IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MASSACHUSETTS
Boston Division

MINUTEMAN HEALTH INC. 38 Chauncy Street BOSTON, MA 02111 Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES 200 Independence Avenue, SW Washington, DC 20201 CENTERS FOR MEDICARE AND MEDICAID SERVICES 200 Independence Avenue, SW Washington, DC 20201 SYLVIA MATHEWS BURWELL Secretary of the United States Department of Health and Human Services, in her official capacity, 200 Independence Avenue, SW Washington, DC 20201 And ANDREW M. SLAVITT Acting Administrator for the Centers for Medicare and Medicaid Services, in his official capacity, 200 Independence Avenue, SW Washington, DC 20201, Defendants.	Civ. No. 16-cv-11570 (Judge Saylor)

AMENDED COMPLAINT

Pursuant to the Scheduling Order entered by this Court on January 5, 2017, Plaintiff Minuteman Health, Inc. hereby submits its Amended Complaint.

I. Introduction

1. The Department of Health and Human Services ("HHS") has one clear mandate under the Risk Adjustment provision of the Affordable Care Act: develop and implement a Risk Adjustment methodology that mitigates the impact of health insurance plans drawing healthier or sicker members than others, so that the success of a health plan is not based on whether its insureds are healthier or sicker but on the plan's ability to compete through efficiency, cost, and service. *See* Ex. 1, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016), at 1, available at https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf; Ex. 2, CMS, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (Mar. 2012), at 3, available at https://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf.

2. HHS has not followed Congress's clear instructions and intent.

3. HHS, together with the Centers for Medicare and Medicaid Services ("CMS"), has chosen instead to implement a methodology that utilizes factors wholly unrelated to the health or sickness of plan members and utterly fails to consider the most important aspects of the ACA and Risk Adjustment: the goals of providing access to affordable health care regardless of health status.

4. In doing so, HHS and CMS have unlawfully acted beyond their statutory authority.

5. Their reckless actions have had disastrous, real world consequences. Because of the arbitrary and capricious Risk Adjustment methodology developed and implemented by HHS and CMS, numerous health insurers have shuttered their doors and several

others are teetering on the brink of insolvency because they were saddled with massive Risk Adjustment assessments that wiped out their cash reserves.

6. This is not just bad news for the defunct insurance companies and their employees. It is devastating to their members and to the healthcare insurance market more broadly. Fewer insurers means less competition, less pressure to keep premiums low, and less incentive to innovate and provide high quality health care through new and meaningful initiatives. Consumers are left to choose new insurance from a smaller pool of options with higher rates. And for consumers receiving subsidies – currently ~85% of those on public exchanges – Risk Adjustment is forcing government spending higher as premiums rise.

7. Even for those carriers that are not facing imminent closure, the Risk Adjustment methodology has nevertheless had devastating consequences. Plaintiff Minuteman Health, Inc. ("Minuteman"), a select network issuer providing affordable, quality coverage to tens of thousands of consumers in New Hampshire and Massachusetts, has been hit with Risk Adjustment assessments totaling more than $16 million for benefit year 2015 – over $1200 per member. On June 30, 2016, CMS assessed Minuteman a 2015 Risk Adjustment payment in New Hampshire of more than $10 million, amounting to a whopping 40% of its members' premiums. Massachusetts, which operates a Risk Adjustment program that mirrored the federal program and was certified by CMS, imposed a charge of $6,110,676, which represents 39% of members' premiums in that state. These numbers are all the more shocking in light of Minuteman's small market share. For example, in New Hampshire, despite having only 19% of the on-exchange market share for individual policies, Minuteman is responsible for paying 90% of the Risk Adjustment charges in that state. Such punitive assessments, which threaten Minuteman's provider-focused, cost-saving, business model, are plainly not what Congress intended.

8. In the health insurance industry, well-managed, successful companies hope for a margin of between 2% - 5% a year. Paying out 40% of premium in one year can wipe out a carrier's margins for years to come. The only way to mitigate the very real risk of such large assessments is to artificially increase premiums to pay what is in effect a non-legislated premium tax. And that is exactly what is happening. Insurers across the country are implementing double digit percentage premium increases, causing millions of Americans to scrape together more money each month to pay for health care coverage or forego it altogether – a dynamic that runs counter to the core purpose of the Affordable Care Act.

9. In 2010, Congress enacted the Patient Protection and Affordable Care Act ("ACA"), Pub. Law No. 111-148, 42 U.S.C. § 18001, to expand access to health care coverage in the United States by making it *affordable* and *accessible*, regardless of an individual's health history.

10. With the influx of new insureds and the ACA's prohibition against rejecting enrollees or setting premiums based on individual health history, Congress recognized that there was likely to be some uncertainty in the market after the ACA went into effect. To address this uncertainty, Congress enacted a trio of risk stabilizing measures often referred to as the "3 Rs": the Reinsurance, Risk Corridor, and Risk Adjustment programs. Risk Adjustment, which is the focus of this action, is the only permanent program. It is supposed to mitigate bias in the distribution of insureds by compensating insurers in the individual and small group markets whose enrollees are considered to be sicker and, therefore, costlier. The theory of Risk Adjustment is that plans should not fail or succeed only because they attract sicker or healthier enrollees, but rather should compete based on price, efficiency, and service quality.

11. It is within this framework that Minuteman developed its business model – a model designed to invigorate competition, drive costs down, and increase the quality of health care delivered to consumers in the individual and small group markets.

12. Minuteman set out to offer affordable health care coverage by securing low reimbursement rates (prices for services) from a select network of health care providers. Minuteman excludes high-priced and inefficient hospital systems from its network and instead directs its members' care to low-cost, high-quality health care providers. In essence, Minuteman drives down the cost of healthcare services by partnering with providers willing to offer low rates without sacrificing quality, and then passes those price savings on to its members through lower insurance premiums.

13. Minuteman's business model is sound and successful. Since it entered the market in 2014, Minuteman has expanded coverage to 25,000 members, many of whom are cost conscious and had been frustrated for years with the overpriced health insurance plans being offered in two of the most expensive insurance markets in the country. Minuteman is currently generating positive cash flows before Risk Adjustment.

14. But the volatile Risk Adjustment program changes everything, and Minuteman has been forced to make harmful, outsized payments into the Risk Adjustment program that punish Minuteman and its members for building an efficient, narrow network business model that contains costs and keeps premiums low. CMS has implemented a program that is forcing Minuteman's cost-conscious members to subsidize those who chose to purchase a more expensive product. For plan year 2015, this payment – basically, a non-legislated tax levied by CMS – amounted to about $360 per Minuteman member, a total of $4,673,188.

15. What accounts for this perverse dynamic? It is the collective effect of several decisions by CMS to design and implement a Risk Adjustment formula that is beyond the scope of, and contrary to, the intent of the Affordable Care Act.

16. CMS has implemented a program that imposes charges and assessments based upon factors outside of the statutorily authorized issue of member risk.

17. CMS has created a program that does not *adjust* for actuarial risk because it does not accurately *calculate* actuarial risk in the first place.

18. CMS's Risk Adjustment program is, in short, arbitrary, capricious, and contrary to the express statutory language and intent of Congress.

19. One of the most problematic aspects of the Risk Adjustment methodology is its use of the Statewide Average Premium as a multiplier when calculating the dollars that one insurer must pay to another.

20. Under CMS's Risk Adjustment methodology, after each plan is scored for the relative health of its enrollees, CMS uses the Statewide Average Premium as a multiplier to calculate each insurer's Risk Adjustment transfer amount. But the use of the Statewide Average Premium has nothing to do with how healthy or sick individual insureds are, but rather is driven by how well carriers manage their provider costs and administrative expenses. The use of the Statewide Average Premium penalizes carriers like Minuteman that have found innovative, aggressive ways to drive down costs and pass savings on to consumers in the form of lower premiums. It also acts as a subsidy to higher-priced and inefficient issuers. This subsidy is paid by a combination of taxpayers and consumers and small business premium dollars.

21. In Massachusetts, New Hampshire, and other states, the Statewide Average Premium is largely driven by the higher cost, intractable insurers like Anthem and Blue

Cross/Blue Shield of Massachusetts who have dominated their local insurance markets for decades and forced consumers to fork over more and more premium dollars.

22. The Statewide Average Premium in both states is substantially higher than Minuteman's premiums not because Minuteman's population is healthier, but because Minuteman's business model includes effective cost containment measures and because Minuteman's members are more likely to purchase less-expensive Bronze plans than other pricier options. Said another way, the Statewide Average Premium penalizes Minuteman both because more of its members chose less expensive plan designs (e.g., Bronze versus Gold) and also because *all* of Minuteman's so-called metallic products were more affordable than those offered by large competitors.

23. The use of the Statewide Average Premium has had a direct and enormous effect on Minuteman's Risk Adjustment assessment. As noted above, Minuteman's 2015 Risk Adjustment assessment for New Hampshire was $10,540,869. Of that amount, $2,656,898 was directly attributable to improper use of the Statewide Average Premium multiplier. Similarly, Minuteman's 2015 Risk Adjustment assessment for Massachusetts was $6,110,676 with $2,016,290 directly attributable to the Statewide Average Premium multiplier.

