No. 18-2583

IN THE UNITED STATES COURT OF APPEALS
FOR THE SECOND CIRCUIT

UNITEDHEALTHCARE OF NEW YORK, INC. and OXFORD HEALTH INSURANCE, INC.,

Plaintiffs-Appellants,

v.

MARIA T. VULLO, in her official capacity as Superintendent of Financial Services of the State of New York,

Defendant-Appellee.

On Appeal from the United States District Court
for the Southern District of New York

BRIEF FOR THE UNITED STATES AS AMICUS CURIAE

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INTRODUCTION

The United States respectfully submits this amicus brief in response to the Court's request for the government's views.

STATEMENT

A. Statutory and Regulatory Background

1. The ACA's Insurance-Market Reforms

The Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), as amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029, was designed to expand coverage in the individual health-insurance markets. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). To that end, the ACA authorized billions of dollars of subsidies every year to help individuals pay for insurance. *Id.* at 2489. The Act barred insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.* It provided for the creation of Exchanges, which are virtual marketplaces in each State where individuals and small groups can purchase health coverage. 42 U.S.C. §§ 18031-18041. And the Act required that all plans offered through an Exchange provide essential health benefits and comply with other requirements. *Id.* § 18021.

The ACA established three premium-stabilization programs in order to distribute risks among insurers. Informally known as the "3Rs," these ACA programs consist of reinsurance, risk corridors, and risk adjustment. *See* 42 U.S.C. §§ 18061-18063. The reinsurance program was a temporary program for the 2014, 2015, and

2016 calendar years, under which amounts collected from insurers and self-insured group health plans were used to fund payments to issuers of eligible plans that covered high-cost individuals in the individual market. *See id.* § 18061. The risk-corridors program was a temporary program for the 2014, 2015, and 2016 calendar years, under which amounts collected from profitable insurance plans were used to fund payments to unprofitable plans. *See id.* § 18062. The risk-adjustment program, which is at issue here, is a permanent program under which amounts collected from insurers whose plans have healthier-than-average enrollees are used to fund payments to insurers whose plans have less-healthy-than-average enrollees. *See id.* § 18063.

2. State Flexibility and Preemption Under Section 1321 of the ACA

In section 1321 of the ACA, Congress directed the United States Department of Health and Human Services (HHS) to issue regulations that establish standards for the requirements related to the Exchanges, the offering of qualified health plans through the Exchanges, the reinsurance and risk-adjustment programs, and such other requirements as HHS determined appropriate. *See* 42 U.S.C. § 18041(a) ("Establishment of standards").

Section 1321 gave each State flexibility to decide whether to administer these statutory requirements or defer to HHS to do so. A State that elected to administer the requirements was required to adopt and have in effect either (1) the federal standards established by HHS, or (2) a state law or regulation that HHS determines

implements the federal standards within the State. *See* 42 U.S.C. § 18041(b) ("State action"). For States that did not elect to administer the federal requirements, the statute directed HHS to establish and operate the Exchange within the State and take such actions as are necessary to implement the other statutory requirements. *Id.* § 18041(c) ("Failure to establish Exchange or implement requirements").

Section 1321 also addressed preemption. It states: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d) ("No interference with State regulatory authority").

3. HHS's Risk-Adjustment Regulations

a. Pursuant to Section 1321(a) of the ACA, HHS issued regulations that established standards for the ACA's risk-adjustment program. Those regulations provide that any risk-adjustment methodology used by a State, or HHS acting on behalf of a State, must be a federally certified risk-adjustment methodology. *See* 45 C.F.R. § 153.320(a). To become federally certified, the risk-adjustment methodology must either (1) be developed by HHS and published in rulemaking in advance of the benefit year, or (2) be submitted by a State to HHS, reviewed for compliance with specified regulatory standards and certified by HHS, and published by HHS in the applicable annual rulemaking. *See id.*

In practice, the only State to run its own risk-adjustment program was Massachusetts, which ran its program in the 2014, 2015, and 2016 benefit years and

then ceded responsibility to HHS beginning in the 2017 benefit year. *See Minuteman Health, Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 181 (D. Mass. 2018). Thus, since the 2017 benefit year, HHS has been administering the risk-adjustment program in every State, pursuant to the methodology that HHS develops through annual rulemaking and publishes in advance of the applicable benefit year. *See* 45 C.F.R. § 153.310(a)(2) (providing that States that do not administer risk-adjustment programs "will forgo implementation of all State functions" and that HHS "will carry out all of the provisions [relating to risk adjustment] on behalf of the State").

