

**IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF NEW MEXICO**

NEW MEXICO HEALTH CONNECTIONS,
a New Mexico Non-Profit Corporation,

Plaintiff,

v.

Case No. 1:16-cv-00878-JB/WPL

UNITED STATES DEPARTMENT OF HEALTH
AND HUMAN SERVICES, CENTERS FOR
MEDICARE AND MEDICAID SERVICES;
THOMAS E. PRICE, M.D. Secretary of the
United States Department of Health and Human
Services, in his official capacity, and SEEMA
VERMA, Acting Administrator for the Centers for
Medicare and Medicaid Services, in her official
capacity,

Defendants.

**PLAINTIFF'S REPLY AND OPPOSITION TO
DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT**

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I. Introduction

The exchange marketplaces created by the Affordable Care Act (“ACA”) are in crisis, as insurance carriers flee, leaving many counties with only one issuer offering coverage.¹ Where issuers remain, they are requesting massive premium increases in 2018, many well in excess of 30%.² As New Mexico Health Connections (“NMHC”) showed in its opening Memorandum, HHS’s³ unlawful, arbitrary, and capricious risk adjustment program, which penalizes price-cutting and innovation and underestimates the costs of insuring all but the most chronically ill individuals, has played a large role in crippling the exchanges. Due to the sit-on-our hands approach of HHS, as acknowledged in its Memorandum, the problems continue to mount. Indeed, the Massachusetts Department of Insurance recently publicly blamed a slew of

¹ See Ex. A, *Many U.S. Counties Will Only Have One Option for ACA Coverage in 2018*, The Associated Press (June 22, 2017), http://www.omaha.com/money/many-u-s-counties-will-have-only-one-option-for/article_12b136a6-4178-50a8-89e2-99da536a1177.html (“[M]ore than 40 percent of U.S. counties to have only one insurer selling coverage on the exchange”).

² See e.g., Ex. B, *Maryland Insurers Request 38.5 Percent Rate Increase for Individuals*, Baltimore Business Journal (May 5, 2017), <http://www.bizjournals.com/baltimore/news/2017/05/04/maryland-insurers-request-38-5-percent-rate.html> (In Maryland, “[i]he proposed rate increases average at 38.5 percent”); Ex. C, JC Reindl & Todd Spangler, *Obamacare Rates in Michigan Could Skyrocket as Much as 31% in 2018*, Detroit Free Press (June 14, 2017), <http://www.freep.com/story/money/2017/06/14/obamacare-rates-michigan/392687001/> (“Some health insurers in Michigan will be seeking record-level rate hikes next year for plans they sell to individuals – potentially as much as 31%.”); Ex. D, Zachary Tracer, *New York Health Insurers Ask for 16.6% Boost to Obamacare Rates*, Bloomberg (June 7, 2017), <https://www.bloomberg.com/news/articles/2017-06-07/new-york-health-insurers-ask-for-16-6-boost-to-obamacare-rates> (“Insurers [in New York] are seeking to boost their premiums 16.6 percent on average...[T]he requested increases rang[e] from 4.4 percent to 47.3 percent, depending on the insurer...In Maryland, Virginia and Connecticut, premiums will rise more than 20 percent on average...”); Ex. E, The Associated Press, *Nevada Health Insurance Rates Face Proposed Increases*, U.S. News (July 1, 2017), <https://www.usnews.com/news/best-states/nevada/articles/2017-07-01/nevada-health-insurance-rates-face-proposed-increases> (Nevada silver plans face an average increase of 38% under proposed rates for 2018); Ex. F, Patricia Donna, *Most CT Insurers Propose Double-Digit Rate Hikes*, Hartford Business (May 8, 2017), <http://www.hartfordbusiness.com/article/20170508/NEWS01/170509936> (“the state of Connecticut is about to grapple with double-digit rate increase requests from insurers that go as high as 33.8 percent.”)

³ All defendants are collectively referred to as “HHS.” Citations to documents NMHC001687 – NMHC001850 are contained in the Supplemental Appendix being filed contemporaneously with this Reply.

double-digit premium increases upon HHS's out of control risk adjustment program.⁴ This merely joins the deafening chorus of state insurance regulators who have denounced HHS's risk adjustment scheme.⁵ That chorus has included New Mexico's Superintendent of Insurance, who has criticized risk adjustment as "completely backwards" for taking money from small, low-cost innovators like NMHC and handing it over to entrenched, higher-priced competitors.⁶

Yet HHS asks this Court to ignore the disastrous effects of the agency's actions. Instead, HHS's Memorandum first directs the Court to focus on the agency's hopes in 2012, when it put together the initial Benefit Year 2014 risk adjustment rule. HHS then tries to justify its decision to ignore all later developments, supposedly because "it is important to maintain model stability." *See* Defendants' Memorandum in Support of its Cross-Motion for Summary Judgment and Opposition to Plaintiff's Motion for Summary Judgment (Dkt. No. 52), at 37 (hereafter "HHS Br."). But when Rome begins to burn, it is arbitrary and capricious for the Emperor to fiddle. HHS cannot ignore or wish away the real world. To the contrary, the Administrative Procedures Act ("APA") requires the agency to evaluate its programs and adjust

⁴ *See* Ex. G, Jessica Bartlett, *Three Health Insurers Plan Double-Digit Rate Hikes for Third Quarter*, Boston Business Journal (May 18, 2017), http://www.bizjournals.com/boston/news/2017/05/16/three-health-insurers-plan-double-digit-rate-hikes.html?ana=RSS&s=article_search ("Three Massachusetts insurers will see double-digit rate hikes in the third quarter, which the state's Division of Insurance says is largely due to volatility of the Affordable Care Act's risk adjustment program.")

⁵ *See* NMHC Amended Complaint (Dkt. No. 21), at ¶¶ 34-41. HHS has very recently reaffirmed, again, the primary expertise of the states in insurance regulation. *See* Ex. H, HHS, Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients, 82 Fed. Reg. 26,885, 26,887 (proposed June 12, 2017) ("HHS is interested in soliciting public comments about changes to existing regulations or guidance, or other actions within HHS's authority, that could further the following goals with respect to the individual and small group health insurance markets: . . . 4. *Affirming the traditional regulatory authority of the States in regulating the business of health insurance.* Which HHS regulations or policies have impeded or unnecessarily interfered with States' primary role in regulating the health insurance markets they know best?").

⁶ *See* Ex. I, Amy Goldstein, *Critics say ACA "risk" strategies are having reverse Robin Hood effect*, The Washington Post (Jan. 13, 2016), https://www.washingtonpost.com/national/health-science/critics-say-aca-risk-strategies-are-having-reverse-robinhood-effect/2016/01/13/e41cf574-b48f-11e5-a842-0feb51d1d124_story.html?utm_term=.692451f2d64a.

course based upon what actually happens. As detailed below and in NMHC's opening Memorandum, HHS's risk adjustment regulations violate the APA and should be vacated.⁷

II. Argument

A. HHS Has No Discretion To Ignore Real World Developments

In its Memorandum, HHS breezily dismisses the mass of evidence that NMHC marshalled about how risk adjustment has wreaked havoc. HHS asks the Court to do the same by arguing that (i) it made an "informed conjecture" in 2012 when crafting the original risk adjustment rule for benefit year 2014 and (ii) the agency then had the right to sit on its hands in all later years (despite initiating a separate rulemaking proceeding for each year), in the name of stability. Under HHS's logic, because the only rulemaking that should be reviewed is the original one for the 2014 benefit year (all others getting a free pass), the only evidence the Court should review is what was before the agency in 2012/2013 during that first rulemaking, before the program started. *See* HHS Br. at 12-13, 17-18, 27, 36-37.