24. Statewide Average Premium is not the only illegal failing of CMS's scheme. CMS's program categorically penalizes insurers that sell a large number of low-cost products – known as "Bronze" plans – to price-sensitive consumers. The adjustments made to Bronze plans are not based on actuarial risk. Congress directed CMS to transfer dollars among issuers on the basis of actuarial risk alone; not to levy a tax on mission driven issuers catering to consumers who want a low-priced product.

25. In addition, the Risk Adjustment program penalizes smaller issuers. Carriers with relatively low market share in a given state are much more likely to have large and distorted Risk Adjustment transfers and are likely to experience more volatility in year over year Risk Adjustment liability. *See* Ex. 3, CHOICES, *Impact of Risk Adjustment on Carriers' 2015 Financial Performance in the Individual Market* (July 29, 2016), at 1, 4-6, available at http://www.choicescoalition.org/documents/CHOICES_Financial%20Analysis%20WP.pdf. This is a peculiar outcome for a statute supposedly designed to foster market stability, competition, innovation, and lower health care costs, and it is proof that the Risk Adjustment methodology employed by CMS improperly exceeds its statutory mandate.

26. The Risk Adjustment program, by design, inserts confusion into the market. All insurers must file premium rates two years *before* they learn their Risk Adjustment liability. In other words, issuers were required to file premium rates for 2017 products in the first half of 2016 before even knowing the outcome for the 2015 Risk Adjustment program. Because the Risk Adjustment program transfers, on average, 10% of nationwide premiums, this timing ensures that no insurer can properly price their products. Due to early 2016 rate filing deadlines, 2017 is the first year that carriers have an opportunity to incorporate information from the *2014* Risk Adjustment program. This same timing problem means that issuer Risk Adjustment liability cannot be known when issuers file their annual audited financial reports. Insurers have to base audited annual filings on their best guess regarding future Risk Adjustment liability. There is no industry standard – and CMS has refused to provide one – for how insurers should estimate their Risk Adjustment liability or how those estimates should be reported on their financial statements. Actuarial and accounting firms often will not certify specific carrier Risk Adjustment estimates; they will instead provide wide ranges of potential outcomes, which

could easily exceed 15% of a carrier's entire revenue base. As a result, annual financial statements are unreliable and non-comparable, and create a serious challenge for regulators and policy makers alike who seek accurate information about issuer financial status.

27. The Risk Adjustment program is designed to remove risk selection from the equation so that health insurance companies can compete – and fail or succeed – on the basis of other factors such as premium competitiveness, product design, customer service, and provider network make-up. Therefore, perhaps the most troubling aspect of the Risk Adjustment program is that it is not putting insurers on a "level playing field" as intended. Instead, CMS is picking winners and losers. Recent analysis of the 2015 Risk Adjustment transfer payments show that insurers that receive Risk Adjustment payments are much more likely to have positive margins than those insurers making Risk Adjustment payments. *See id.* at 1, 6-7.

28. CMS and HHS are well aware that they have acted outside of their authority as these issues have been repeatedly raised by various insurers (including Minuteman) and others in the health care industry. Minuteman first raised concerns with CMS in 2014. Along with other issuers, Minuteman has continued to raise concerns until this day. For example, in late 2015, CHOICES, a multi-state coalition of health care plans, submitted to Defendant Sylvia Burwell, in her capacity as Secretary of the Department of Health and Human Services, a white paper written with the technical assistance of Richard S. Foster, Chief Actuary of CMS from 1995 through 2012. *See* Ex. 4, CHOICES, et. al., *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans* (Nov. 4, 2015), available at http://www.choicescoalition.org/documents/CHOICES%20White%20Paper%20on%20Risk%20Adjustment.pdf. That paper detailed numerous problems with the ACA's Risk Adjustment and

Risk Corridor programs and offered this foreboding prediction: unless changes are made to the Risk Adjustment and Risk Corridor programs, the viability of "efficient, public-focused health insurance plans will be severely jeopardized." *Id.* at 1.

29. This prediction was all too accurate. Unlike large, entrenched issuers that can cross-subsidize losses from other lines of business to weather the volatile ACA storm, many new, quickly growing, innovative insurance companies across the country have been forced into insolvency or have chosen to exit the individual exchange market because of exorbitant Risk Adjustment assessments. Most recently, Oregon Health CO-OP, HealthyCT, and Land of Lincoln all announced that they must shutter their doors due to their 2015 Risk Adjustment assessments, which were issued on June 30, 2016. Moda Health has announced that it will exit the individual health market in Alaska, and Preferred Medical is off the exchange in Florida. Health Republic Insurance of New Jersey announced its closure on September 12, 2016, arising in part from its Risk Adjustment liability. Their insureds must now scramble for different coverage and their providers are left wondering if they will get paid for pending claims. In states where insurers elect to remain in the market, the media has widely reported large premium increases and/or continued high pricing for 2017.

30. Kevin Counihan, CEO of the Health Insurance Marketplace for Defendant CMS, recently testified in federal court to the rising premiums, conceding that 2017 premiums are on average 22% higher than they were in 2016, with some states seeing increases of 50%. *See* Ex. 5, Transcript of Bench Trial at 2616-17, United States et al. v. Aetna, Inc. et al., No. 16-1494 (D.D.C. Dec. 16, 2016).

31. Not only insurers have cried out for mandatory reform; state insurance regulators from across the country have asked CMS and HHS to fix the Risk Adjustment program.

32. Maryland Insurance Commissioner Redmer has made multiple proposals to CMS to mitigate the volatile impact of the Risk Adjustment program, including a proposed order that would cap Risk Adjustment payments. *See* Ex. 6, Al Redmer, Jr., Written Testimony (Feb. 25, 2016), available at https://oversight.house.gov/wp-content/uploads/2016/02/2016-02-25-Written-Testimony-Redmer-MIA.pdf.

33. On September 14, 2016, Commissioner Redmer testified on behalf of the National Association of Insurance Commissioners before the U.S. House Oversight and Government Reform Subcommittee on Health Care, Benefits, and Administrative Rules: "over the past couple of years, many health insurance carriers have seen their risk corridor payments slashed, have received unexpectedly high risk adjustment bills, and are receiving reduced reinsurance payments, which may be reduced even further. Ironically, the very programs that were designed to bring stability to the markets have actually increased uncertainty, which has contributed to premium increases in a significant way." Ex. 7, Al Redmer, Jr., Written Testimony (Sept. 14, 2016), at 5-6, available at https://oversight.house.gov/wp-content/uploads/2016/09/2016-09-14-Redmer-NAIC-Testimony.pdf.

34. Connecticut Insurance Commissioner Wade has met with CMS along with multiple other Commissioners to request changes, and even met personally with Secretary Burwell. *See* Ex. 8, Conn. Ins. Dept., *Insurance Department Places HealthyCT Under Order of Supervision* (July 5, 2016), available at http://www.ct.gov/cid/cwp/view.asp?a=1269&Q=582452.

35. New York's Superintendent of Financial Services wrote to HHS articulating her concern with the Risk Adjustment program's disparate impact on new, smaller insurance issuers, and requesting "immediate changes" to obviate these disparities and ensure the solvency of New York issuers. Ex. 9, Letter from Maria T. Vullo, NY Superintendent of Financial Services, to Sylvia M. Burwell, Secretary, HHS, & Andrew Slavitt, Administrator, CMS (June 28, 2016).

36. On September 9, 2016, New York's Department of Financial Services announced that it had promulgated an emergency regulation to counter the problems caused by the Risk Adjustment program. *See* Ex. 10, Press Release, New York Department of Financial Services, DFS Issues Emergency Regulation to Address New York Factors Necessary to Remedy Adverse Impact of Federal Risk Adjustment Program on New York Insurers (Sept. 9, 2016), available at http://www.dfs.ny.gov/about/press/pr1609091.htm. In its press release, the Department explained that the federal program has resulted in transfers of upwards of 30% of premium to other insurers. *Id.* "These transfers are due to some factors that are not necessarily related to the relative health of each insurer's members. In particular, the risk adjustment program's calculations include administrative expenses and profits rather than only using claims. In addition, the risk adjustment computations may not give appropriate consideration to the way in which New York's tiered rating structure counts a member's children." *Id.*

37. On September 15, 2016, several state insurance departments were represented in testimony before the Committee on Homeland Security and Governmental Affairs. For example:

a. Iowa's Commissioner Gerhart testified regarding the adverse effect of Risk Adjustment on narrow network plans: "Iowa's Marketplace cannot be sustainable if the carriers who choose to control costs with narrow networks…are required to pay those carriers who offer broad-based plans." Ex. 11, Nick Gerhart, Written Testimony (Sept. 15,

2016), at 5-6, available at http://www.hsgac.senate.gov/hearings/the-state-of-health-insurance-markets.

b. Wisconsin's Deputy Commissioner Wieske testified that HHS's management of the Three Rs has left insurers "struggl[ing] to plan for and capture their estimated risk and receive their fair share of funding from these programs." Ex. 12, J.P. Wieske, Written Testimony (Sept. 15, 2016), at 4, available at http://www.hsgac.senate.gov/hearings/the-state-of-health-insurance-markets.

c. Washington State Insurance Commissioner Kreidler voiced general support for the ACA, but expressed concern that Risk Adjustment assessments are unpredictable. *See* Ex. 13, Mike Kreidler, Written Testimony (Sept. 15, 2016), at 3, available at http://www.hsgac.senate.gov/hearings/the-state-of-health-insurance-markets.