Developing the HHS risk-adjustment methodology was a complex task. Although HHS has refined its methodology over time, the basic features have remained the same since HHS first published its methodology in 2013, after two years of consideration that included input from state insurance commissioners and other stakeholders. *See* 78 Fed. Reg. 15,410, 15,417-34 (Mar. 11, 2013). In broad terms, the HHS methodology involves three steps. First, the actuarial risk of each enrollee is calculated through models that use demographic and diagnostic data to determine the relative cost of insuring an enrollee. *See id.* at 15,419. Second, risk scores for each enrollee in a plan are aggregated to determine the plan's average risk score. *See id.* at 15,432. Third, HHS multiplies the plan's average risk score by a statewide average premium, *see id.* at 15,430, and then makes certain additional adjustments, *see id.* at 15,430-34. Using this methodology, HHS is able to convert actuarial risk into charge

or payment dollar amounts for particular plans in the State market risk pool. *See Minuteman*, 291 F. Supp. 3d at 198.

The HHS regulations require that insurers be given advance notice of the methodology to be used for a particular benefit year, so that insurers can rely on that methodology when they set their annual rates and benefits for that year. *See* 45 C.F.R. § 153.320(a). To initiate the annual rulemaking process, HHS generally publishes a proposed risk-adjustment methodology in November or December of the year two years prior to the applicable benefit year. *See Minuteman*, 291 F. Supp. 3d at 182. After a public comment period, the final rule is generally published in February or March of the year prior to the applicable benefit year. *See id.* After the benefit year ends, plans must submit their risk-adjustment data to HHS, typically by April 30 of the following year. *See* 45 C.F.R. § 153.730. Charge and payment amounts are announced two months later, by June 30. *See id.* § 153.310(e). HHS then collects charges and uses those collections to make payments to issuers, typically within thirty to sixty days of collection. *See id.* § 156.1215.

b. Some state regulators and insurers have criticized the HHS methodology for imposing unexpectedly large risk-adjustment charges on new, rapidly growing, and smaller insurers. *See* 81 Fed. Reg. 29,146, 29,152 (May 11, 2016). Until recently, HHS's regulations did not provide an opportunity for a State to request that HHS reduce the risk-adjustment transfer amounts dictated by the HHS methodology.

In April 2018, HHS finalized a new regulation that gives States flexibility to request a reduction of up to fifty percent in the risk-adjustment transfers, beginning with the 2020 benefit year. *See* 83 Fed. Reg. 16,930 (Apr. 17, 2018) (adding 45 C.F.R. § 153.320(d)). Under the terms of the regulation, any such request must be submitted by August 1 of the year that is two calendar years *prior to* the applicable benefit year (*e.g.*, requests were due by August 1, 2018 for the 2020 benefit year). *See* 45 C.F.R. § 153.320(d)(2). The request must include supporting evidence and analysis demonstrating the state-specific factors that warrant an adjustment to more precisely account for the differences in actuarial risk in the state market. *See id.* § 153.320(d)(1). HHS will approve a state request (in whole or in part) if HHS determines—based on the review of the information submitted as part of the State's request, along with other relevant factors, including the premium impact of the transfer reduction for the state market, and relevant public comments—that a reduction in the transfers is justified or that the requested reduction would have *de minimis* impact on the premium increase needed to cover the transfers for issuers that would receive reduced transfer payments. *See id.* § 153.320(d)(4). HHS will publish any approved or denied state reduction requests in the final rule for the applicable benefit year. *See id.* § 153.320(d)(3).