But the APA does not permit HHS to disregard evidence of the damage its rules have done: "when there is a known or significant change or trend in the data underlying an agency decision, the agency must either take that change or trend into account, or explain why it relied solely on data pre-dating that change or trend." *Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d 1141, 1149 (10th Cir. 2016); *see also Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv.*, 707 F.3d 462, 473 (4th Cir. 2013) ("[W]hen an agency acknowledges that its data are either outdated or inaccurate, it should, at the very least, analyze the new data or explain why it nevertheless chose to rely on the older data."). Where an agency chooses to

⁷ NMHC agrees with HHS that "summary judgment procedures do not apply to adjudication of this action, . . . and therefore, Local Rule 56.1's requirement that all material facts be specifically disputed lest they be deemed undisputed does not apply." HHS Br. at 15. Accordingly, neither party is required to respond to the other party's numbered paragraphs of Facts.

ignore new data without adequate explanation, its conduct is arbitrary and capricious. *See e.g., Zen Magnets*, 841 F.3d at 1149 (vacating agency’s safety standard for magnets where agency, without reasoned explanation, ignored data showing “significant market changes triggered by” the agency’s earlier regulatory efforts); *Dow AgroSciences*, 707 F.3d at 472-73 (agency opinion on pesticides was arbitrary and capricious where agency, without adequate explanation, ignored “more recent available data” showing reductions in pesticides due to EPA regulation); *Sierra Club v. EPA*, 671 F.3d 955, 968 (9th Cir. 2011) (agency’s approval of an environmental plan was arbitrary and capricious where plan was based on old data from an outdated model); *Maine Assoc. of Interdependent Neighborhoods v. Petit*, 659 F. Supp. 1309, 1322-23 (D. Me. 1987) (HHS’ rule was arbitrary and capricious where HHS relied on old data that was no longer accurate and HHS “offered no evidence” to show that its rule was still reasonable).

Even if HHS could not have anticipated the monumental flaws in its risk adjustment formula when it devised the 2014 rule,⁸ it certainly was well aware of the problems shortly after the program commenced. After the monetary assessments for the first year of risk adjustment were published in 2015, and a new notice and comment period opened for the Benefit

⁸ Any such assertion is highly dubious. With the exception of bias against bronze plans, all of the issues in this case were raised in the original rulemaking for 2014. *See* Blue Cross Blue Shield Assoc. Comment re: Amendments to NBPP for 2014, at 1, 7, Rec. at 004301, 004307 (statewide average premium and HCC estimation bias); Blue Cross Blue Shield Assoc. Comment re: NBPP for 2014, at 49, Rec. at 003095 (pharmacy data); State of CA Dept. of Ins., et al. Comment re: NBPP for 2014, at 2, attachment at 1, Rec. at 003539, 003540; New York Health Benefit Exchange Comment re: NBPP for 2014, at 1, Rec. at 002981 (same); OregonIns. Div. of the Dept. of Consumer and Business Servs. Comment re: NBPP for 2014, at 1, NMHC001687 (same); Pharmaceutical Research and Manufacturers of America Comment re: NBPP for 2014, at 1, 4-6, Rec. at 002765, 002768-002770 (same); WellCare Health Plans, Inc. Comment re: NBPP for 2014, at 2, Rec. at 002890 (same); Association for Community Affiliated Plans Comment re: NBPP for 2014, at i-iii, 2-8, 13-15, NMHC001579-001581, 001583-001589, 001594-001596 (partial year enrollment); National Association of Community Health Centers Comment re: NBPP for 2014, at 2-5, Rec. at 003187-003190 (HCC estimation bias); Washington Association of Community & Migrant Health Centers Comment re: NBPP for 2014, at 2-4, Rec. at 003415-003417 (same); Hank Frantz Comment re: NBPP for 2014, at 2, Rec. at 003251 (statewide average premium). HHS nevertheless contends that the question of estimation bias for enrollees without an HCC was not raised in the 2014 rulemaking. *See* HHS Br. at 28, n. 9. But, the Blue Cross Blue Shield Association clearly raised the issue: “testing of the risk adjustment methodology indicates that it over-compensates issuers for members with HCCs, while under-compensating issuers for members without HCCs.” Blue Cross Blue Shield Assoc. 2014 Amendment Comment, attachment at 5, Rec. at 004307.

Year 2017 Rule, the agency was flooded with comments by NMHC and others, backed up by real world data, describing how the methodology, as implemented, was a disaster.⁹ Having received these comments, the agency could no longer idly sit back and rest on its prior analysis. It was required to meaningfully respond. *Zen Magnets*, 841 F.3d at 1149.

HHS also was required to address comments raised after the 2014 rulemaking because it was presented with requests for reconsideration of its prior risk adjustment rules. Under the APA, the agency is required to “give an interested person the right to petition for the . . . amendment, or repeal of a rule.” 5 U.S.C. § 553(e). Any interested person therefore has a statutory right to seek reconsideration of a rule. In evaluating such a request, the agency is required to provide a “reasoned” explanation for its decision to grant or deny the request. *Am. Horse Prot. Ass’n v. Lyng*, 812 F.2d 1, 5 (D.C. Cir. 1987). For its analysis to pass muster, an agency must have “considered the relevant factors, [and] explained the ‘facts and policy concerns’ relied on,” demonstrating that the “facts have some basis in the record.” *Id.* (quotation and citation omitted).

⁹ See e.g., Aetna Comment re: NBPP for 2017, at 3, 9-10, Rec. at 008419, 008425-008426; America’s Health Insurance Plans (“AHIP”) Comment re: NBPP for 2017, at 18, NMHC001690-001747; American Academy of Actuaries Comment re: NBPP for 2017, at 2-4, Rec. at 008137-008139; American Hospital Association Comment re: NBPP for 2017, at 9, Rec. at 008293; Anthem Comment re: NBPP for 2017, at 3, 8-10, NMHC001523, 001528-001530; Blue Cross Blue Shield Association Comment re: NBPP for 2017, at 2, 11, 13-14, 35-36, NMHC001748-001828; NMHC Comment re: NBPP for 2017, at 1-4, App. A at 1, App. B, CHOICES, Technical Issues with Risk Adjustment and Risk Corridor Programs (Nov. 4, 2015), NMHC001452-001455, 001456, 001457-001472; Common Ground Healthcare Cooperative Comment re: NBPP for 2017, at 1, NMHC001829-001831; CVS Health Comment re: NBPP for 2017, at 1-2, Rec. at 008348-008349; Evergreen Health Comment re: NBPP for 2017, at 1-2, Rec. at 009435-009436; Evolent Health Comment re: NBPP for 2017, at 4, NMHC001832-001837; Express Scripts Comment re: NBPP for 2017, at 1, NMHC001838-001842; Land of Lincoln Health Comment re: NBPP for 2017, at 1-5, Rec. at 009003-009007; Minuteman Health Comment re: NBPP for 2017, at 3-7 and attachment (CHOICES, Technical Issues with Risk Adjustment and Risk Corridor Programs (Nov. 4, 2015), NMHC001439—001443, 001437.001-001437.016; National Association of Insurance Commissioners Comment re: NBPP for 2017, at 2-5, Rec. at 009363, 009366; Pharmaceutical Care Management Association Comment re: NBPP for 2017, at 2, 5-7, NMHC001659, 001662-001663; Priority Health Comment re: NBPP for 2017, at 2-3, Rec. at 009344-009345; Viva Health Comment re: NBPP for 2017, at 2-4, NMHC001564-001566; Health New England Comment re: NBPP for 2017, at 1-7 and attachments, Rec. at 008483-008489, 008490-008651.

