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Legal Sidebar

Ripple Effects: Assessing Impacts of the Supreme Court's Risk Corridors Decision

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Although most eyes tracking Affordable Care Act (ACA) litigation may be drawn to *California v. Texas* during the Supreme Court's upcoming term, the Court handed down an ACA decision this past term that may have numerous ripple effects in other ACA cases and programs. Specifically, in *Maine Community Health Options v. United States*, the Court considered whether the United States is obligated, under the temporary Risk Corridors Program, to make payments to health insurance providers who offered coverage at a loss in the ACA's individual and small group markets. Though the Department of Health and Human Services (HHS) calculated insurer payments for the 2014, 2015, and 2016 program years, HHS paid a fraction of that amount. Limitations in HHS's annual appropriations acts prevented use of annually appropriated funds to make payment in full. Despite this lack of available appropriations, the Court held that the United States incurred obligations to insurers under the Risk Corridors statute for which insurers could obtain payment through litigation.

This ruling is important in its own right for what it teaches about private parties' ability to sue the federal government to recover on statutory obligations, even when Congress has not provided for payment of such obligations outside of litigation. Notwithstanding the affirmance of this right, questions of the government's full liability for Risk Corridor payments could potentially linger for several years. Separately, the Court's decision may affect insurer claims for payment under the ACA's cost-sharing reduction (CSR) program, which compensates insurers to help cover the cost of required reductions in an insured's cost sharing. Finally, HHS and insurers may need to consider how Risk Corridor settlements or judgments should be treated under the ACA's medical loss ratio calculation rules. This Sidebar examines each of these potential ripple effects in turn and notes considerations for Congress.

Remaining Risk Corridors Program Litigation

The claims resolved in *Maine Community Health Options* itself represented a relatively small portion of the pending claims against the United States for failing to make payments under the Risk Corridors Program. By the government's count, insurers have brought more than 64 other cases asserting similar Risk Corridor claims. The Court's decision will likely spur judgments or settlements in these other cases, likely drawing billions of dollars from the U.S. Treasury in the process. But the full extent of the government's liability for unmet Risk Corridor payments may not be known for several years.

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The pending cases fall into two general categories. First, individual insurers have brought suit seeking money judgments against the United States for Risk Corridor payments. Second, two insurers have filed class actions, the first covering the 2014 and 2015 Risk Corridors program years and the second covering the 2016 program year. The classes consist of all persons or entities for whom HHS calculated payments owed during the relevant years and who have decided to become class members. More than one hundred insurers have opted into each class.

The Supreme Court's decision in *Maine Community Health Options* will resolve the government's liability in these pending cases so long as the plaintiff's theory of liability mirrors that affirmed in the Court's opinion. But a key issue remains: how much, exactly, are individual insurers owed? The Risk Corridors statute specifies a formula, elaborated upon in regulations, for calculating payments. The formula compares an insurer's "target amount" (essentially, premiums earned less certain administrative costs) with its "allowable costs" (simplified greatly, its claims and costs). The value given to these variables will generally differ by insurer, and while HHS calculated payments in the past, HHS made partial payments to certain insurers for specific program years. Thus, the parties will have to agree on, or a court will have to decide, the payments still owing to any particular plaintiff or class member to arrive at either a settlement or a judgment amount, which would then be payable from the Judgment Fund. For the most part, the parties appear set to agree on judgment amounts. Disputes are possible, though, as to whether certain insurers should have their recovery reduced because of debts allegedly owed to the government under ACA programs. In the aggregate, judgment amounts for pending cases will likely be significant. The classes alone seek payments exceeding several billion dollars.

These pending cases aside, it is also possible that insurers who are neither party to a pending lawsuit nor a class member could file new lawsuits, patterned on the claims and theories affirmed in *Maine Community Health Options*. Insurers likely have six years to bring a civil action against the United States related to Risk Corridor payments. This six-year clock begins to tick when a claim "first accrues," which is when "the plaintiff can file suit and obtain relief" because all of the events leading to the government's alleged liability have occurred. Several accrual dates are possible, though one relevant date could be when HHS announced program-year payments, which occurred in November of the year following the end of the relevant program year. To take an example, insurers for whom HHS calculated payments for the 2016 program year (the last year of the Risk Corridor Program) learned their payment amounts in November 2017. Based on this accrual date, these insurers could file suit as late as November 2023. Thus, it may be several years before the full extent of the government's liability for Risk Corridor payments is known.

Cost-Sharing Reduction Payments

The Supreme Court's decision in *Maine Community Health Options* may also affect ongoing litigation regarding a different provision of the ACA—the cost-sharing reduction payments under Section 1402 of the ACA. Section 1402 requires insurers participating in an exchange to reduce cost sharing (e.g., deductibles, co-payments) for certain enrollees who receive premium subsidies under the ACA. Section 1402 also directs the Secretary of HHS to make CSR payments to such insurers "equal to the value of the reductions" provided to enrollees to compensate those insurers for the reduced revenue.

Although the Obama Administration requested annual appropriations for CSR payments, Congress did not provide any, prompting questions about whether the constitutional requirements to draw funds from the federal treasury had been met with respect to such payments. Article I, Section 9, clause 7 of the Constitution, commonly referred to as the Appropriations Clause, provides that "No Money shall be drawn from the Treasury but in Consequence of Appropriations made by Law . . . ." Notwithstanding such concerns, HHS made such payments to insurers beginning in 2014, the effective date of Section 1402, using a permanent indefinite appropriation for tax refunds. In response, the U.S. House of Representatives sued the Secretary of HHS in the U.S. District Court for the District of Columbia, which issued an

injunction blocking the CSR payments in May 2016. That injunction was stayed pending appeal to the U.S. Court of Appeals for the D.C. Circuit, and HHS continued making CSR payments to insurers. However, in October 2017, while that appeal was pending, the Trump Administration informed the D.C. Circuit that HHS would immediately comply with the House's demand and cease making CSR payments to insurers.

