS make full, annual risk corridors payments.[10]

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[8] *See* Zachary Tracer, *Obamacare Benchmark Premiums to Rise 25% in Sharpest Jump Yet*, Bloomberg, Oct. 24, 2016, *available at* https://www.bloomberg.com/news/articles/2016-10-24/obamacare-benchmark-premiums-to-rise-25-in-sharpest-jump-yet; Paul Demko, *Obamacare's sinking safety net*, POLITICO (July 13, 2016), *available at* http://www.politico.com/agenda/story/2016/07/obamacare-exchanges-states-north-carolina-000162 ("Millions are now being covered through the law, but they're older, sicker and more expensive to insure than anyone anticipated. To compensate, health plans are raising premiums, in some cases by a lot."); Louise Radnofsky & Anna Wilde Mathews, *Health Insurers Struggle to Offset New Costs*, Wall St. J. (May 4, 2016), *available at* http://www.wsj.com/articles/health-insurers-struggle-to-offset-new-costs-1462404298 ("Insurers have begun to propose big premium increases for coverage next year under the 2010 health law, as some struggle to make money in a market where their costs have soared.").

[9] *See Health Republic Ins. Co. v. United States*, No. 16-259C (Sweeney, J.); *First Priority Life Ins. Co. v. United States*, No. 16-587C (Wolski, J.); *Blue Cross and Blue Shield of North Carolina v. United States*, No. 16-651C (Griggsby, J.); *Moda Health Plan, Inc. v. United States*, No. 16-649C (Wheeler, J.); *Land of Lincoln Mutual Health Ins. Co. v. United States*, No. 16-744C (Lettow, J.); *Maine Cmty. Health Options v. United States*, No. 16-967C (Merow, J.); *New Mexico Health Connections v. United States*, No. 16-1199C (Bruggink, J.); *BCBSM, Inc. v. United States*, No. 16-1253C (Coster Williams, J.); *Blue Cross of Idaho Health Service, Inc. v. United States*, No. 16-1384C (Lettow, J.); *Minuteman Health Inc. v. United States*, No. 16-1418C (Griggsby, J.); *Montana Health CO-OP v. United States*, No. 16-1427C (Wolski, J.); *Alliant Health Plans, Inc. v. United States*, No. 16-1491C (Braden, J.); *Blue Cross and Blue Shield of South Carolina v. United States*, No. 16-1501C (Griggsby, J.); *Neighborhood Health Plan, Inc. v. United States*, No. 16-1659C (Bruggink, J.); *Health Net, Inc. v. United States*, No. 16-1722C (Wolski, J.); *HPHC Ins. Co., Inc. v United States*, No. 17-87C (Griggsby, J.); *Medica Health Plans v. United States*, No. 17-94C (Horn, J.); *Blue Cross and Blue Shield of Kansas City v. United States*, No. 17-95C (Braden, J.); *Molina Healthcare of California, Inc. v. United States*, No. 17-97C (Wheeler, J.).

[10] Initially, in response to the Court's second issue, we note that the March 23, 2012 rule in the Federal Register was a final rule, not a proposed rule, that resulted in HHS' adoption of, *inter alia*, 45 C.F.R. § 153.510(a)-(c), following a notice-and-comment period. *See, e.g.*, 77 FR 17220, 17220 (Mar. 23, 2012) ("ACTION: Final

The March 23, 2012 final rule formalized HHS' adoption of the implementing regulations to Section 1342, including 45 C.F.R. § 153.510(a)-(c). *See* 77 FR 17220, 17251 (Mar. 23, 2012). As explained above, HHS' implementing regulations mirror Section 1342's mandatory payment obligation, and, like the statute, also require full, annual risk corridors payments. There is no language in the regulation conditioning the payment of risk corridors payments – calculated annually based on the prescribed statutory formula – on any appropriation, source of funds or "payments in," nor affording the Secretary discretion to pay qualifying QHPs less than the full amount due. Significantly, the implicit "budget neutrality" limits now urged by Defendant are not found anywhere in the text of the March 23, 2012 Final Rule implementing Section 1342. *See generally* 45 C.F.R. § 153.510. Judge Sweeney and Judge Wheeler both agreed that this particular regulation unambiguously required annual payment, and although Judge Sweeney's RCFC 12(b)(1) analysis did not reach the question of full payment, Judge Wheeler did answer the question on the merits and concluded that full risk corridors payments are required annually. *See Health Republic*, 129 Fed. Cl. at 773-78; *Moda*, 2017 WL 527588, at *12-22.