38. Illinois' Acting Director Dowling went so far as to order an insurer in her state not to make Risk Adjustment payments. *See* Ex. 14, ILL. DEPT. OF INS., AGREED CORRECTIVE ORDER: NO. 2016-1 (June 27, 2016), available at http://insurance.illinois.gov/newsrls/2016/06/coop_06302016.pdf.

39. These are the people recognized by CMS (and by Congress in the ACA) as the "primary regulators of their insurance markets," and whose very job is to ensure the stability of the health insurance market and to protect consumers. *See* Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 29,146, 29,152 (May 11, 2016). These state insurance commissioners are the true subject-matter experts, but CMS has inappropriately silenced them and disregarded their warnings.

40. Despite the numerous warning signs, the pleas for help, and the mounting casualties, HHS and CMS have chosen not to bring the Risk Adjustment program within the statutory mandate. In response to concerns, criticism, and emerging data, CMS insisted through 2014 and 2015 that the Risk Adjustment program was working exactly as expected. Much later, in the spring of 2016, CMS finally admitted publicly that the Risk Adjustment program is indeed flawed. Despite that admission, CMS has not offered sufficient solutions, instead making it clear

that no timely, meaningful relief will be coming to insurers and their enrollees who are suffering under this arbitrary program.

41. When HHS published the Notice of Benefit and Payment Parameters for 2018 in the Federal Register on September 6, 2016 ("2018 Proposed Rule"), it again admitted that Risk Adjustment is not working. In the 2018 Proposed Rule, HHS finally proposed "several updates" to the Risk Adjustment methodology "intended to refine the methodology's ability to estimate risk." HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61,455, 61,457 (proposed Sept. 6, 2016). Those "updates" included use of limited prescription drug data in the Risk Adjustment model starting in benefit year 2018 and adjustments to better represent the risk of partial year enrollees to be applied starting in 2017. But the proposed updates intended to refine the methodology were far from sufficient to right the ship and to bring the agency's regulations into accordance with law.

42. Minuteman and several other insurers submitted extensive comments regarding the deficiencies with the 2018 Proposed Rule. Minuteman even commissioned an analysis of the 2018 Proposed Rule from the actuarial firm Axene Health Partners LLC. Minuteman and Axene offered substantive comments on several problems, including the Proposed Rule's improper use of the Statewide Average Premium, discrimination against Bronze plans, underestimating risk for low HCC enrollees, and HHS's proposed use of limited prescription drug data in the Risk Adjustment methodology.

43. As Minuteman stated in its comments: "While Minuteman welcomes changes to Risk Adjustment, the Proposed Rule does not do enough and does not act fast enough to correct the problems that infect the current Risk Adjustment scheme. The majority of the proposed changes, which are still inadequate to correct the methodology, would not go into

effect until *benefit year 2018*. Under HHS and CMS's plan, the current, fatally flawed scheme that has driven numerous insurers into insolvency and driven others off the Exchanges would stay in place for two more years. That is unacceptable. HHS and CMS need to act *now* to mitigate the harm they have already caused and to prevent future harm and further destabilization of the health insurance market. It is incumbent upon them to effectuate the purpose of the ACA – to expand access to high quality health care regardless of health status and provide greater consumer choice." Ex. 15, Minuteman Health, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018; Proposed Rule (CMS-9934-P)* (Oct. 6, 2016), at 8, available at https://www.regulations.gov/document?D=CMS-2016-0148-0598.

44. On December 22, 2016, the Final HHS Notice of Benefit and Payment Parameters for 2018 was published in the Federal Register. As previewed by the 2018 Proposed Rule, it does too little. And what little it does, it does too late. The 2018 Final Rule makes modest adjustments to the formula to better calculate the actuarial risk for partial year enrollees and incorporates limited prescription drug utilization data, beginning in benefit years 2017 and 2018, respectively, but not for earlier years – even though Risk Adjustment will not be calculated for benefit year 2016 until late Summer 2017, at the earliest.

45. HHS acknowledged that the use of the Statewide Average Premium had improperly included non-risk elements. To account for non-risk related administrative expenses, HHS will reduce the Statewide Average Premium by 14% across the board. But this is no solution. Using a uniform reduction for all carriers masks the fact that low-cost carriers are able to offer lower premiums in part because they have lower administrative expenses. This is by design – it is a key aspect of the way in which they compete. The uniform 14% number wrongly assumes that administrative expenses are static and uniform across carriers rather than an

element of competition on the merits. A uniform reduction does not incentivize competition. Nor does it remedy the perverse dynamic in which small, lower cost carriers get punished under the transfer formula because the Statewide Average Premium is driven by large, higher cost carriers. An across the board reduction like this may actually encourage issuers to raise rates, not work to lower them.

46. Moreover, HHS only adjusts for administrative expenses. But a key part of Minuteman's strategy to lower premium costs is the use of selective contracting to drive its members' care to high-quality but lower-cost hospitals like Tufts Medical Center. HHS's adjustment continues illegally to penalize Minuteman's strategy of partnering with lower-cost hospitals and physicians to deliver lower insurance premiums to consumers.

47. Finally, even this grudging and insufficient downward adjustment will not be effective until 2018 – leaving Minuteman and other innovative low-cost carriers in the lurch from 2014-2017.

48. The 2018 Final Rule does nothing to correct two of the most fundamental flaws with the Risk Adjustment methodology: (1) discrimination against Bronze plans; and (2) undervaluing the actuarial risk of healthy enrollees.

49. CMS has turned a cold shoulder to innovative health plans, large and small, trying to effect real, meaningful change in the health insurance market and the thousands of new insureds who have found affordable coverage that suits their needs and limited pocketbooks.

50. In short, CMS's response has ranged from defensive assurances that the Risk Adjustment methodology works well enough because it is "directionally appropriate" to outright hostility.

51. The assertion that Risk Adjustment is "directionally appropriate" – *i.e.* generally, in the aggregate, transfers money from insurers with lower risk populations to insurers that enroll higher risk populations – misses the point. Apparently, CMS does not think it matters whether an insurer pays out $2M, $20M, or $200M of its members' premiums; so long as the insurer was supposed to pay out some amount of money, any amount will do.

52. This is not just a situation of a well-intentioned, but imperfect rollout of the Risk Adjustment program leading to unfortunate consequences. It is not a situation of reasonable minds disagreeing about the minutiae in a complicated mathematical formula. Nor is it a situation where there must be winners and losers and those who are losing are just bitter about their lot in life.

53. Rather, this is a situation where HHS and CMS ignored their clearly delineated statutory authority and Congressional mandate and went rogue in developing and implementing a methodology that guts Congressional intent to create affordable health insurance in stable marketplaces.

54. Having been rebuffed by HHS and CMS, Minuteman is forced to seek intervention from the Court. Minuteman brings this action for declaratory and injunctive relief to put a stop to this system that is supposed to stabilize the market but instead has already caused tremendous destabilization and wreaked havoc for thousands of consumers trying to find an affordable health insurance policy. If not stopped, HHS and CMS, through their unlawful, arbitrary and capricious Risk Adjustment program will cause further turmoil and will undermine competition, consumer choice, and access to affordable health care. The public already has suffered more than enough from these runaway regulatory abuses, and it is clear that CMS and HHS are not going to take the steps necessary to end them. It is time for this Court to step in.

II. Jurisdiction and Venue

55. This Court has subject matter jurisdiction over the Plaintiff's claims under Article III of the United States Constitution and 28 U.S.C. § 1331. Judicial review is authorized by the Administrative Procedure Act, 5 U.S.C. § 701 *et seq.* which permits "[a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute . . . to judicial review thereof." 5 U.S.C. § 702.

56. Venue is proper in this district under 28 U.S.C. § 1391(e)(1) because a substantial part of the events or omissions giving rise to the claim occurred in this district.

III. The Parties

57. Plaintiff Minuteman Health Inc. is a nonprofit corporation based in Boston, with its principal place of business located at 38 Chancy Street, Boston, MA 02111. Minuteman offers health insurance coverage in Massachusetts and New Hampshire's individual and small group markets.

58. Defendant HHS is the federal agency responsible for overseeing federal administration of the ACA.

59. Defendant CMS is the agency within HHS immediately responsible for overseeing federal administration of the ACA, including the Risk Adjustment program.

60. Defendant Sylvia Mathews Burwell is the Secretary of HHS and is responsible for the overall administration of HHS. She is sued in her official capacity.

61. Defendant Andrew M. Slavitt is the Acting Administrator of CMS and is responsible for overseeing CMS. He is sued in his official capacity.

62. Defendants are collectively referred to as "the Government." Defendants' address is 200 Independence Avenue, SW, Washington, DC 20201.

IV. Factual Background

A. The Affordable Care Act is Enacted to Provide Access to Affordable Health Care Coverage

63. Enacted in 2010, the ACA brought major health care reform to the United States. As noted *supra*, one major goal of the ACA was to foster competition in the insurance market because, as Defendant Burwell has explained, competition improves health care from both a cost and quality perspective: "[w]hen there is competition, that creates downward price pressure, and it also creates upward quality pressure." Ex. 16, Zachary Tracer, *Top U.S. Health Official Highlights Need for Insurer Competition,* BLOOMBERG (July 15, 2016), available at http://www.bloomberg.com/news/articles/2016-07-15/top-u-s-health-official-highlights-need-for-insurer-competition.