One State—Alabama—submitted a request to reduce the small-group market risk-adjustment transfers for the 2020 year. *See* 84 Fed. Reg. 17,454, 17,484-85 (Apr. 25, 2019). HHS approved the requested reduction of fifty percent, finding that

Alabama's submissions demonstrated that the presence of a dominant carrier in the small group market precludes the HHS-operated risk-adjustment transfer methodology from working as precisely as it would with a more balanced distribution of market share. *Id.* at 17,485. HHS also found that any necessary premium increase set by issuers likely to receive payments, which they would impose as a result of a fifty-percent reduction to risk-adjustment transfers in the Alabama small group market for the 2020 benefit year, would not exceed one percent (the *de minimis* threshold). *Id.*

State requests to reduce the risk-adjustment transfers for the 2021 year were due to HHS on August 1, 2019. We are informed that only Alabama submitted such a request.

B. Factual Background and Prior Proceedings

The central question in this case is whether a State, acting unilaterally, may use its own authority to effectively reduce the federal risk-adjustment transfers required under the HHS methodology. In September 2016, New York's Department of Financial Services issued a regulation that authorized the State's Superintendent of Financial Services to undo a percentage of the federal risk-adjustment transfers for the 2017 benefit year. *See* 11 N.Y.C.R.R. § 361.9. The state regulation directed the Superintendent to "review the impact of the federal risk adjustment program" following release of the federal risk-adjustment results. *Id.* § 361.9(d). If, after that review, the Superintendent deemed it "necessary," she was authorized to require all

insurers that received risk-adjustment payments to "remit to the superintendent an amount equal to a uniform percentage of that payment transfer," not to exceed thirty percent. *Id.* § 361.9(e)(1). Those remitted funds would then be distributed to the insurers that paid risk-adjustment charges under the HHS methodology. *Id.* § 361.9(e)(2). In other words, the regulation authorized the State of New York to reverse a portion of the risk-adjustment payments calculated according to the federal methodology. The Superintendent subsequently promulgated a substantially identical rule for the 2018 benefit year. *See id.* § 361.10. No such rule was promulgated for the 2019 benefit year, nor has New York applied to HHS for a reduction in risk-adjustment transfers for the 2020 benefit year.

Plaintiffs are two major health insurers that received risk-adjustment payments for the 2017 and 2018 benefit years. They sued the New York Superintendent claiming, *inter alia*, that the ACA preempts the state regulation.

The district court dismissed the complaint, concluding that the New York regulation was "complementary . . . to the [federal risk-adjustment program] designed to take into account unintended local consequences in New York." J.A. 160. The Superintendent then announced that New York would implement its regulation for the 2017 benefit year, by requiring recipients of risk-adjustment payments in New York to remit eighteen percent of the funds they received for that year pursuant to the HHS risk-adjustment methodology.

This Court granted plaintiffs' motion for a stay of the New York regulation pending appeal. After briefing and oral argument, the Court requested HHS's views on particular questions. The Court's letter focused on the preamble to the new state-flexibility regulation that was finalized in April 2018. The letter noted that during the notice-and-comment period on that proposed regulation, HHS was asked whether States were allowed to make unilateral adjustments—that is, adjustments without HHS approval—to the HHS risk-adjustment methodology. *See* Court's Letter at 1 (citing 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018)). The letter noted that HHS responded that States were permitted to take "local approaches under State legal authority" to ameliorate the impact of the transition for new participants to the health insurance markets, but that "the flexibility finalized" in the new regulation would require HHS review because that flexibility "involve[d] a reduction to the risk adjustment transfers calculated by HHS." *Id.* (quoting 83 Fed. Reg. at 16,960) (alteration in original). The letter asked HHS to address the following four issues:

(1) Whether, when a State participates in the federal risk-adjustment program, a state program that reverses a percentage of the federal risk-adjustment payments constitutes a "local approach[] under State legal authority." Court's Letter 2 (quoting 83 Fed. Reg. at 16,960) (alteration in original).