In 2016, NMHC clearly indicated that, in addition to submitting comments to the proposed new 2018 rule, it also sought reconsideration of prior rules. *See* NMHC 2018 Comment, at 16, NMHC000850 (“[HHS] need[s] to implement the aforementioned changes now in 2016, in all future years (including 2017 and 2018), and apply them retroactively to benefit years 2014 and 2015”) and at 5, NMHC000839 (incorporating by reference original Complaint in this action seeking relief for 2014-2017); *see also* Declaration of Martin Hickey, MD (Oct. 5, 2016), NMHC 2018 Comment, Ex. B-1, at ¶¶ 72, 79, 98, 104, NMHC000878-879, 881, 886, 887-888.

Importantly, when responding to a request for reconsideration of a prior rule, the agency is required to examine the newly submitted data supporting such a request, including, if appropriate, other comments addressing the issue. *See Lyng*, 812 F.2d at 5. That is, the agency is required to consider materials before it *at the time of the petition for reconsideration*, which here was in October 2016. The requirement to reconsider new information is especially critical when the petition for reconsideration alerts the agency to new data and developments since a rule’s inception. *Id.* In *Lyng*, the court held that when an agency refused to initiate a rulemaking and there is evidence demonstrating the problems with that rule, the agency was required to present a “reasonable explanation” for its denial of new rulemaking. The agency failed to meet its burden where it relied upon “conclusory” and “stale” justifications for deferring its rulemaking to the future, “particularly in light of” the newly submitted study. *Id.* at 6. Here, HHS is trying to engage in exactly the type of behavior rejected in *Lyng*. Despite having received a request for reconsideration supported by voluminous data and analyses, it believes it can ignore the evidence and maintain the status quo merely because it (inadequately) addressed the issues raised in its

very first rulemaking – *before* there was any available data on how HHS’s methodology would actually work in practice. This is simply not permitted under the APA.

B. HHS’s Use Of The Statewide Average Premium Is Contrary To Law And Arbitrary And Capricious

1. The Use Of The Statewide Average Premium Violates The ACA

Congress was clear on what it intended the risk adjustment program to do:

“assess a charge on health plans and health insurance issuers . . . if the *actuarial risk* of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year” and “provide a payment to health plans and health insurance issuers . . . if the *actuarial risk* of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year.” 42 U.S.C. § 18063(a)(1)-(2) (emphasis added).

The problem is that HHS transfers funds not based on actuarial risk (*i.e.*, the relative health or sickness of the plan’s enrollees), but rather by multiplying relative actuarial risk against the statewide weighted average premium. The statewide average premium sweeps in all the cost elements of an insurance plan, many of which are unrelated to the relative health or sickness of its insureds. Among the non-risk factors that drive premiums are whether an issuer can control its costs by paying lower prices to hospitals and doctors, by doing a better job managing its members’ medical care, and by reducing administrative overhead. *See e.g.*, NMHC 2018 Comment, at 11, NMHC000845; CHOICES, *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans* (Nov. 4, 2015), NMHC 2018 Comment, Ex. E-2, at 9, NMHC000998; Letter from CHOICES to CMS (Apr. 22, 2016), NMHC 2018 Comment, Ex. E-5, at 2-3, NMHC001018-1019; David V. Axene & Gregory G. Fann, *Comments on Proposed Rule (Patient Protection and*

Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018) (Oct. 5, 2016), Minuteman 2018 Comment, Ex. I-1, at 8-14, NMHC000597-603; NMHC 2017 Comment, at 3, NMHC001454. HHS has conceded this point. *See CMS, March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion White Paper* (Mar. 24, 2016), at 93, NMHC001168 (“[A]lthough a number of sources of premium variation – such as metal level, age, and geographic cost factors – are explicitly addressed in the transfer equation, others – such as network differences [i.e., which hospitals and doctors are included in an insurer’s network], plan efficiency, or effective care coordination or disease management – are not”).

NMHC discussed in its opening Memorandum the detailed actuarial expert white papers in the administrative record that demonstrate that, to the extent a low-cost competitor like NMHC undercuts the statewide average premium by bringing down its non-risk related costs, its risk adjustment charges will be artificially inflated. *See Memorandum of Law in Support of New Mexico Health Connections’ Motion for Summary Judgment* (Dkt. No. 33), at 18-21 (hereafter “NMHC Br.”). In response, HHS does not even try to rebut this evidence. Instead, HHS seizes upon the fact that the statute does not use the word “only” before “actuarial risk.” HHS thus asserts that it had a blank check to transfer funds based on other factors so long as “actuarial risk [is] the dispositive factor in determining whether to assess a risk adjustment charge or make a risk adjustment payment...” HHS Br. at 19. That is, according to HHS, once it divides insurers into creditors and debtors in the risk adjustment program, it can set the *amount* of those payments and credits however it pleases.

This is an absurd reading of the statute. There is nothing in the statute’s text that indicates charges and payments will be based on any factor other than “actuarial risk.” *See generally* 42 U.S.C. § 18063(a)(1)-(2). Nor does HHS cite to anything in support of its sweeping

claim other than the *absence* of the word “only.” Courts do not presume that Congress intends to give totally unbounded discretion to administrative agencies. *California v. FCC*, 905 F.2d 1217, 1230 (9th Cir. 1990) (“an agency’s discretion is not boundless.”). There is no reason to depart from the plain language of the statute, here the best and sole guide to Congressional intent.¹⁰ *Id.*

No doubt recognizing that it is overreaching in the extreme, HHS falls back to the argument that NMHC’s reading of the statute must be wrong because it is impossible to devise a payment formula that perfectly converts relative actuarial risk into the expected incremental costs derived solely from such actuarial risk. But this is not a case about *de minimis* leakage of non-actuarial risk factors. Roughly one in every six dollars of risk adjustment payments that NMHC made in 2015 was due to pricing below market average premiums. *See* Hickey Decl., at ¶ 67, NMHC000876. In 2016 nearly 25% of NMHC’s transfer amount for the small group market can be attributed to the difference in NMHC’s premiums to the market average. HHS’s formula misses the mark by a dangerously wide margin.¹¹

¹⁰ The one case cited by HHS to support its statutory interpretation argument, *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36 (D.D.C. 2012), is off point. *See* HHS Br. at 19. There, a rural critical access hospital argued that HHS lacked authority to reduce its Medicare reimbursement rates because a particular statute only authorized the reduction in rates to a different grouping of hospitals. The court rejected the argument that the statute’s silence as to rural critical access hospital rates should be given dispositive weight. 891 F. Supp. 2d at 45. But NMHC’s argument is not from statutory silence. Rather NMHC relies on the sole indicia of Congressional intent here – the plain text of the ACA – which speaks only of “actuarial risk” and nothing else. NMHC seeks to give import to Congress’s words; it is HHS that grasps for straws from the ACA’s silence on the exact configuration of the payment formula.