64. This sentiment was recently echoed by senior CMS official Kevin Counihan, who testified in a federal antitrust trial to the importance of competition to satisfy consumer choice and also to act as a "check on price." Ex. 5, Transcript of Bench Trial at 2639-40, *Aetna,* No. 16-1494.

65. While cost and quality (improved through competition in the market) are important ACA goals, another critical component of the ACA is to ensure the availability of care to all Americans, regardless of their medical history or health status. Prior to the implementation of the ACA, insurers were free to deny coverage or raise premium rates based on individual factors such as medical history or preexisting conditions. The ACA changed this landscape through its "guaranteed issue" and "community rating" provisions, which prohibited insurance issuers from denying coverage or increasing rates based on an individual's health status.

66. While providing a crucial step in expanding access to health care coverage, these provisions were problematic for health insurance issuers as they made it difficult

to accurately predict health care costs, which could result in premium volatility. Issuers had no way of assessing health care costs for this new class of previously uninsured Americans, and were unable to adjust premium costs to account for unpredictable costs that may accompany new members. Due to these inherent financial risks and in order to provide stability and certainty for health insurance issuers (and to encourage participation on the newly created individual health insurance exchanges), the ACA established three premium stabilization programs: the Reinsurance, Risk Corridor and Risk Adjustment programs.

67. These inter-related programs, colloquially referred to as the "Three Rs", were designed to mitigate the difficulties and uncertainties during the ACA's rollout "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance," particularly during the first few years of full ACA implementation. Ex. 17, CMS, *The Three Rs: An Overview* (Oct. 1, 2015), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html. Congress recognized that uncertainty in the early years of the new regime could lead insurers to increase premiums and cause instability in the market, and the Three Rs were designed to alleviate these potential problems and minimize an insurer's losses due to market participation under the ACA's new rules.

68. Just one of the "Three Rs" is at issue in this Complaint: Risk Adjustment.

B. Congress Directed HHS to Implement a Risk Adjustment Program Solely to Mitigate Adverse Selection by Adjusting for Actuarial Risk

69. The Risk Adjustment program is the only permanent "R" program; the other two are temporary programs that will sunset after 2016. The Risk Adjustment program, which aims to protect consumer access to coverage options by "reducing the incentive for insurance companies to seek only to insure healthy individuals," is supposed to distribute funds

to and make assessments against insurers based on the actuarial risk (*i.e.* the relative health or sickness) of their enrollees. *Id.* Theoretically, issuers with healthier populations will make payments to CMS and issuers with sicker populations will receive payments from CMS. The program aims to "level the playing field" between insurers, normalizing the negative cost impact of member health status, or, in other words, preventing carriers from making or losing money solely because they draw healthier or sicker enrollees.

70. States may offer their own Risk Adjustment program or allow the federal government to administer their program for them. Massachusetts was the only state that chose to operate its own Risk Adjustment program. All other states, including New Hampshire, have programs administered by CMS. Beginning in 2017, Massachusetts will transition to a CMS-run Risk Adjustment program.

71. Specifically, the text of the ACA statute provides that:

> each State shall assess a charge on health plans and health insurance issuers [in the individual or small group market within the state] . . . 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 that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974). . . .
>
> each State shall provide a payment to health plans and health insurance issuers [in the individual or small group market within the state] . . . 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 that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974). ACA, Pub. L. No. 111-148, § 1343 (codified at 42 U.S.C. § 18063).

72. At the most basic level, Risk Adjustment assessments and payments are based on "risk scores" ascribed to a plan's membership base. Members' risk scores are intended

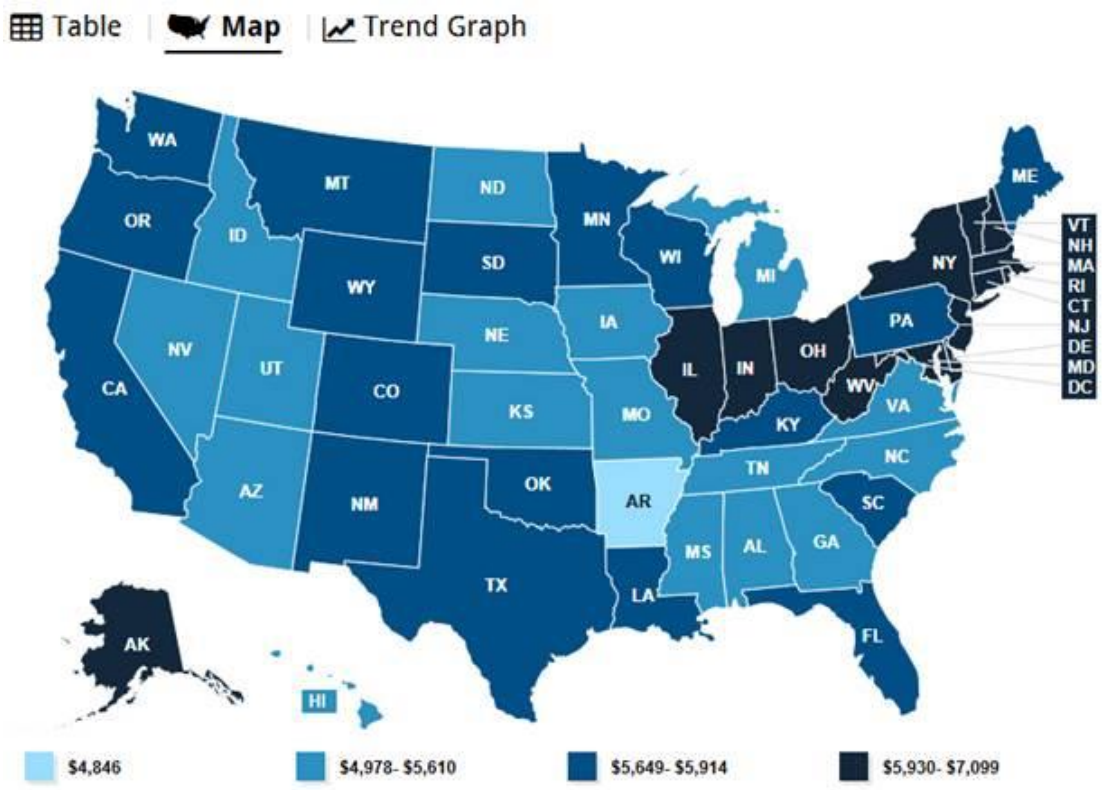
to reflect their anticipated health care claims costs based on their age, gender, and medical diagnoses. An individual with more complex medical needs (and, presumably, higher health costs) should be ascribed a higher risk score. A membership base's risk score is then compared with the average risk score within the relevant state and market. The government then calculates Risk Adjustment payments and assessments based on these relative risk scores. Insurers with higher risk (sicker) individuals should receive Risk Adjustment payments, and insurers with lower risk (healthier) members should make payments.

73. Unfortunately, the Risk Adjustment program as implemented by CMS and HHS in New Hampshire and in Massachusetts does not assess only the relative health status or actuarial risk of an enrollee. Rather, it assesses irrelevant factors, wholly unrelated to actuarial risk, such as relative differences in premiums, consumer choice of metallic tier, and length of member enrollment. As a result, the program flouts Congressional intent, drives up premiums, and chokes off competition.

C. Minuteman is Formed to Provide an Innovative and Affordable Health Insurance Option in New Hampshire and Massachusetts

74. Minuteman chose Massachusetts and New Hampshire to launch its new company because consumers in those two states have historically shouldered the burden of skyrocketing health care costs and been forced to pay premiums among the highest in the country.

75. Consumers in both states have been plagued by exorbitant premiums for years. In 2014, premiums in both New Hampshire and Massachusetts, in both the individual and group markets, were more expensive than premiums in *over 45 other states. See* Ex. 18, Henry J. Kaiser Family Foundation, *Average Single Premium per Enrolled Employee for Employer-Based Health Insurance* (2014), available at http://kff.org/other/state-indicator/single-coverage/.



[1]

76. These skyrocketing costs and high premiums are largely due to dominant insurance carriers and providers in both states who have used their market power to control the health care market.

Massachusetts

77. In Massachusetts, Blue Cross Blue Shield of Massachusetts ("BCBS") is by far the largest commercial health insurer, controlling approximately 45% of the small group markets in Massachusetts. *See* Ex. 19, Ctr. for Health Info. & Analysis, *Enrollment Trends Databook* (July 2016), available at http://www.chiamass.gov/enrollment-in-health-insurance/.

[1] Map Shows Average Single Premium per Enrolled Employee for Employer-Based Health Insurance

78. BCBS and other incumbent insurers have exploited their market power by creating a cycle in which they pay a handful of brand name hospitals disproportionately high prices for their services, while many other superb facilities receive artificially depressed rates.