HHS provided its interpretation of Section 1342 in the preamble to the March 23, 2012 Final Rulemaking. HHS made many relevant statements in that interpretation, detailed below, which also demonstrate that the agency intended risk corridors payments to be made annually and in full. Notably, nothing in the implementing regulation, nor the preamble, addressed the budget neutrality that Defendant now argues must have been implicit. In fact, one year later, HHS stated in rulemaking 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

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rule."); *Moda*, 2017 WL 527588, at *3-4 ("After a notice and comment period, HHS published its final rule on March 23, 2012."). The proposed rule was dated July 15, 2011, and was published at 76 FR 41929. *See* 77 FR 17220, 17221.

required under section 1342 of the Affordable Care Act." 78 FR 15410, 15473 (Mar. 11, 2013).

HHS' intention was most expressly stated at pages 17238-39 of the March 23, 2012 Final Rulemaking, where it endorsed a 30-day risk corridors payment period and promised it would issue future guidance on the risk corridors payment deadline – which never came. Thus, the following statements from the Final Rulemaking were HHS' last guidance on the issue of the deadline for risk corridors payments before QHPs, like BCBSNC, prepared for and committed to the CY 2014 Exchanges in 2013:

- "While we did not propose deadlines in the proposed rule, we discussed in the preamble timeframes for QHP issuers to remit charges to HHS. We suggested, for example, that a QHP issuer required to make a risk corridors payment may be required to remit charges within 30 days of receiving notice from HHS, *and that HHS would make payments to QHP issuers that are owed risk corridors amounts within a 30-day period after HHS determines that a payment should be made to the QHP issuer. QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers.* We sought comment on these proposed payment deadlines in the preamble to the proposed rule. Considering the comments received, we are finalizing this section as proposed, with a few clarifying modifications." 77 FR 17220, 17238 (Mar. 23, 2012) (emphasis added).

- "Comments: A number of commenters addressed the risk corridors payment deadline. Three commenters agreed that 30 days was a reasonable timeframe for both payments and charges, and one commenter recommended that payments and charges be paid once per year. One commenter suggested requiring issuers of QHPs to submit risk corridors data within 30 days after submission of a request for payment to HHS or receipt of demand for payment from HHS. *Response: We plan to address the risk corridors payment deadline in the HHS notice of benefit and payment parameters.*" *Id.* at 17239 (emphasis added).[11]

HHS repeatedly acknowledged that because Section 1342 requires mandatory payments pursuant to the statutory formula, the regulation HHS was adopting (45 C.F.R. § 153.510(a)-(c)) would mimic the statutory text:

- "Section 1342 provides that HHS *must* establish a temporary risk corridors program that will apply to QHPs in the individual and small group markets *for the first three*

[11] Again, HHS failed to address the risk corridors payment deadline thereafter.

years of Exchange operation (2014 through 2016)." 77 FR 17220, 17238 (Mar. 23, 2012) (emphasis added).

- "In § 153.510, we also established the payment methodology for the risk corridors program, using the thresholds and risk-sharing levels *specified in statute*." *Id.* (emphasis added).

- "In § 153.510(b), we described the method for determining payment amounts to QHP issuers. For a QHP with allowable costs in excess of 103 percent but not more than 108 percent of the target amount, HHS *will pay* the QHP issuer 50 percent of the amount in excess of 103 percent of the target amount. For a QHP with allowable costs that exceed 108 percent of the target amount, the Affordable Care Act directs HHS to pay the QHP issuer an amount equal to 2.5 percent of the target amount plus 80 percent of the amount in excess of 108 percent of the target amount." *Id.* (emphasis added).