¹¹ HHS argues that its use of the statewide average premium must be upheld because use of an issuer’s own premium would be no better. *See* HHS Br. at 20-23. This misstates the role of judicial review. This Court assesses whether HHS’s regulations comport with the requirements of the APA; if not, the agency on remand must consider alternative formulations. *Steinhorst Assocs. v. Preston*, 572 F. Supp. 2d 112, 125 (D.D.C. 2008). This Court does not weigh one option against the other as a super-agency rewriting the regulations itself. *Citizens for Balanced Env’t & Transp. v. Volpe*, 650 F.2d 455, 462 (2d Cir. 1981). Use of an issuer’s own premium is one alternative to the statewide average, which NMHC favors and which HHS itself seriously considered; other commenters have also suggested using medical claims costs instead of any measure of premium at all. *See* Land of Lincoln 2017 Comment, at 5, Rec. at 009007 (suggesting that HHS use a plan’s own premium *or* average claim costs instead of the statewide average premium); Alliance Community Health Plan Comment re: NBPP for 2018, at 3, NMHC001845; Anthem Comment re: NBPP for 2018, at 18, NMHC001490 (suggesting HHS use actual market average claims, plus an allowance for claims-related expenses). There may be others, and the agency is free to consider any of them on remand.

2. Use Of The Statewide Average Premium Is Arbitrary And Capricious

In the alternative, to the extent that the statutory text is not the end of the matter, HHS's use of the statewide average premium is arbitrary and capricious. In reviewing HHS's conduct under the arbitrary and capricious standard, the Court must conduct a "sufficiently probing review to ensure that the agency has not relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *San Luis & Delta-Mentodota Water Auth. v. Locke*, 776 F.3d 971, 994 (9th Cir. 2014) (citation omitted). The Supreme Court has cautioned that "[e]xpert discretion is the lifeblood of the administrative process, but unless we make the requirements for administration action strict and demanding, expertise, the strength of modern government, can become a monster which rules with no practical limits on its discretion...Congress did not purport to transfer its legislative power to the unbounded discretion of the regulatory body."¹² *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167 (1962) (quotations and citations omitted).

¹² HHS suggests that, because risk adjustment is technically complex, this Court should rubber stamp its decisions. See e.g., HHS Br. at 2-3, 16-17, 33. But the requirement that an agency decision "must not be arbitrary and capricious ... exists even in technical areas." *Puerto Rico Sun Oil Co. v. United States EPA*, 8 F.3d 73, 77 (1st Cir. 1993). A court "may not automatically defer to an agency's conclusions, even when those conclusions are scientific." *Locke*, 776 F.3d at 994 (internal citation omitted). "Rather, [a court's] review must be sufficiently probing" in order to determine the validity of the agency's decision. See *id.*; see also *NRDC Inc. v. Pritzker*, 828 F.3d 1125, 1139 (9th Cir. 2016) (agency's scientific decision was arbitrary and capricious); *Natural Resources Defense Council, Inc., v. EPA*, 824 F.2d 1258, 1282 (1st Cir. 1987) (invalidating scientific decision where the agency "has presented no reasoned explanation"); *N. Plains Res. Council, Inc. v. Surface Transp. Bd.*, 668 F.3d 1067, 1075, 1079 (9th Cir. 2011) (agency's scientific decision was arbitrary and capricious); *Puerto Rico Sun Oil Co.*, 8 F.3d at 78 (agency's scientific decision was arbitrary and capricious); *United States Sugar Corp. v. EPA*, 830 F.3d 579, 629 (D.C. Cir. 2016) (agency's scientific action was arbitrary and capricious). "A different approach would not simply render judicial review generally meaningless, but would be contrary to the demand that courts ensure that agency decisions are founded on a reasoned evaluation of the relevant factors." *Locke*, 776 F.3d 971, 994-95 (quotation and citation omitted).

As discussed above, the one factor that Congress directed HHS to consider in devising a risk adjustment program was relative “actuarial risk.” Yet HHS’s use of the statewide average premium sweeps in the many factors unrelated to actuarial risk that impact premiums, such as how effectively a plan negotiates prices with hospitals and physicians, how well it manages its members’ medical care, and how ably it controls administrative expenses.

The use of the statewide average premium also undermines the ACA’s policy of promoting competition and innovation to reduce premiums. HHS concedes that Congress intended to promote competition and innovation. *See* HHS Br. at 25 (“the ACA as a whole seeks to promote competition, efficiency, and innovation...”). Outside of this litigation, HHS’s statements have rung the alarm loudly about how lack of competition can destroy the reforms of the ACA by preventing access to affordably priced insurance products:

A stabilized individual and small group insurance market will depend on greater choice to draw consumers to the market and vibrant competition to ensure consumers have access to competitively priced, affordable, and quality coverage. Higher rates, particularly for consumers who are not receiving advance payments of the premium tax credit (APTC) or claiming the premium tax credit, resulting from minimal choice and competition, can cause healthier individuals to drop out of the market, further damaging the risk pool and risking additional issuer attrition from the market.

Ex. J, HHS, Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18,346, 18,346 (Apr. 18, 2017).¹³ As detailed on pages 17-21 of NMHC’s opening

Memorandum, however, using the statewide average premium artificially penalizes carriers that

¹³ HHS has objected to NMHC’s citation to government statements outside of the rulemaking records and to media articles. *See* HHS Br. at 18, n. 3. But this Court can and should properly take judicial notice of these public materials. *See e.g., Banner Health v. Burwell*, 126 F. Supp. 3d 28, 61 (D.D.C. 2015) (taking judicial notice of public statements by CMS, an HHS report, and two amicus briefs); *Pharm. Research & Mfrs. of Am. v. HHS*, 43 F. Supp. 3d 28, 33 (D.D.C. 2004) (taking judicial notice of FAQs page on FDA website); *N.M. ex rel. Richardson v. BLM*, 565 F.3d 683, 307 n. 22 (10th Cir. 2009) (taking judicial notice of websites of federal agencies); *Am. Bankers Ass’n v. NCUA*, 347 F. Supp. 2d 1061, 1068 (D. Utah 2004) (taking judicial notice of a news article).

have lowered premiums beneath that average by innovating to secure lower prices from hospitals and doctors, better management of enrollees' health care, and low administrative overhead.