79. These provider price disparities cause significant harm in the Massachusetts market. Providers who render care at equally good or better quality of care levels than their higher-paid brand name competitors are deprived of the capital and resources to grow and expand their services. This creates a gap between resource-rich favored providers and resource-starved disfavored providers. Resource-strapped providers are unable to invest in updating facilities, purchasing new equipment, and developing new programs that are essential to maintaining and growing their service offerings even though their existing quality may be excellent. As a result, volume shifts away from low price providers to higher priced providers, increasing costs – and premiums – for all consumers. Finally, price sensitive consumers that generally utilize lower-cost providers subsidize the premiums of less price-sensitive consumers who purchase the most expensive services from the most expensive providers. *See* Ex. 20, MA. Office of Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (June 22, 2011), at 27-31, available at http://www.mass.gov/ago/docs/healthcare/2011-hcctd.pdf.

80. This market dysfunction and the resulting increase in health care costs has not gone unnoticed by Massachusetts officials, who have worked for over a decade to institute government reform to try to curb health care spending. Noting that a "wide variation in the prices health insurance companies pay providers for similar services, unexplained by differences in quality" are a "major reason for escalating health care premiums," the Commonwealth of Massachusetts advanced a range of initiatives to lower health care costs and address market dysfunction. Ex. 21, MA. Office of Attorney General, *Examination of Health Care Cost Trends*

and Cost Drivers (Sept. 18, 2015), at 1, available at http://www.mass.gov/ago/docs/healthcare/cctcd5.pdf. Many of these efforts seek to strengthen effective market operation by improving the information and incentives available to consumers to choose insurance plans and health care providers based on cost and quality. *Id.*

81. Massachusetts has also enacted reforms to mandate that carriers in the state offer narrow network or tiered network insurance plans at discounted prices to try producing innovation that will result in lower premiums for consumers. MASS. GEN. LAWS ANN. ch. 176J §11 (2016).

New Hampshire

82. New Hampshire's consumers have similarly suffered at the hands of market dominant insurance companies. Until 2015, New Hampshire's dominant insurance company, Anthem, faced virtually no competition in New Hampshire's commercial insurance market. Unsurprisingly, this insurer's monopolistic market share drove consumer premium prices to exorbitant levels.

83. While Anthem does share some of the small employer market with another carrier, these two issuers have traditionally dominated the market to the near exclusion of all other issuers. This duopoly has enabled these two legacy insurers to pile on ever greater price increases.

84. Consumers in New Hampshire in the individual market face another hurdle. Prior to Minuteman's market entrance, *only one insurance company* offered insurance products on the New Hampshire health care marketplace. While there were other national companies offering individual coverage, those companies refused to offer plans on the New Hampshire exchange in 2014.

D. Massachusetts Providers Sponsor the Creation of Minuteman to Create Competition and Drive Down Premiums

85. A group of Massachusetts providers, including Tufts Medical Center ("Tufts MC"), New England Quality Care Alliance ("NEQCA") and Vanguard Health Systems, came together to find a way to break the market impasse in Massachusetts that has continually harmed consumers by sponsoring the creation of a new insurance carrier that would focus on driving down costs and steering patients to providers committed to bending the health care cost curve.

86. Those providers are an excellent example of the hospitals and physicians harmed by the dysfunctional market dynamic in Massachusetts. For example, Tufts MC is a world class academic medical center that works with NEQCA, an affiliated network of over 1,500 physicians, which provides high-quality, sophisticated care to tens of thousands of residents of Massachusetts every year. But Tufts MC has been shown time and time again to be underpaid compared to other academic medical centers in the Boston region. *See* Ex. 22, MA. Office of Attorney General, *Examination of Health Care Cost Trends and Cost Drivers* (Mar. 16, 2010), available at http://www.mass.gov/ago/docs/healthcare/2010-hcctd-full.pdf.

87. These providers sponsored the formation of Minuteman, a non-profit health plan, to drive down costs by building a select network of highly qualified, yet traditionally underfunded providers, and excluding overpriced name brand hospitals. They wanted the network to provide Massachusetts consumers with a low cost, quality insurance option.

88. Put simply, Minuteman planned to hold down insurance premiums by paying lower prices for medical care through smarter shopping among the different hospitals and health care providers in the marketplace.

89. Minuteman's actuaries' early estimates found that Minuteman's approach would yield members up to *25%* in premium savings. Even using more conservative figures, the plans would yield a *minimum* of 16% premium savings for members. These savings projections were based entirely on Minuteman's select network approach and were not based on any assumptions that Minuteman would have healthier than average members. In actuality, Minuteman's approach – partnering with a select network of providers and pricing for an average risk population, assuming no savings from lower than average claims expenses – has provided individuals with low-cost options that are up to 40% lower than the major issuers in Massachusetts.

E. Minuteman Launches in Massachusetts and New Hampshire

90. HHS approved Minuteman's select-network business plan and awarded it funding through the CO-OP program to enter the Massachusetts market. On August 13, 2012, Minuteman signed a loan agreement ("Loan Agreement") with HHS to fund its initial formation and operation in Massachusetts. *See* Ex. 23, Loan Agreement, CMS & Minuteman (Aug. 13, 2012). It signed an amendment to the Loan Agreement in November 2013 for additional funding to enter the New Hampshire market. *See* Ex. 24, First Amendment to Loan Agreement, CMS & Minuteman (Nov. 2013).

91. The Loan Agreement required Minuteman to comply with all standards set forth in Section 1311(c) of the ACA, all state specific standards, and any CO-OP regulatory standards. Minuteman was also required to offer at least two-thirds of its plans as QHPs in these markets.

92. In other words, unlike its larger, entrenched competitors, Minuteman is *required* to offer products on the individual insurance exchanges established by the ACA, and is *required* to do substantially all of its business in the individual and small group markets – the

very markets impacted by the Risk Adjustment program. Minuteman cannot simply flee the market or turn to other business lines to avoid the volatile Risk Adjustment program, as its competitors have.

F. Minuteman Delivers New, Innovative Low Cost Insurance Products

93. Minuteman delivered on its plans. It entered the Massachusetts market in 2014 and the New Hampshire market in 2015 with lower cost products.

94. In 2015, in the individual market for the "Bronze" tier plans often preferred by cost-conscious consumers, Minuteman's lowest monthly premiums ranged from $196-$232 while BCBS's monthly premiums for its Bronze product ranged from $348-$392. Similarly, in "Silver" products, Minuteman's monthly premiums ranged from $241-$285 while BCBS charged monthly premiums from $384 to $433.

95. Minuteman achieved similarly impressive cost savings for New Hampshire. In 2015, Minuteman's Bronze premium for a non-smoker in New Hampshire was only $188 per month, compared to $224 per month for Anthem, $238 per month for Harvard Pilgrim, $260 per month for Maine Community Health Options, and nearly $400 per month for Assurant.

96. Likewise for Silver plans for non-smokers in New Hampshire in 2015, Minuteman set a monthly premium of only $238, compared to $283 for Anthem, $295 for Harvard Pilgrim, $304 for Maine Community Health Options, and $474 for Assurant.

97. Consumers reacted positively to the opportunities for cost savings that Minuteman offered them. Despite the fact that problems with the Massachusetts Connector website impacted Minuteman's launch in 2014, Minuteman has grown rapidly. Starting with just over 1,400 members in 2014, Minuteman quickly expanded to over 13,000 new members in 2015, and to nearly 25,000 members in 2016.

98. Minuteman's innovative approach to driving down hospital and physician prices led to its success, while at the same time achieving the goals of the ACA and its CO-OP program. But the flawed Risk Adjustment methodology created by CMS has stripped Minuteman of vast revenue. In 2015, Minuteman was assessed a Risk Adjustment payment of $10,540,869.00 in New Hampshire, representing 40% of its premiums sold in that state. In Massachusetts, the 2015 Risk Adjustment payment was calculated to be $6,110,676.00, representing 39% of Minuteman's premiums in that state. Minuteman is currently ahead of its budget and is generating positive operating cash flows before Risk Adjustment. Minuteman is enjoying this success because of its efficient business design, spearheaded by executives with many years of industry experience. These Risk Adjustment assessments threaten to destroy the success built upon these efficiencies and threaten Minuteman's future growth.

99. This upside-down system is a direct result of CMS applying the Risk Adjustment program in an arbitrary, capricious, and unlawful manner that flouts the intent of Congress and the express statutory mandate to HHS. Minuteman has been a success. That success is threatened solely because CMS has instituted Risk Adjustment in a way that penalizes carriers regardless of the relative health or sickness of their population. The Risk Adjustment program punishes and fines Minuteman for doing exactly what consumers want: holding down premiums by cutting the cost of health care services.

V. CMS' Risk Adjustment Methodology Is Arbitrary and Capricious, and Violates the Text and Intent of the Statute

100. In Section 1343 of the ACA, Congress set forth the requirements of the Risk Adjustment program: CMS must (1) "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

(2) "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…" ACA, Pub. L. No. 111-148, § 1343(a)(1)-(2) (codified at 42 U.S.C. § 18063(a)(1)-(2)).

101. While CMS theoretically permitted Massachusetts to develop and operate its own Risk Adjustment program, it required Massachusetts to adhere to CMS's own fatally flawed directives. When Minuteman challenged its 2014 Risk Adjustment assessment through Massachusetts administrative procedures, the state agency replied that it had no authority to vary its formulas because CMS would not provide any regulatory flexibility. *See* Ex. 25, Commonwealth Health Ins. Connector Auth., *Decision on Minuteman Health's Request for Reconsideration First Round Review* (Oct. 7, 2015), at 5. Indeed, at one point, the Massachusetts state agency announced on a conference call with carriers that it was slashing all 2014 Risk Adjustment assessments by 50% to restore market stability, but then failed to follow through on that promise reportedly because CMS vetoed its plan. Because CMS has prevented Massachusetts from genuinely running its own program, the flaws described below apply with equal force to both the federal formula applied in New Hampshire and the purportedly separate Massachusetts state program.