Following the cessation of those CSR payments, several health insurers brought suit in the Court of Federal Claims, including a class action by more than 90 insurers, seeking to recover unpaid amounts. The court ruled in favor of the plaintiff-insurers in several cases, two of which were then consolidated on appeal to the U.S. Court of Appeals for the Federal Circuit. Given the similarity in the underlying fact pattern (i.e., a statute directing payment but lacking a sufficient appropriation), many of the arguments raised in the CSR litigation mirror those resolved by the Supreme Court in *Maine Community Health Options.* For example, the government has argued that the CSR's directive that the HHS Secretary "shall make periodic and timely payments" was qualified by the Anti-Deficiency Act, which generally bars federal officials from making payments without a valid appropriation, and was insufficient to create a legally enforceable obligation on the part of the government. The Supreme Court expressly rejected this argument in *Maine Community Health Options* with respect to the Risk Corridors statute. The government has consequently abandoned that argument in the CSR appeals.

However, the government continues to argue that the CSR program is distinguishable from the Risk Corridors Program. Specifically, because CSR payments are only required with respect to enrollees who receive premium tax credits under the ACA, the government argues that the insurers can use a workaround known as "silver loading" to offset the lack of future CSR payments through increased premiums. The government argues that all states have adopted some form of silver loading in response to the cessation of CSR payments. Because insurers have an alternate means of compensation available to them, and have in fact increased premiums, the government asserts that Congress could not have intended insurers to effectively be compensated further through suits against the United States, or alternatively, that the measure of damages suffered by the insurers should be reduced accordingly. For their part, the insurer-plaintiffs argue that the practice of "silver loading" is not the kind of comparable remedial scheme that the Court alluded to in *Maine Community Health Options* as a potential reason to disallow suits against the federal government for unpaid obligations, and the fact that insurers have increased premiums does not eliminate their statutory right to recover CSR payments. A decision by the Federal Circuit in the CSR program appeal is currently pending.

Medical Loss Ratios

The *Maine Community Health Options* decision may also affect Section 2718 of the Public Health Service Act, a second ACA provision that generally requires health insurers to provide rebates to enrollees if the insurers do not meet a target medical loss ratio (MLR). Broadly speaking, the MLR is calculated by dividing an insurer's costs by premiums revenue for a given plan year. If an insurer's MLR falls below a given target percentage, the insurer is required to pay rebates of premiums to enrollees in proportion to the degree of the MLR shortfall (e.g., a 3% rebate of premiums based on an 82% MLR and an 85% target). MLR calculations are based on a rolling three-year average.

Notably, the statute defines "premium revenue" as including Risk Corridor receipts for the plan year. Because the judgments received as a result of the *Maine Community Health Options* decision are unpaid Risk Corridor payments, Section 2718 would seemingly require them to be included in the denominator for MLR calculations, increasing the possibility of a required premium rebate for enrollees. That may raise the question of which plan year to include the Risk Corridor payments in the denominator: the year for which the Risk Corridor payments were calculated (e.g., 2015, 2016, or both) or the plan year in which the judgments were paid (likely 2020 or later).

Typically, Risk Corridor payments calculated for a given program year (e.g., 2014) were used to adjust premium revenue for the same year even though the actual Risk Corridor payment would be received in a subsequent year, suggesting that receiving the judgments now would require MLR recalculations for prior program years. Current regulations require issuers to retain MLR records for seven years and to report "any risk corridors payment or charge" unaccounted for in a prior year. If past enrollees are no longer enrolled with the insurer, current regulations also provide that an insurer must make a "good faith effort" to locate the enrollee for the purposes of any rebate. Payment of rebates may also be deferred in whole or in part to future years if the payment would affect the insurer's solvency. Although it may be possible to address such payments through the existing MLR process, Congress or HHS may explore providing special rules for addressing such payments for MLR purposes, given the manner in which these Risk Corridor payments have arrived (e.g., as a multiyear lump-sum received by insurers well after the program has ended).

Considerations for Congress

Congress may have limited ability to respond to some of these ripple effects, and greater flexibility to respond to others. Attempts by Congress to abrogate existing obligations without compensation to obligees, such as those owed to insurers under the Risk Corridors statute, may raise constitutional questions under the Fifth Amendment. On the other hand, Congress could amend relevant statutes, such as Section 1402, to prospectively provide that any new obligations created under the statute would be limited to the amounts provided in an appropriation for that purpose. Such a limiting amendment could avoid a result like that of the Risk Corridors cases: lingering obligations that only become payable from the Judgment Fund after protracted litigation. But this type of amendment would have costs of its own. Insurers' entitlement to payment would vary with Congress's annual appropriations decisions. This variability could undermine program effectiveness, as insurers might be less able to predict the extent of the government's obligations to them. Congress also may consider continued oversight as to these ripple effects. For example, as Risk Corridor judgments are paid out and incorporated into MLR calculations, Congress may monitor the impact of such payments toward the MLR provision's stated goal of "ensuring that consumers receive value for their premium payments."

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