In fact, use of the statewide average premium prevents consumers from benefitting from new low-cost competition. To the extent that a new entrant uses innovative strategies and operating efficiencies to drive down premiums below the statewide average, it will see its risk adjustment charges artificially inflated by the difference between its low premiums and the higher statewide average. *See* NMHC Br. at 18-20. HHS rules that effectively penalize price-cutting will either drive out the new entrant or force it to raise premiums.

These are not theoretical concerns. In the ACA, Congress established and appropriated billions of dollars for the Consumer Oriented and Operated Plans ("CO-OP") program, in which HHS extended loans to new insurance start-ups to inject low-priced competition into stagnant insurance markets around the country. *See* NMHC Br. at 10 (describing program). However, roughly three-quarters of CO-OP's have failed since the launch of the exchanges in 2014. An investigation by the House Energy and Commerce Committee squarely blamed excessive risk adjustment assessments for destroying many CO-OPs.¹⁴ *See* Maj. Staff of H. Comm. on Energy & Com., 114th Cong., *Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program* (Sept. 13, 2016), NMHC 2018 Comment, Ex. C-1, at 19-22, NMHC000910-913.

The various justifications tossed up by HHS for its competition-thwarting formula are legally wrong, lack evidentiary basis, or are simply implausible:

¹⁴ HHS suggests that the risk corridors program should mitigate any excessive risk adjustment assessments. *See* HHS Br. at 6. It would be charitable to call this point disingenuous, as HHS woefully underpaid its risk corridors obligations, leading to massive litigation in the Court of Federal Claims. *See e.g., Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (Fed. Cl. 2017). NMHC, like two dozen others (including a class action), has filed a lawsuit in Claims Court for the risk corridors funds it is due. *See New Mexico Health Connections v. United States*, Docket No. 1:16-cv-01199 (Fed. Cl. Sept. 26, 2016).

Premiums are not a proxy for actuarial risk: HHS’s first justification is that premiums are a proxy for actuarial risk because insurance plans price to cost. *See* HHS Br. at 20-21. However, HHS nowhere addresses the evidence that NMHC cited showing that premiums are not proxies for actuarial risk, because there are many other types of costs that impact premium-setting. *See* NMHC Br. at 16-21. Nor does HHS explain its own admissions, outside this litigation, that premiums sweep in many non-risk related costs. *See id.* at 29.

Instead, HHS cites three sets of materials. First, HHS cites to a memorandum by its contractor RTI, which notes in passing that actuarial risk has an impact on premiums. *See* Ex. A to HHS Br., at 2, Rec. at 000810. While true, this does not address NMHC’s argument that there are many other costs driving premium-setting too, such as operating efficiency or the ability to manage members’ medical care. The very previous paragraph in RTI’s Memorandum makes NMHC’s point:

The purpose of these transfer payments is to reduce as much as possible differences in plan premiums that result from favorable or unfavorable selection (differences in health status). Risk adjustment is *not* intended to reduce or account for premium differences between plans due to differences in services covered, ***differences in internal plan expenditures or cost, plan profit, or other plan features associated with differences in plan cost . . .***

Id. (emphasis added).

Second, HHS cites to page 40 of its 2011 White Paper, *see* HHS Br. at 20, but that merely describes an actuarial table and model that the agency ran.

Third, HHS cites certain of its statements made in the course of the 2014 rulemaking process. *See id.* at 20-21. HHS cites its statements that “claims and administrative costs include elements of risk selection” and that “plans ‘price to cost.’” *Id.* But once again this ignores the problem of the many other, non-risk selection costs that feed into a premium.

Finally, HHS points to its statement that “use of a plan’s own premium may cause unintended

distortions.” *Id.* at 21. But the underlying cited Federal Register page, Rec. at 000249, provides no explanation of what these “distortions” are. Nor did HHS provide any evidence that these “distortions” exist. This Court owes no deference to the agency’s naked say-so.¹⁵ *McDonnell Douglas Corp. v. U.S. Dep’t of the Air Force*, 375 F.3d 1182, 1187 (D.C. Cir. 2004)

There is no Congressional intent to use risk adjustment to prevent plans from dodging sicker enrollees: HHS’s second justification is that use of the statewide average premium “reduce[s] incentives for plans to avoid high risk enrollees.” HHS Br. at 21. Although HHS argues this was Congress’s goal in enacting risk adjustment, it cites no statutory text or legislative history in support of that contention. *See id.* at 6-7. The ACA already has separate statutory provisions forbidding carriers from denying coverage or raising premiums for sicker enrollees. 42 U.S.C. § 300gg-3. There is nothing in the text of the ACA that suggests that Congress intended risk adjustment to somehow be the enforcement mechanism for these provisions. While risk adjustment is clearly intended to neutralize the impact of actuarial risk in marketplace competition, there is no reason to believe – as HHS insists – that risk adjustment was further intended as a mechanism to guarantee access to coverage for sicker enrollees, such that the program should over-compensate plans with sicker enrollees.

Nonetheless, HHS asserts that risk adjustment must be used to protect sicker enrollees because otherwise carriers will use underhanded means to dodge them. *See* HHS Br. at 6-7. HHS cites no evidence of this actually happening, but rather hypothesizes that “a plan might offer lower premiums by excluding from its provider networks specialty hospitals and doctors that treat high cost conditions.” *Id.* at 7. But Congress already addressed this issue by

¹⁵ While HHS’s lawyers in this case introduce this cite with their own spin, this Court only reviews what the agency said in the Federal Register during the rulemaking process. The agency’s *post hoc* convenient litigating position receives no deference. *Amerijet Int’l, Inc. v. Pistole*, 753 F.3d 1343, 1351 (D.C. Cir. 2014).

giving HHS the authority to set and police provider network adequacy standards for carriers selling plans on the exchange. 42 U.S.C. § 18001; Network Adequacy Standards, 45 C.F.R. § 156.230. This is not an issue for the risk adjustment program.

HHS further claims that carriers will manipulate their marketing practices. *See* HHS Br. at 7. But state insurance regulators already comprehensively regulate insurance marketing practices. *See e.g.* N.M. Stat. § 59A-23B (2006). Congress expressly provided that the ACA would not preempt, but would work in tandem with, such state regulatory schemes. 42 U.S.C. § 18041(d).

There is no basis for the program’s alleged budget neutrality: Third, HHS asserts that it is appropriate to use the statewide average premium “because the risk adjustment program is self-funded and budget-neutral, payments and charges must balance.” *See* HHS Br. at 22. But HHS does not explain why this is so. Nor does HHS respond at all to the multiple arguments made by NMHC on pages 22-24 of its Memorandum regarding the program’s lack of budget neutrality. The only argument HHS makes – in a footnote – is that, if a state operated risk adjustment, then HHS did not think it had authority to obligate the state budget. *See id.* at 22, n. 4. But HHS itself has operated the New Mexico risk adjustment program each year.¹⁶

The statewide average premium is not predictable: Finally, HHS contends that NMHC can easily plan for any risk adjustment assessments: “Armed with knowledge of how the formula operates, NMHC can use an average level of efficiency when pricing expected risk adjustment charges and a higher level of efficiency when pricing the costs of its own healthier

¹⁶ NMHC further pointed out that, even if risk adjustment were required to be budget neutral, that would not require a formula that guarantees perfect mathematical balance of payments in and out each year, as HHS implicitly asserts by claiming that the statewide average premium is needed to assure budget neutrality in the formula. In the related reinsurance and risk corridors programs, HHS makes pro rata adjustments if payments in are insufficient to fund payments out; it could simply do the same with risk adjustment as well. *See generally* NMHC Br. at 24-25.

membership.” HHS Br. at 25. To begin with, HHS admits in this sentence that the risk adjustment scheme forces more efficient plans like NMHC to artificially increase their premiums, at least in part.