102. The express directive and clear purpose of Section 1343 is to assess payments only for "actuarial risk" – *i.e.* how sick an enrollee is.

103. But the Risk Adjustment methodology developed by CMS instead assesses payments for differences in premiums, consumer choice of metallic tier, and length of member enrollment. CMS thereby sweeps in numerous factors that have nothing to do with actuarial risk. As a result, CMS has created a program that dictates which insurers will be

winners or losers based on issues that have nothing to do with the health of their members. Risk Adjustment rewards insurers that sell the most expensive products, that do not grow, and that do not offer products on the public marketplace.

104. Like any business, health insurance companies have a number of expenses. Those include payments to providers for health care services provided to enrollees, which is affected both by the amount of utilization of services and by negotiated rates (prices) with providers; employee salaries and associated overhead costs; marketing expenses, etc.

105. These expenses must be covered by revenue – *i.e.* premiums collected from plan enrollees.

106. To maintain a viable business, an insurance company must collect more in premiums than it pays out in collective expenses. The higher an insurer's expenses, whatever their nature might be, the higher it must set its premiums. In a well-functioning competitive market, carriers will be forced to innovate to cut their costs so they can lower their premiums and attract more members.

107. Under the ACA, insurers are prohibited from setting discriminatory insurance premiums based on an individual's health status and corresponding risk profile. ACA, Pub. L. No. 111-148, § 2701 (codified at 42 U.S.C. § 300gg). In addition, insurers lack control over who they enroll in their plans. With that lack of control comes risk that a disproportionate number of sicker individuals (*i.e.* individuals with higher actuarial risk) will enroll in certain plans while healthier individuals who require less care will enroll in other plans. This is the singular issue that CMS is permitted to address through the Risk Adjustment formula.

108. All other factors must be left out of the formula. In other words, the Risk Adjustment formula cannot assess a payment against an insurer because it runs a more efficient

business, separate and apart from the health status of its enrolled population. It cannot penalize an insurer for negotiating lower rates with providers or running a lean enterprise with lower administrative costs. It cannot penalize an insurer for executing on a mission to provide price-sensitive consumers with lower priced Bronze products. It cannot penalize an insurer for being new, or high growth. It cannot penalize members who choose to use their own money to buy lower cost products.

109. Likewise, the Risk Adjustment formula cannot be used to subsidize insurance companies that have high administrative costs or pay excessive prices to brand name hospitals. It cannot be used to reward insurers that cater to consumers that can afford the most expensive metallic tier products. And it cannot be used to subsidize entrenched insurers that have been in business longer or have decided not to grow on the exchanges. But that is exactly what CMS's Risk Adjustment formula does.

A. Use of the Statewide Average Premium Violates the Text and Intent of the ACA by Penalizing Low Cost, Efficient Insurers

110. The Statewide Average Premium is, as its name suggests, a calculation of the average premium charged by all insurers across a given state and then weighted by plan share of statewide enrollment in the risk pool.

111. Accordingly, the Statewide Average Premium is largely driven by the premiums set by the plans with the most market share. As noted *supra,* in Massachusetts, the market is dominated by BCBS. *See* Ex. 19, Ctr. for Health Info. & Analysis, *Enrollment Trends Databook* (July 2016). In New Hampshire, in 2015 Anthem accounted for nearly 60% of individual QHPs offered on the exchange. Ex. 26, NHID, *2015 QHP Monthly Membership Report*, available at https://www.nh.gov/insurance/consumers/documents/2015mktplc_month_enrl_rpt.pdf.

112. When calculating Statewide Average Premiums, the prices charged by these large insurers will skew the "average" closer to their actual, high premium prices.

113. Consistent with its business plan and the purpose of the ACA, Minuteman has built a business model that allows it to deliver lower premiums to its members regardless of their health status.

114. Because of its innovative and efficient business model, Minuteman's premiums are substantially lower than those of Anthem and BCBS. It is important to note that Minuteman does *not* have lower premiums because it has healthier members. In fact, Minuteman assumed an average risk score (an actuarial population of the market average, 1.0) when it set its premiums. In other words, Minuteman priced to an average risk population to ensure that its premium prices would be sufficient to account for the impact of the Risk Adjustment program. If the Risk Adjustment program were working correctly, and if Minuteman ended up having a healthier than average population (say, with an actuarial risk of 0.5) then the "extra" premium built into its rates would cover Minuteman's Risk Adjustment transfer payment. Of course, that is not how Risk Adjustment works due to its multiple flaws.

115. In addition, Minuteman sells more Bronze products as compared to other insurers. That means that Minuteman's average premium is lower because all of its premiums are lower, and also because Minuteman sells a larger proportion of lower cost Bronze products as compared to other issuers in the market.

116. The 2014 Statewide Average Premium in Massachusetts was $435 per month while Minuteman's average premium was $254 per month. The 2015 Statewide Average Premium in Massachusetts was $418 per month, while Minuteman's average premium was $255 per month.

117. The 2015 Statewide Average Premium in New Hampshire for individual plans was $379 per month while Minuteman's average premium was $283. *See* Ex. 27, CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (June 30, 2016), App. A, available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/.

118. The cost efficiencies built into Minuteman's business model are thus wiped out by the Risk Adjustment transfer formula's use of the Statewide Average Premium.

119. Minuteman's Risk Adjustment assessment in 2014 was $3,064,679. Of this amount, $1,162,398 was directly attributable to the Statewide Average Premium multiplier.

120. Minuteman's Risk Adjustment assessment for Massachusetts in 2015 was $6,110,676. Of this amount, $2,016,290 was directly attributable to the Statewide Average Premium multiplier.

121. Similarly, in New Hampshire, Minuteman's 2015 Risk Adjustment assessment was $10,540,869. Of that amount, $2,656,898 was directly attributable to the Statewide Average Premium multiplier.

122. These impacts are summarized in the table below:

State	Minuteman's Premium	Statewide Average Premium	2015 Risk Adjustment Assessment	RA Amount Attributable to Statewide Average Premium
New Hampshire	$283	$379	$10,540,869	$2,656,898
Massachusetts (2014)	$254	$435	$3,064,679	$1,162,398
Massachusetts (2015)	$255	$418	$6,110,676	$2,016,290

123. Minuteman has been directed to pay over $19.7 million to its competitors, including the largest, most established insurers in each state; over $5.8 million of the $19.7

million has nothing to do with Minuteman's members being healthier, but is because Minuteman fulfilled its mission and business plan to serve its enrollees by keeping premiums low. Over the last two years, CMS has in effect levied a $5.8 million plus tax on Minuteman for doing exactly what the ACA intended: offering a low cost, high quality product to consumers.

124. The Risk Adjustment formula developed and implemented by CMS, at the direction of the Secretary, is not an actuarial Risk Adjustment formula at all. Rather it is a premium adjustment formula. By design, it punishes insurers that keep premiums low and rewards insurers that charge the highest rates.

125. The greater a low cost plan deviates from the Statewide Average Premium, the harder it is hit by the Risk Adjustment formula**.** The lower a plan's premiums are compared to the Statewide Average Premium, the higher the percent of that plan's Risk Adjustment assessment is directly attributable to lower premiums. CMS, through its illegal Risk Adjustment formula, has structured a system where carriers are *penalized* for competing with lower premium prices and are *rewarded* for raising rates.

126. This is the antithesis of the ACA mandate and flies in the face of Secretary Burwell's recent call for greater competition in the health care insurance market: "When there is competition, that creates downward price pressure, and it also creates upward quality pressure … We've always thought and talked about why competition is an important part of the overall picture, and that's not just in the marketplace but overall for the nation in terms of our health care." Ex. 16, Tracer, *Top U.S. Health Official Highlights Need for Insurer Competition*, BLOOMBERG (July 15, 2016). Burwell was also reported to have praised competition because it fosters innovation and negotiations between providers, hospitals, and insurers: "Competition

needs to be at a provider level and needs to be at an insurer level ... When there's competition in both settings, that creates an even playing field for both sets of players." *Id.*

127. Despite HHS's call for increased competition in the health insurance market and the clear purpose of the ACA, the Risk Adjustment methodology developed and implemented by CMS stifles competition and ensures that consumers will suffer ever increasing premiums.

128. HHS and CMS are well aware of the problems with the Risk Adjustment formula, including use of the Statewide Average Premium. As discussed *infra*, there have been numerous comments submitted regarding the Statewide Average Premium. In addition, CMS has held public meetings and discussions on the topic of Risk Adjustment. *See* Ex. 1, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016).