HHS acknowledged that under the risk corridors program, *the Government* shares risk with QHPs to reduce/stabilize annual premiums during the first years of the program. The only way for this mechanism to work properly – for the Government to *actually* share in the risk – is for full, annual payments to be paid, otherwise insurers are left sharing risk only with other insurers:

- "The temporary Federally administered risk corridors program serves to protect against uncertainty in rate setting by qualified health plans *sharing risk* in losses and gains *with the Federal government*." 77 FR 17220, 17220 (Mar. 23, 2012) (emphasis added).

- "Risk corridors create a mechanism for *sharing risk* for allowable costs *between the Federal government and QHP issuers*." *Id.* at 17236 (emphasis added).

HHS also recognized that the risk corridors program was designed to limit insurers' losses and gains. That design is defeated if the Government failed to pay full, annual risk corridors payments, otherwise there would be no actual limitation on insurer losses:

- "The risk corridors program, which is a Federally administered program, *will protect* against uncertainty in rates for QHPs *by limiting the extent of issuer losses* (and gains)." 77 FR 17220, 17221 (Mar. 23, 2012) (emphasis added).

- A chart includes a "Risk corridors" column with the following information: "What … *Limits issuer losses (and gains)*"; Why … *Protects against inaccurate rate-setting*";

"When … *After* reinsurance and risk adjustment" – which are annual. *Id.* (emphasis added).

- "Furthermore, because the temporary risk corridors program is *designed to limit the extent of actual issuer losses* (and gains) with respect to QHPs, the program will use actual data, not projected data," submitted on an annual basis. *Id.* at 17238 (emphasis added).

- "The temporary federally administered risk corridors program *serves to protect against rate-setting uncertainty for QHPs by limiting the extent of issuer losses* (and gains)" on an annual basis. *Id.* at 17243 (emphasis added).

- "Payments through reinsurance, risk adjustment, and risk corridors *reduce the increased risk of financial loss that health insurance issuers might otherwise expect to incur in 2014*. Insurers charge premiums for expected costs plus a risk premium, in order to build up reserve funds in case medical costs are higher than expected. Reinsurance, risk adjustment, and risk corridors payments *reduce the risk to the issuer, reducing the risk premium*." *Id.* at 17244 (emphasis added).

Additionally, HHS stated that the risk corridors program provides insurers stability against the threat of adverse selection. Such stability cannot exist without full, annual payments. As set forth below, HHS made clear that such "greater payment stability" would "begin in 2014," "from year one of the implementation," and would occur "as insurance market reforms are implemented." 77 FR 17220, 17221 (Mar. 23, 2012) (emphasis added). Nowhere in the March 23, 2012 Final Rulemaking does HHS state that payment would come at some undetermined time *after* the end of the program, as Defendant now suggests:

- "In addition, *to further minimize the negative effects of adverse selection and foster a stable marketplace from year one of implementation*, the Affordable Care Act establishes transitional reinsurance and temporary risk corridors programs, and a permanent risk adjustment program to provide payments to health insurance issuers that cover higher-risk populations and to more evenly spread the financial risk borne by issuers. The transitional reinsurance program and the temporary risk corridors program, *which begin in 2014*, are *designed to provide issuers with greater payment stability as insurance market reforms are implemented*." 77 FR 17220, 17221 (Mar. 23, 2012) (emphasis added).

- "This rule implements standards for States related to reinsurance and risk adjustment, and for health insurance issuers related to reinsurance, risk corridors, and risk adjustment consistent with the Affordable Care Act. These programs *will mitigate the impacts of potential adverse selection and stabilize the individual and small group*

markets as insurance reforms and the Exchanges are implemented, starting in 2014." *Id.* at 17243 (emphasis added).

- "These programs *aim to mitigate the impacts of potential adverse selection and stabilize the individual and small group markets as insurance reforms* and the Affordable Insurance Exchanges *are implemented, starting in 2014*. The Affordable Care Act structures reinsurance and risk adjustment as State-based programs with Federal guidelines on methodology, while it establishes risk corridors as a federally run program." *Id.* at 17244 (emphasis added).