But more fundamentally, risk adjustment is not predictable at all. For a small carrier like NMHC, the statewide average premium is not predictable because its premiums (as opposed to competitors with large market shares) are too small to meaningfully impact the statewide weighted average. Notably, NMHC must file its premiums with state regulators before a relevant benefit year, but only learns of its risk adjustment liability several months after that benefit year has ended. *See* NMHC Br. at 25-26. Moreover, as NMHC and its competitors file premiums with state regulators at the same time, NMHC cannot have advance knowledge of its competitors’ rates to use in setting its own.

HHS cites no evidence whatsoever that risk adjustment results have been readily predictable. And with good reason: as NMHC showed, citing industry studies that HHS ignores, carriers failed miserably at estimating their risk adjustment liabilities or payments. *See id.* at 26. HHS once more hides from the actual facts in the real world.¹⁷

C. HHS Fails To Account For The Actual Health Care Costs Of Healthier Enrollees

As NMHC showed in its opening Memorandum, HHS’s risk adjustment formula underestimates the medical costs of insureds without a chronic disease (HCC) classification by 10%-35%, resulting in the absurd situation that, net of risk adjustment, carriers lose money on

¹⁷ Nor is HHS’s belated decision to reduce the statewide average premium by 14% starting in 2018 a solution to the problems identified by NMHC. This is still a weighted average of all premiums, just now with a downward adjustment, and thus continues to penalize operating efficiency and innovations that allow a carrier to have lower costs than the market average. HHS implicitly agrees, because its arguments in defense of the 2018 methodology are identical to its arguments in defense of the pre-2018 methodology. HHS Br. at 38 (defending 2018 methodology because “*as discussed above*, there is nothing arbitrary and capricious about using a mean to approximate overall health costs in a state” (emphasis added); and repeating flawed arguments about budget neutrality and predictability).

every enrollee who is not chronically ill. *See* NMHC Br. at 33-34. This is despite the fact that this past April HHS stated that “[w]e are acutely aware of the importance of attracting healthy consumers to the individual market, and Exchanges in particular, in order to stabilize and improve the risk pool.” *See* Ex. J, 82 Fed. Reg. at 18,357. HHS recently requested comments as to how to “increase the number of younger and healthier consumers purchasing plans...” Ex. H, 82 Fed. Reg. at 26,887. Even in this case, HHS concedes a “sicker-than-expected risk pool” has resulted in skyrocketing premiums and insurance carrier insolvencies. HHS Br. at 26, n. 8.

While HHS waxes poetic on what it hoped its formula would be able to do when it was drawn up in 2012, *see id.* at 26-28, it nowhere addresses the evidence that the formula just flat out does not work in predicting costs of medical care. Outside of this litigation, HHS has reluctantly admitted to this estimation bias flaw. *See* HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61,455, 61,472 (proposed Sept. 6, 2016), Rec. at 009530.

Although careful not to acknowledge the problem, HHS nonetheless claims it appropriately responded to attempts to address it. First, HHS notes that it will add preventive services to the cost estimation model beginning in 2017. *See* HHS Br. at 40. But both commenters and HHS agreed that this is a minor tweak which will not make a material dent in the estimation bias flaw. *See* Anthem 2017 Comment, at 8-9, NMHC001528-29; HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203, 12,218 (Mar. 8, 2016), Rec. at 007762. Once again, HHS simply ignores the evidence.

Second, HHS concedes that, in the 2018 rulemaking, NMHC submitted a proposal to fix the estimation bias authored by the agency’s own former Chief Actuary, Richard Foster. *See* NMHC Br. at 36; HHS Br. at 39. As NMHC pointed out, HHS failed to respond to this

proposal. *See generally* NMHC Br. at 36. HHS nonetheless tries to claim it did respond to Mr. Foster's proposal by citing the following language from the Federal Register:

Finally, we evaluated an approach in which we would directly adjust plan liability risk scores outside of the model for these subpopulations. For example, we could make an adjustment to the plan liability risk scores calculated through the HHS risk adjustment models that would adjust for such an underprediction or overprediction in actuarial risk by directly increasing low plan liability risk scores and directly reducing high plan liability risk scores in order to better match the relative risks of these subpopulations. We noted that while we believe modifications of this type could improve the model's performance along this specific dimension, there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well. . .

Response: We believe that some of the modeling approaches we considered could improve the model's predictive ability for certain subgroups of enrollees. However, we are still evaluating the tradeoffs that would need to be made in model predictive power among subgroups of enrollees. We continue to focus on encouraging plans to attract high-risk enrollees through the risk adjustment model, but agree with commenters that we should further evaluate solutions prior to making any adjustments to the model. We will continue to explore these modeling approaches . . .

See HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94,058, 94,083 (Dec. 22, 2016), Rec. at 009620, cited in HHS Br. at 40.

There is no reference to Mr. Foster's proposal here whatsoever, much less any explanation for the supposed conclusion that Mr. Foster's unreferenced model "could unintentionally worsen model performance along other dimensions on which the model currently performs well..."¹⁸ But where an agency receives "significant" or "critical commentary," it must

¹⁸ In a fit of desperation, HHS also contends that Mr. Foster's proposal could only apply to 2015 and 2016. HHS Br. at 39. This point is nowhere in the administrative record. It is a *post hoc* rationalization from HHS's litigation counsel, entitled to no deference whatsoever. *Amerijet Int'l, Inc.*, 753 F.3d at 1351. Nor is there any merit to this contention. NMHC's 2018 Comment proposed applying Foster's proposal to all years from 2014 through 2018. *See* NMHC 2018 Comment, at 10, NMHC000844. There is nothing about Foster's methodology that was limited to 2015 and 2016.

“respond in a reasoned manner” to that comment. *See e.g., FMBE Bank Ltd. v. Lew*, 209 F. Supp. 3d 299, 333 (D.D.C. 2016); *N.C. Growers Ass’n v. UFW*, 702 F.3d 755, 769 (4th Cir. 2012); *Dow Agrosciences LLC*, 707 F.3d at 471.