(2) Whether the challenged New York regulation constitutes a "reduction to the risk adjustment transfers calculated by HHS." Court's Letter 1 (quoting 83 Fed. Reg. at 16,960);

(3) Whether certain informal communications from HHS officials constituted a determination under 42 U.S.C. § 18041(b)(2) and the HHS risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330), that the challenged New York regulation implements the federal standards in New York; and

(4) Whether HHS is authorized under 42 U.S.C. § 18041(b)(2) and its risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330) to make a retroactive determination that state regulations implement the federal standards, and if so, under what circumstances HHS may make such a retroactive determination.

ARGUMENT

New York's regulations would reverse a percentage of the federal risk-adjustment transfers that were dictated by HHS's risk-adjustment methodology— a methodology that New York opted into. As HHS explained in the preamble to the state-flexibility regulation that HHS finalized in April 2018, such reductions to the risk-adjustment transfers calculated by HHS cannot occur without HHS's approval. Although there is no authority for HHS to grant retroactive approval of such reductions, States may request that HHS reduce transfer amounts for future benefit years by making the showing required under the state-flexibility regulation.

A. The New York Regulations Are Not Permitted by HHS's Preambles (Questions 1 and 2).[1]

The Court's first and second questions ask whether the New York regulation—which directed insurers to remit a portion of the risk-adjustment payments they received from HHS pursuant to HHS's risk-adjustment methodology—was a permissible "local approach[] under State legal authority" that a State could implement unilaterally, or instead a "reduction to the risk adjustment transfers calculated by HHS" that required HHS approval. 83 Fed. Reg. at 16,960.

The New York regulation was a reduction to the risk-adjustment transfers calculated by HHS that could not be implemented through unilateral state action. The preamble to the rule that finalized HHS's state-flexibility regulation specifically addressed New York's regulation. The preamble explained that one commenter "noted that the New York adjustment could be seen as permitting States to make adjustments without HHS approval and requested clarification that States making adjustments to the risk adjustment formula must first obtain approval from HHS under the risk adjustment program prior to implementing any State-specific adjustments." 83 Fed. Reg. at 16,960. In response, HHS clarified:

> States are the primary regulators of their insurance markets, and as such, we encourage States to examine whether any local approaches under State legal authority are warranted to help ease the transition for new participants to the health insurance markets. States that take such actions and make adjustments do not generally need HHS approval as

[1] Parenthetical references in the format "Question #" refer to the questions posed in the Court's February 19, 2019 letter to HHS.

> these States are acting under their own State authority and using State resources. *However, the flexibility finalized in this rule involves a reduction to the risk adjustment transfers calculated by HHS and will require HHS review as outlined above.*

Id. (emphasis added). The emphasized language made clear that a reduction to the risk-adjustment transfers is not the type of "local approach[] under State legal authority" that a State may implement unilaterally, but instead "will require HHS review" pursuant to the state-flexibility regulation. *Id.*; *see also* 81 Fed. Reg. 94,058, 94,159 (Dec. 22, 2016) (noting that "States in which HHS is operating its risk adjustment methodology are *not permitted to modify the methodology*, but . . . may take temporary reasonable measures under State authority to mitigate effects under their own authority") (emphasis added).

It makes no difference that New York did not, in advance, order plans that owed money under the federal risk-adjustment methodology to make lower payments to HHS, but instead directed insurers to remit to New York a percentage of the risk-adjustment payments that they received from HHS. The practical effect is the same: for insurers receiving money pursuant to the HHS risk-adjustment methodology, the New York regulation would reduce the payments that those insurers received. The New York regulation is therefore preempted, because it prevents the application of the ACA's risk-adjustment program as implemented by HHS. *See* 42 U.S.C. § 18041(d) (indicating that the ACA preempts a state law that "prevent[s] the application of the provisions" of Title I); *see also St. Louis Effort for AIDS v. Huff*, 782

F.3d 1016, 1024-27 (8th Cir. 2015) (concluding that the ACA preempted a state law that interfered with the federal duties of Exchange "navigators"); *Coons v. Lew*, 762 F.3d 891, 902 (9th Cir. 2014) (concluding that the ACA preempted a state law that purported to undo the ACA's "individual mandate"); *cf. Hillman v. Maretta*, 569 U.S. 483, 490-99 (2013) (state scheme is preempted when it "displaces the beneficiary selected" by federal law "and places someone else in her stead"); *Gade v. National Solid Wastes Mgmt. Ass'n*, 505 U.S. 88, 97-100 (1992) (plurality op.) (concluding that the Occupational Safety and Health Act—which required States to seek federal approval to promulgate state health and safety standards—impliedly preempted a state law establishing a standard without federal approval, even if that standard merely supplemented federal law); *id.* at 111 (Kennedy, J., concurring on express-preemption grounds).