Finally, HHS also repeatedly recognized the interconnected nature and purpose of the 3Rs in stabilizing premiums:

- "Since all three programs will play important and different roles in stabilizing premiums *beginning in 2014*, we believe that *both* the risk adjustment and reinsurance programs should be taken into account as after-the-fact adjustments *for purposes of the risk corridors calculation, as required by the statute*." 77 FR 17220, 17240 (Mar. 23, 2012) (emphasis added).

3. Whether the Court should dismiss Count I of the complaint pursuant to Rule 12(b)(6) of the Rules of the United States Court of Federal Claims ("RCFC"), if the Court concludes that plaintiff is not entitled to "presently due money damages" under Section 1342 of the Patient Protection and Affordable Care Act ("ACA")?

No. Every judge of this Court that has thus far issued a decision on the issue of "presently due money damages" has agreed that it is not a requirement for jurisdiction or ripeness in the risk corridors context, has distinguished the risk corridors claims brought to enforce the money-mandating statute and regulations from the Defendant's inapplicable *King* and *Todd* line of cases, and has rejected the identical "presently due" arguments that Defendant has repeated in this case. *See Land of Lincoln*, 129 Fed. Cl. at 97-98; *Health Republic*, 129 Fed. Cl. at 770-72; *Moda*, 2017 WL 527588, at *11-14. The Court in each of these three cases recognized that the "presently due money damages" urged by Defendant was not a bar to jurisdiction or ripeness, and all three Judges held that both Section 1342 and its implementing regulations are money-mandating sources of law. Notably, none of the three Judges reviewing and rejecting the Defendant's "presently due" arguments found that they had any bearing on

whether the plaintiffs had stated viable claims for relief. Indeed, Defendant has never argued that "presently due money damages" is a merits issue, but has consistently asserted in this and other risk corridors cases that it is only a jurisdictional or ripeness issue. Unsurprisingly, Defendant has not identified any authority demonstrating, much less suggesting, that "presently due money damages" is an element necessary to state a claim for BCBSNC's statutory claim asserted in Count I.

Rather, as Judge Sweeney concluded, and as Judge Wheeler agreed, "the Government's 'presently due' argument [is] a ripeness argument in disguise." *Moda*, 2017 WL 527588, at *11 (citing *Health Republic*, 129 Fed. Cl. at 772). Because BCBSNC's statutory claim in Count I under Section 1342 and its implementing regulations, like the statutory claims in *Health Republic* and *Moda*, claims "immediate monetary damages," not equitable relief as in the *King* and *Todd* cases relied upon by Defendant, the "presently due money damages" argument has no relevance here. *See Moda* at *11; *Health Republic* at 772 ("The distinction drawn by the Supreme Court in *King* is not applicable in this [risk corridors] case; an insurer's entitlement to unpaid risk corridors payments is not dependent upon the insurer first obtaining a declaratory judgment"); *Land of Lincoln*, 129 Fed. Cl. at 97. Therefore, Count I is not subject to dismissal under RCFC 12(b)(6) if the Court finds that BCBSNC is not entitled to "presently due money damages," because RCFC 12(b)(6) addresses "failure to state a claim upon which relief can be granted."

To state a claim for violation of the Government's mandatory "shall pay" payment obligation under Section 1342 and its implementing regulations, BCBSNC is only required to plausibly allege three things: (1) plaintiff is a QHP, (2) plaintiff experienced sufficient losses in a plan year to trigger the Government's mandatory risk corridors payment obligations, and (3) the