D. HHS Violates Congressional Intent To Have A Robust Market In Bronze Plans

HHS’s own data from its Spring 2016 white paper show that bronze plans are *always* net payors into risk adjustment. *See* NMHC Br. at 42-43. As a result, the risk adjustment formula renders it extremely difficult for bronze plans to be profitable, *see id.*, even though Congress expressly intended for there to be bronze plans available in the ACA exchange marketplaces. *See* 42 U.S.C. § 18022(d)(1)(A). This dynamic will either lead to carriers dropping bronze plans or hiking their premiums substantially, which defeats Congress’s goal of having low-cost products available that are attractive to healthier individuals. As HHS has acted directly contrary to the clear Congressional intent that there be a robust market in bronze plans, its actions are arbitrary and capricious. *See Ctr. for Biological Diversity v. Nat’l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1194 (9th Cir. 2008) (“We ‘must reject administrative constructions which are contrary to clear congressional intent.’” (citation omitted)). Moreover, HHS did not even bother to respond to NMHC’s comments on this point in the 2018 rulemaking, which independently is a basis to find that the agency’s conduct was arbitrary and capricious. *See Zen Magnets*, 841 F.3d at 1149; *Sierra Club v. Van Antwerp*, 661 F.3d 1147, 1157 (D.C. Cir. 2012).

HHS does not dispute any of this evidence, nor does it point to any on the record response to NMHC’s comment. Instead, the agency argues that since there are still some bronze plans left in the marketplace, “at least some issuers must find them profitable.” HHS Br. at 40. But outside this case, HHS has recently admitted that “the health and competitiveness of the Exchanges, as well as the individual and small group markets in general, have recently been

threatened by issuer exit and increasing rates in many geographic areas.” Ex. J, 82 Fed. Reg. at 18,369. HHS itself admits that the “sicker-than-expected risk pool” is heavily to blame, *see* HHS Br. at 26, n. 8, and that “Bronze plans tend to attract healthier enrollees,” *see id.* at 4 – the very enrollees HHS admits are needed for a balanced, stable marketplace. It is unclear why HHS believes this Court cannot act until the entire flimsy edifice completely crashes down.

HHS’s second argument is that there is no need for judicial relief because the agency is thinking about the problem. *Id.* at 41. But HHS entirely ignored the comments in the 2018 rulemaking regarding discrimination against bronze plans; it is manifestly *not* developing a solution. Judicial intervention is needed.¹⁹

E. HHS Wrongfully Excluded Prescription Drug Data Before The 2018 Rule

Prior to 2018, the risk adjustment methodology failed to accurately capture HCC status because of HHS’s refusal to utilize prescription drug data. *See* NMHC Br. at 37-39. This is despite the fact that HHS has acknowledged that such data would improve the accuracy of its estimation of relative actuarial risk. *See e.g., CMS, March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016), at 40-41, NMHC000292-293; HHS-Operated Risk Adjustment Methodology Meeting Transcript (Mar. 31, 2016), at Supp000074 (“I think we all agree that prescription drugs as a different source for folks that are having trouble getting diagnosis data might be good.”). Why, then, does the pre-2018 model not include prescription drug data? HHS offers a series of flimsy excuses that do not withstand even minimal scrutiny.

First, HHS complains that incorporating drug data was too “difficult”. HHS Br. at 32. But burden and complexity are not sufficient justifications to ignore a proposed solution to a

¹⁹ HHS also suggests the addition of the cost of preventive care services to the formula will make bronze plans viable. *See id.* at 41, n. 16. It will not. *See* NMHC Br. at 35.

problematic methodology. *See Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 660 (9th Cir. 2011) (HHS cannot substitute Congressional intent for “an alternative that it considers more convenient and less burdensome”). HHS itself ultimately agreed, in Fall 2016, when the apparent difficulties seem to have disappeared, and HHS announced the incorporation of drug data into the model starting in 2018. *See* 81 Fed. Reg. at 94,071, Rec. at 009608.

Second, HHS (without citing any evidence) claims that the inclusion of prescription drug data might inappropriately incentivize physicians to steer patients towards drugs, instead of other therapies. To be clear, HHS has dreamt up a scenario in which a *physician* would alter her treatment decisions and prescribe unnecessary medications, potentially committing medical malpractice and serious ethical violations, in order to benefit an *insurer* because the prescription might correlate to an HCC that might lead to a higher risk score. This is pure fantasy and cannot be taken seriously given the absence of any supporting real world evidence. *See Tripoli Rocketry Ass’n v. Bureau of Alcohol, Tobacco, Firearms, & Explosives*, 437 F.3d 75, 83 (D.C. Cir. 2006) (“[W]here its action is founded on unsupported assertions or unstated inferences we will not abdicate the judicial duty [to] carefully [] review the record to ascertain that the agency has made a reasoned decision based on reasonable extrapolations from some reliable evidence”) (quotations and citations omitted); *see also McDonnell Douglas Corp.*, 375 F.3d at 1187 (Courts do “not defer to the agency’s conclusory or unsupported suppositions.”).

HHS’s next excuse is that “drug usage can be a biased indicator of health status because populations with better adherence to drug therapies [such as higher income and better educated populations] will appear sicker and therefore, insurers would have weaker incentives to enroll patients with lower income or lower education.” HHS Br. at 32 (internal quotations and

citation omitted). This argument does not fare any better than the argument that physicians will commit malpractice to enrich insurance companies.

It is undisputed that adding prescription drug data will more accurately capture risk for those who receive prescription drug treatment. Failing to accurately reflect the health status of those who do adhere to their drug regimens is no fix for failing to capture reliable data on those who do not. Rather, efforts should be made to increase compliance with prescription drug treatment regimens so that the potential bias HHS identifies is mitigated.

Moreover, the current diagnosis code model *already* creates a bias against lower income enrollees because risk scores are biased downward in poorer rural areas where the intensity of care is lower. *See* Health New England 2017 Comment, at 2-5, Rec. at 008484-86. In these areas there are fewer physician visits per capita, which results in a lower coding intensity and an ultimate understatement of enrollee risk. *Id.*²⁰

F. HHS's Formula Fails To Account For Partial Year Enrollees

The problem with partial year enrollment is purely one of timing – if the enrollee does not receive a diagnosis from a doctor *during his/her enrollment in the plan*, the issuer will have no knowledge of it and the enrollee's risk score will be understated. *See* Hickey Decl., at ¶ 95, NMHC000885. HHS dismisses this concern because “an enrollee who never visits a doctor to receive an HCC-qualifying diagnosis also is not likely to be consuming substantial treatment

²⁰ HHS also argues that excluding prescription drug data is “presumptively valid” because Congress directed the agency to use Medicare’s risk adjustment programs as a model, which do not use this data to identify diagnoses. HHS Br. at 31. But HHS itself has recognized that it cannot simply copy the Medicare programs because the populations are too different; thus, HHS used datasets for commercially insured individuals, and not Medicare enrollees, to develop its formula. *See e.g.*, HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,127 (proposed Dec. 7, 2012), Rec. at 000122 (HHS risk adjustment model was calibrated using commercial data); *see also id.* at 73,128-29, Rec. at 000123-24 (“The [Medicare] CMS HCCs were developed using data from the aged and/or disabled Medicare population... [and] for some conditions (such as pregnancy) the sample size in the Medicare population is quite low. With larger sample sizes in the commercial population, HCCs [for HHS risk adjustment] were re-examined for infant, child, and adult subpopulations... As such, HCCs and [diagnosis groups] may not be the same between the Medicare and HHS risk adjustment models.”).

costs.” HHS Br. at 30. But a short-term enrollee (who may only be insured by NMHC for one or two months) with a chronic condition may only visit the doctor during the portion of the year during which he was not yet covered by the plan in question. *See Hickey Decl.*, at ¶ 93-95, NMHC000884-885. Once again, the proof is in the data. In the agency’s own words:

[E]nrollees that didn’t have a full year’s enrollment, so those that were in the one month to 11 month group enrollment, enrollment duration groups, these enrollees, their predicted expenditures with the 2014 adult silver model under predicted expenditures, so compared to their actual, what their actual expenditures were, their predicted expenditures were lower. The lower enrollment groups particularly, particularly for the one to seven months of enrollment were under predicted by the 2014 model. On the other hand, enrollees that had a full year of enrollment, a 12-month enrollment, were slightly over predicted by the 2014 silver model.