Although the preamble to HHS's state-flexibility regulation did not describe the types of local approaches that a State may adopt unilaterally, it was limited to approaches in which States were "acting under their own State authority and using State resources." *See* 83 Fed. Reg. at 16,960. New York's regulation does not satisfy that requirement, because it relies heavily on *federal* resources to redistribute *federal* transfers between private parties.

By contrast, we are informed by HHS that permissible local approaches may take the form of modifications to the State's own insurance regulations. For example, if a State's rating requirements are stricter than the federal community-rating

standards, a State could mitigate the impact by relaxing its rating requirements. Likewise, a State could reduce its capitalization requirements for new entrants to insurance markets. By contrast, a State may not modify charge or payment amounts determined under the HHS risk-adjustment methodology—either in advance or on the back end—without obtaining HHS approval under the procedure set out in the state-flexibility regulation.

B. HHS Lacks Authority To Approve New York's Regulations (Questions 3 and 4).

The Court's third question asks whether certain informal communications from HHS employees constituted a determination under 42 U.S.C. § 18041(b)(2) and the HHS risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330) that the challenged New York regulation implements the federal standards in New York. The Court's fourth question asks whether HHS is authorized to make such a determination retroactively and, if so, under what circumstances.

The informal communications noted by this Court included various telephone calls in 2016 and 2017, in which HHS employees at the Center for Consumer Information and Insurance Oversight apparently raised no objection to New York's regulation. In addition, an HHS staff member wrote an email to a New York

employee in October 2017 saying "please let us know if anything would be helpful on our end as you operationalize your regulation." Powell Decl. ¶ 49.[2]

These informal communications did not constitute a determination under 42 U.S.C. § 18041(b)(2) and the HHS risk-adjustment regulations (45 C.F.R. §§ 153.310, 153.320, 153.330) that the challenged New York regulation implements the federal standards in New York. The cited provisions allow a State that wishes to run its own risk-adjustment program to submit an alternative risk-adjustment methodology to HHS for review and approval as a federally certified risk-adjustment methodology. New York did not seek to run its own risk-adjustment program; instead, New York deferred to HHS to run the risk-adjustment program in the State, and HHS thus collected charges from New York insurers and made payments to New York insurers in accordance with HHS's own risk-adjustment methodology.

Moreover, a State that wishes to run its own risk-adjustment program must show that the alternative methodology meets specified substantive requirements, *see* 45 C.F.R. § 153.330, and, if approved by HHS, that alternative methodology must be published in the applicable annual HHS Notice of Benefit and Payment Parameters, *see id.* § 153.320(a)(2). The informal communications noted by this Court would not

[2] The Court's amicus invitation letter included the declaration of John Powell, a New York policymaker. That declaration details New York's view of the correspondence between HHS and New York. Although HHS is unable to verify the details of the telephone conversations discussed in the declaration, it has confirmed that the declaration accurately quotes the email correspondence.

satisfy these requirements, nor is there authority in the regulations for HHS to approve a State's alternative risk-adjustment methodology retroactively. *See* 81 Fed. Reg. at 94,072 (emphasizing the importance of establishing the risk-adjustment methodology ahead of time and describing comments supporting that practice).

CONCLUSION

For the foregoing reasons, the judgment of the district court should be reversed.

Respectfully submitted,

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August 2019

CERTIFICATE OF COMPLIANCE

This brief complies with 30-page limit set by the Court's letter of February 19, 2019, inviting the views of the United States. This brief complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

/s/ Joshua Revesz
Joshua Revesz

CERTIFICATE OF SERVICE

I hereby certify that on August 2, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Second Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

/s/ Joshua Revesz
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