129. A November 2015 white paper published by the CHOICES coalition with the technical assistance of Rick Foster, former CMS chief actuary, identified how the Risk Adjustment methodology failed to adjust for actuarial risk. Ex. 4, CHOICES, et. al., *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans* (Nov. 4, 2015). That paper detailed seven specific problems, one of which was "use of the Statewide market average premium in the risk transfer formula." *Id.* at 9. That white paper concluded:

> To the extent that a plan's actual premiums are significantly lower (or higher) than the market average, then its estimated premium difference will be significantly exaggerated. In particular, for efficient, high-performing plans focusing on thorough care management, cost-efficient care, effective provider networks, low administrative costs, and, in some cases, low nonprofit margins, member premiums will generally be well below average in an area, for a given mix of enrollees. If such a plan's premium is, say, 20%

> below the market average, then the risk transfer formula's estimate of the plan's premium related to unallowed health factors will be 20% greater than the reality.
>
> ***
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> Use of a plan's *actual* average premium in the risk transfer formula, rather than the Statewide market average premium, would eliminate this significant source of estimation error and result in much fairer transfers among plans. *Id.*

130. The Statewide Average Premium is purportedly used by CMS because "it simplifies the calculations and automatically results in plan payments and charges that sum to zero." *Id.* *See also* Ex. 28, CCIIO, *Risk Adjustment Implementation Issues* (Sept. 12, 2011) available at https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf. Under CMS's methodology, the Risk Adjustment transfers are artificially set to be budget neutral such that the amount of money collected from issuers matches, to the dollar, the amount of money paid out to other issuers. But there is no statutory requirement that Risk Adjustment be budget neutral. There is, however, a statutory requirement that Risk Adjustment be based on actuarial risk and not other factors such as relative premium rates.

131. CMS's Risk Adjustment methodology uses a factor – Statewide Average Premium – unrelated to actuarial risk to achieve an artificial result not directed by the statute. In developing this methodology, CMS and HHS have acted in flagrant disregard of their limited authority and the directions expressly given by Congress in the plain text of the statute.

132. The 2015 CHOICES white paper, which was submitted to HHS during the comment period for the 2017 Notice of Benefit and Payment Parameters, was met with complete disregard. So too were other comments submitted regarding Statewide Average Premium. HHS acknowledged receipt of the comments, but shrugged them off: "We did not propose changes to

the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking." HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203, 12,230 (Mar. 8, 2016).

133. More recently, CMS acknowledged problems with the Risk Adjustment formula, including the use of the Statewide Average Premium. On March 24, 2016, CMS issued a Discussion Paper in advance of its March 31, 2016 HHS-Operated Risk Adjustment Methodology Meeting. *See* Ex. 1, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016). In that Discussion Paper, CMS wrote:

> [T]he Statewide average premium is intended to reflect average administrative expenses and average claims costs for issuers in a market and State. We received comments from the public who believe that the inclusion of administrative costs in the Statewide average premium incorrectly increases risk adjustment transfers based on costs that are unrelated to the risk of the enrollee population.
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> ***
>
> [W]e understand the concern that including fixed administrative costs in the Statewide average premium may increase risk adjustment transfers for all issuers based on a percentage of costs that are not related to enrollee risk. *Id.* at 92.

CMS concluded that it is considering the possibility of future adjustments "beyond the 2018 benefit year." *Id.* at 93.

134. The March 24, 2016 Discussion Paper also expressly acknowledged the bias built into the Risk Adjustment methodology against small, efficient insurers like Minuteman:

> [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, plan efficiency, or effective care coordination or

> disease management – are not. We are exploring a number of ways of addressing such plan differences in our methodology, including through potentially modifying the transfer equation, perhaps by modifying the equation using a plan's own premium… *Id.*

135. Despite acknowledging the problems and witnessing the devastating consequences of this formula, the response from CMS and HHS has ranged from defending the methodology as working well, to arguing that the program is "directionally" good enough, to vague assurances that they will look into the problem, to, most recently, finalizing a new rule to go into effect for the 2018 benefit year that is far too little too late and utterly fails to correct the obvious and admitted problem with the Statewide Average Premium.

136. The 2018 Final Rule applies just one "correction" to the transfer formula's use of the Statewide Average Premium: an across the board reduction of the Statewide Average Premium by a fixed rate of 14% starting in benefit year 2018 (and thus doing nothing to address the problems for benefit years 2014-2017). *See* HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94,057, 94,099-100 (Dec. 22, 2016). This is completely illogical and does not serve to fix anything.

137. HHS and CMS settled on a 14% reduction because they "determined that the mean administrative cost percentage is 14%" and believe this mean value "represents a reasonable percentage of administrative costs on which risk adjustment transfers should not be calculated." *Id.* at 94,100.

138. As Minuteman and other commenters expressly stated in their comments to the 2018 Proposed Rule, the premise for stripping administrative costs out of the Statewide Average Premium is to encourage competition among insurers and to reward efficient plans that do not have high administrative costs. By calculating a mean administrative cost percentage and applying it across the board, HHS and CMS have destroyed any distinction between plans.

There will be no reward for efficiency. *Every single plan* will experience the same adjustment. A uniform reduction does not incentivize competition. Nor does it remedy the perverse dynamic in which small, lower cost carriers get punished under the transfer formula because the Statewide Average Premium is driven by large, higher cost carriers. An across the board reduction like this may actually encourage issuers to raise rates, not work to lower them. This one-size-fits-all approach is illogical and contrary to the purpose of Risk Adjustment.

139. HHS and CMS stated that the purpose of the 14% adjustment is to account for non-risk related administrative expenses. Thus, there has still been no adjustment at all to account for the other factors unrelated to risk that impact the amount of premium, such as health care provider contracting costs and strategy.

140. HHS and CMS suggested that they are hamstrung in their ability to make further adjustments to the transfer formula, including the Statewide Average Premium, because Risk Adjustment is budget neutral. The agency cited only to such concerns about budget neutrality as a reason that a plan's own average premium cannot be used instead of the Statewide Average Premium. *See id.* According to the agency, if issuers' own premiums were used, high-cost carriers would be entitled to more in Risk Adjustment payments that must be funded by even greater assessments on efficient low-cost carriers like Minuteman, in order to make payments out equate to payments in.

141. That excuse falls flat. There is nothing in the Risk Adjustment statute regarding budget neutrality. HHS and CMS have improperly imposed this limitation on the program without any statutory directive to do so.

142. HHS and CMS effectively concede that the Risk Adjustment statute does not impose a requirement that the methodology be implemented in a budget neutral manner.

They noted in the 2018 Final Rule that commenters complained that implementing Risk Adjustment in a budget neutral way has led to undercompensating issuers for enrollees' risk. HHS and CMS did not dispute this assertion, nor did they point to budget neutrality as a required element of the program. Rather, HHS and CMS blamed lack of funding: "In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner…" *Id.* at 94,101.

143. Lack of funding from Congress does not equate to a requirement that Risk Adjustment be budget neutral.

144. Moreover, even if the program is budget neutral, payments in and payments out do not have to be perfectly equal each year. HHS and CMS have taken that exact approach with the Risk Corridor program – another of the Three Rs. With Risk Corridor, CMS has calculated payments due and assessments owed without regard to budge neutrality. Purportedly because Congress has failed to appropriate funds for the Risk Corridor program, CMS has only made Risk Corridor payments to the extent of assessments collected, which has resulted in payments out of (at best) just under 13 cents on the dollar. However, CMS has publicly acknowledged its obligation to pay the remainder of the calculated payments. The question is where the money will come from, not whether the debt is owed. CMS cannot square the position it has taken on Risk Corridor with the position it is now taking on Risk Adjustment.

145. CMS's assertion that the Risk Adjustment methodology must be budget neutral is not only wrong, it is a red herring. Budget neutral or not, CMS's plan to reduce the Statewide Average Premium by a fixed 14% does not fix the fundamental problem: Risk Adjustment must adjust for *actuarial risk*. Even with a 14% reduction in Statewide Average Premium, CMS is still transferring funds based on relative premiums instead of actuarial risk.

This is not permitted by the Risk Adjustment statute, whether it is applied as budget neutral or not.

146. The Risk Adjustment formula, as developed and implemented by CMS, is arbitrary, capricious, and contrary to the intent and text of the law. HHS and CMS have gone beyond the bounds of their statutory directive, injecting unauthorized factors into the Risk Adjustment methodology. The Risk Adjustment methodology they have created is forcing insurers to shutter, premiums to rise, and American consumers to suffer. It must be invalidated.