HHS-Operated Risk Adjustment Methodology Meeting Transcript (Mar. 31, 2016), at Supp000019. HHS ultimately faults NMHC for not identifying a solution to this problem, but HHS itself identified a solution starting in 2017, by adding enrollment duration factors. *See HHS NBPP for 2018*, 81 Fed. Reg. at 61,468, Rec. at 009526. It needs to apply the fix to all benefit years 2014 forward.

G. HHS’s Jurisdictional Defenses Have No Merit

No doubt recognizing that it cannot defend this case on the merits, HHS contends that NMHC seeks only money damages for past risk adjustment calculations and thus this action belongs in the Court of Federal Claims. This argument is meritless. The Prayer for Relief in NMHC’s Amended Complaint requests only declaratory and injunctive relief. *See NMHC Am. Compl.* (Dkt. No. 21). The Amended Complaint asserts only one count under the APA, which only permits declaratory and injunctive relief. *See 5 U.S.C. §§ 702, 706*. As the 2017 and 2018 risk adjustment rules will not be applied until 2018 and 2019, that part of the action can only be

seeking prospective relief. *See Bowen v. Massachusetts*, 487 U.S. 879, 905 (1988) (“The Claims Court does not have the general equitable powers of a district court to grant prospective relief.”).

Nevertheless, HHS claims that this is really a secret damages case. First, HHS claims it has solved all of NMHC’s challenges in the 2017 and 2018 rulemakings, so that this case is supposedly only about the 2014-2016 rules that have already been applied. *See* HHS Br. at 41-42. But this is just not true: HHS still uses the statewide average premium in the 2017 and 2018 formulae, and still has not addressed the estimation bias and bronze plan discrimination flaws. At most, HHS addressed the partial year enrollee issue in the 2017-2018 rules and the prescription drug data issue in the 2018 rule.

Second, the relief sought for 2014-2016 is also equitable. NMHC is not asking that this court “recalculate and refund charges for prior years.” *See id.* at 42. Rather, as laid out in its Prayer for Relief, NMHC is asking this Court to invalidate regulations for past years so that HHS can then fix the regulatory scheme. If this Court grants the requested relief, HHS will then be directed to conduct a new rulemaking process for those years. *AEP Tex. N. Co. v. Surface Transp. Bd.*, 609 F.3d 432, 444 (D.C. Cir. 2010) (vacating rule and remanding to agency “to reassess its decisionmaking for the 2005 cost of equity estimate.”); *Comm. for Fairness v. Kemp*, 791 F. Supp. 888, 898 (D.D.C. 1992) (vacating regulations and remanding for further rulemaking). If it is determined under that new scheme that HHS owes money back to NMHC (which can only be known after HHS engages in a new rulemaking process after remand), HHS can issue that refund or NMHC can sue in the court of Federal Claims.²¹

²¹ For this reason, HHS’s hand-wringing over the supposed inequity of undoing past risk adjustment transfers is premature, to say the least. That is an issue that the agency can address in its new rulemaking on remand. And, of course, if this Court concurs with NMHC that the program is not budget neutral, HHS does not need to undo any past transfers because it can fund additional liabilities (should there be any) through its general appropriations. *See* NMHC Br. at 24. In addition, HHS already provides in its regulations for rejigging past transfers when necessary. For example, if HHS makes a calculation error under the risk adjustment program, an issuer can file an administrative appeal. *See* 45 C.F.R. §156.1220. The filing of such an appeal does not stay the

There is nothing unusual about NMHC’s challenge here, and the case law is clear that claims in District Court to invalidate regulations under the APA for past years are permissible even if the ultimate effect is that the agency may take action down the road that will result in the payment of money. *See e.g. Lion Health Servs. Inc. v. Sebelius*, 635 F.3d 693 (5th Cir. 2011) (invalidating agency regulation for all years – prior, past, and future – and ordering a recalculation of refunds owed to plaintiffs); *Comm. for Fairness*, 791 F. Supp. 888 (ordering recalculation of funds under a regulation for prior years); *AEP Tex. N. Co.*, 609 F.3d 432 (evaluating whether the agency needed to retroactively recalculate the applicable rates for 1998-2005, but only ordering recalculation for 2005 for being arbitrary and capricious).²²

III. Conclusion

For the reasons set forth herein and in NMHC’s opening Memorandum, NMHC’s motion for summary judgment should be granted, HHS’s cross-motion should be denied and the court should vacate HHS’s risk adjustment regulations for all challenged years, “the typical remedy” under the APA. *See St. Lawrence Seaway Pilots Ass’n v. U.S. Coast Guard*, 85 F. Supp. 3d 197, 208 (D.D.C. 2015). Alternatively this Court has discretion to remand the matter back to HHS without a vacatur. *See Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm’n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993).

transfers of funds. *See id.* Thus, if an issuer prevails on an appeal that its risk adjustment liability was miscalculated, HHS can only grant relief by “unscrambling the egg” and making some retroactive adjustments.

²² The cases cited by HHS do not hold otherwise. In those cases, the courts ruled that they did not have jurisdiction over the plaintiff’s claims because the plaintiff sought a discrete award of money and therefore there was no equitable relief to be granted. *Batsche v. Burwell*, 210 F. Supp. 3d 1130, 1134-35 (D. Minn. 2016) (“Once the Fund collects \$762,663.90 from the Department, there will be no injury left to remedy”); *Gerhart v. Dep’t of Health & Human Servs.*, No. 4:16-CV-00151, 2017 WL 1019816 (S.D. Iowa Mar. 16, 2017) (holding that the court did not have jurisdiction because the claim only targeted “a specific year of risk adjustment payments”, in contrast to a case where there was “a challenge to the entire scheme of risk adjustment . . . payments.”). There is no request in the Amended Complaint for a specific sum of money, nor could there be as NMHC is seeking to have the formula remade, not applied in some way that would trigger a check.

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CERTIFICATE OF SERVICE

I hereby certify that on July 13, 2017, I electronically filed the foregoing Plaintiff's Reply and Opposition to Defendants' Cross-Motion for Summary Judgment using the Court's CM/ECF system, causing a notice of filing to be served upon all counsel of record.

/s/ Nancy R. Long _____
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