Government has failed to make the risk corridors payments alleged to be owed under the money-mandating statute and its implementing regulations. *See, e.g.*, *Fisher v. United States*, 402 F.3d 1167, 1173 (Fed. Cir. 2005). There is no additional requirement that BCBSNC initially establish that "money damages" are "presently due" to state a claim for relief under Count I. *See* BCBSNC's Opp'n Br., ECF No. 14 at 28 ("Because Plaintiff's well-pled facts state a 'facially plausible claim,' and 'provide the grounds of [its] entitle[ment] to relief' for the Government's violation of a money-mandating statute and its implementing regulations, dismissal of Count I on the pleadings would be improper.") (citing *Cambridge v. United States*, 558 F.3d 1331, 1335 (Fed. Cir. 2009) and *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)); *Moda*, 2017 WL 527588, at *15, *22 ("[D]etermining the amount HHS owed Moda in each annual payment is a merits issue that requires further analysis. … Section 1342 requires full annual payments to insurers, and the Government has not made these payments. Furthermore, Congress has not modified the risk corridors program to make it budget-neutral. As a result, there is no genuine dispute that the Government is liable to Moda under Section 1342."); *Health Republic*, 129 Fed. Cl. at 778 ("Because HHS determined that plaintiff is entitled to a $7,884,886.15 risk corridors payment for 2014 and a $13,000,493.30 risk corridors payment for 2015, the only remaining issue is whether plaintiff was entitled to full payment for 2014 in December 2015 and full payment for 2015 in December 2016. … [R]esolution of this issue will require the court to determine, on the merits, whether HHS is permitted to make partial annual risk corridors payments under section 1342 of the [ACA] and its implementing regulations.").

It would violate the RCFC 12(b)(6) standard if the Court dismissed BCBSNC's complaint for failure to allege "presently due money damages," because the Court is required to accept as true BCBSNC's well-pled facts that the Government's payment is presently due when

considering Defendant's motion to dismiss. *See, e.g.*, *Scheuer v. Rhodes*, 416 U.S. 232, 236 (1974); Compl. ¶ 8 ("Defendant has failed to pay the full amount due."); ¶ 72 ("HHS and CMS thus lack statutory authority to pay anything less than 100% of the risk corridor payments due to Plaintiff for CY 2014."); ¶ 87 ("The United States should have paid BCBSNC the full CY 2014 risk corridor payments due by the end of CY 2015, but failed to do so.").

4. Whether the Court should dismiss Counts II-IV of the complaint, pursuant to RCFC 12(b)(6), if the Court concludes that plaintiff is not entitled to "presently due money damages" under Section 1342 of the ACA?

No, for the reasons demonstrated above in response to the Court's third issue regarding Count I, none of Counts II-IV are subject to dismissal under RCFC 12(b)(6) if the Court finds that BCBSNC is *not* entitled to "presently due money damages." *See Land of Lincoln*, 129 Fed. Cl. at 97-98; *Health Republic*, 129 Fed. Cl. at 770-72; *Moda*, 2017 WL 527588, at *11-14. BCBSNC's opposition brief describes the elements required to plausibly allege each of those claims to survive a motion to dismiss. *See* BCBSNC's Opp'n Br., ECF No. 14 at 41 (Counts II and III elements), 55-56 (Count IV elements) & 56-58 (Count V elements). None of those required elements are "presently due money damages," and in over 150 pages of briefing in this case, Defendant has not once argued otherwise. Tellingly, neither Judge Lettow in *Land of Lincoln*, nor Judge Wheeler in *Moda*, found that the Defendant's "presently due money damages" argument in those cases was an impediment to the respective plaintiff's ability to plausibly state alternative claims for breach of express or implied-in-fact contracts resulting from the Government's failure to pay the risk corridors amounts alleged to be owed. The Court in both cases held that the plaintiffs alleged viable, "non-frivolous" claims for breach of contract by pleading the essential elements of those contract claims, which did *not* include whether the

monetary damages alleged were "presently due." *See Land of Lincoln*, 129 Fed. Cl. at 98-99; *Moda*, 2017 WL 527588, at *11.

Indeed, if such an element were required, then an anticipatory breach of contract claim would receive short treatment in this Court, yet even Judge Lettow found jurisdiction over Land of Lincoln's anticipatory breach claim despite Defendant's "presently due" argument. *See Land of Lincoln*, 129 Fed. Cl. at 99. Finally, because BCBSNC's complaint contains well-pled factual allegations that the Government's risk corridors payments *are* presently due under Counts II-IV, *see, .e.g.*, Compl. ¶¶ 8, 72, 87, any dismissal under RCFC 12(b)(6) would be in error.

Date: March 3, 2017

Respectfully Submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on March 3, 2017, a copy of the foregoing Plaintiff's Initial Supplemental Brief was filed electronically with the Court's Electronic Case Filing (ECF) system. I understand that notice of this filing will be sent to all parties by operation of the Court's ECF system.

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