B. The Risk Adjustment Methodology Violates the Intent and Text of the ACA by Penalizing Insurers that Sell Low Cost Bronze Plans

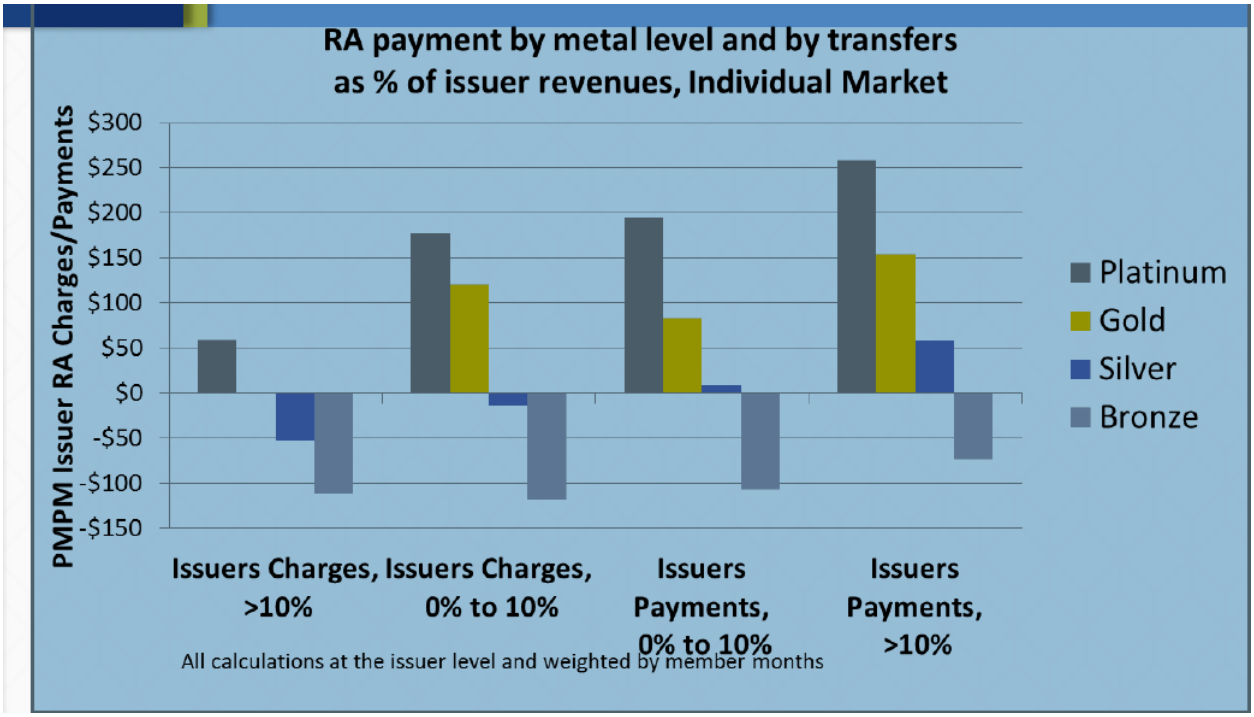
147. Under the ACA, health insurance policies offered on the public exchanges, like those offered by Minuteman in New Hampshire and Massachusetts, must adopt certain standardized terms and conditions for differing types of coverage. Those standards are categorized by metallic levels: Bronze, Silver, Gold and Platinum.

148. The metallic levels differ in how costs are shared between issuer and enrollee. In Bronze plans, the issuer must cover 60% of health care costs, while the issuer covers 70% in Silver, 80% in Gold, and 90% in Platinum. Bronze plans have the lowest premiums but the highest deductibles. Platinum plans, by contrast, have the highest premiums and the lowest deductibles. As a result, consumers that do not anticipate significant health care needs and/or are price-sensitive tend to purchase Bronze or Silver products as opposed to Gold or Platinum products, because of the lower monthly premium expense.

149. Instead of building the Risk Adjustment formula to transfer funds based on underlying member risk, CMS instead built the Risk Adjustment formula to penalize issuers that sell Bronze products – *i.e.* issuers who cater to price sensitive consumers. Once the Risk Adjustment formula is applied, insurance companies *always pay out money on Bronze products*.

This cannot be a function of adjusting solely for actuarial risk of the member population. It is instead a function of adjusting for the *nature of the insurance plan*, resulting in issuers that sell low cost Bronze plans subsidizing those who sell more expensive Gold and Platinum plans to members with the same actuarial profile.

150. CMS's own data shows that in 2014, there was no scenario under which an insurer would receive Risk Adjustment transfer payments for a Bronze plan. Under the Risk Adjustment formula, insurers of all sizes in the small group and individual markets were subject to a Risk Adjustment assessment with respect to their Bronze plans. *See* Ex. 29, CMS, *HHS-Operated Risk Adjustment Methodology Meeting* (Mar. 31, 2016), at 31, available at https://www.regtap.info/uploads/library/RA_ConferenceSlides_033116_5CR_040516.pdf.



151. Because insurers must always pay out Risk Adjustment dollars on Bronze products, those products are likely to have a negative margin after Risk Adjustment. That result is illustrated in Minuteman's own claims data. After Risk Adjustment, Minuteman's medical

loss ratio for Bronze members is 109.2%, more than any other metallic tier and well in excess of the total amount of premium collected for those members.

152. CMS's Risk Adjustment methodology once again uses a factor – this time differential weighting by metallic level – wholly unrelated to actuarial risk to achieve an artificial result not directed by the statute. In developing this methodology, CMS and HHS have acted in flagrant disregard of their limited authority and the directions expressly given by Congress.

153. By making a Bronze plan a money-loser no matter how healthy or sick the insured population is, CMS has *de facto* discouraged insurers from offering Bronze plan designs altogether – a wild policy overreach well beyond the limited Risk Adjustment program that Congress intended, and to the detriment of many consumers who desire and rely on these low-cost products. Not surprisingly, plans around the country are starting to drop their on-exchange Bronze products. *See e.g.*, Ex. 30, *Bronze Woes Raise Flags That Issuers Could Drop Entire Metal Tier*, INSIDEHEALTHPOLICY (May 4, 2016), available at https://insidehealthpolicy.com/daily-news/bronze-woes-raise-flags-issuers-could-drop-entire-metal-tier; Ex. 31, Michelle Andrews, *Virginia Insurer's Decision to Drop Bronze Plans Prompts Concerns*, KAISER HEALTH NEWS (May 27, 2016), available at http://khn.org/news/va-insurers-decision-to-drop-bronze-plans-prompts-concerns.

154. Though Minuteman and other commenters raised this issue in response to the 2018 Proposed Rule, HHS and CMS are taking no action on it. It is barely mentioned in the 2018 Final Rule. *See* HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. at 94,083 (briefly noting, but failing to address, comments suggesting the Risk Adjustment formula disadvantages Bronze plans).

155. Congress surely did not intend, and definitely did not direct, HHS/CMS to penalize mission-driven issuers who expand accessibility to affordable Bronze products and reward issuers that cater to consumers who purchase more expensive products. Quite the contrary.

156. CMS's *ultra vires* actions are plainly outside the statutory mandate. Wiping out Bronze plans is not the result of adjusting for actuarial risk. It is the result of improperly weighting plans by metallic level, separate and apart from the risk profile of their enrollees. The Risk Adjustment statute does not contemplate use of this factor in the Risk Adjustment methodology. It is, therefore, arbitrary, capricious, and unlawful.

C. CMS's Risk Adjustment Methodology is Arbitrary and Capricious Because It Blatantly Ignores the Actuarial Risk of Consumers Without an HCC Score

157. As noted above, CMS's Risk Adjustment formula begins by calculating a risk score for each enrollee. The risk score is intended to reflect the relative health status and, correspondingly, the relative anticipated cost of care that person will utilize. The higher the risk score, the sicker the individual and the greater the anticipated health care costs. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409, 15,419-52 (Mar. 11, 2013) (setting forth the final methodology for calculating Risk Adjustment payments).

158. The calculation for an individual's risk score begins with a coefficient (*i.e.* an assigned numeric value), which is based only on age and gender. That coefficient will be increased if the enrollee has been diagnosed with one or more hierarchal condition categories ("HCCs") documented during the plan year. Each HCC has a corresponding coefficient, with higher values intended to represent more serious and costly health conditions.

159. HCC coefficients are added to the age/gender coefficient to calculate an enrollees' overall risk score. Additional adjustments may be made for disease interaction and severity.

160. Enrollees who do not have an HCC are essentially deemed to be perfectly healthy, having only the risk that is reflected in their base coefficient. The Risk Adjustment methodology presumes these enrollees will not utilize health care services and will cost insurers little to no money.

161. These assumptions are demonstrably false.

162. In reality, enrollees with no HCCs nevertheless utilize health care services, and insurers therefore incur associated costs – costs that invariably exceed the minimal assumptions built into the Risk Adjustment model. Even healthy enrollees must utilize preventive care services and sometimes get sick and need medical care. An individual with no HCC could easily have a year where she contracts strep throat or the flu or experiences a catastrophic injury that is not captured by the HCCs.

163. There is a wide middle ground between being perfectly healthy and being so chronically ill as to merit an HCC score. For example, even though a diagnosis of Type 2 diabetes would trigger an HCC score, a severely overweight adult whose laboratory test results indicate a strong potential to develop diabetes in the future would not receive an HCC score. But such an individual needs clinical intervention immediately in the form of monitoring, nutritional guidance, and medication. In effect, by not adjusting a risk score until a patient is severely ill CMS penalizes early and aggressive preventive care and rewards delaying care until a patient is severely ill and lands in a hospital emergency room.

164. The Risk Adjustment methodology over-adjusts for this "healthy" population. Once the Risk Adjustment transfer formula is applied, insurers end up paying more money than they collect in premiums for this group of members. According to Minuteman's data, after application of Risk Adjustment, the medical loss ratio for its members without an HCC score exceeds 100%.

Number of HCCs	Risk Adjusted MLR
0 HCCs	102.7%
More than 1 HCC	68.8%

165. This means that Minuteman must pay out in medical costs more than it receives in premium payments from these enrollees – an unsustainable proposition. Notably, before application of Risk Adjustment, this same population has a medical loss ratio safely below 100%.

166. Under the Risk Adjustment formula, individuals with no HCCs are *liabilities* to insurance companies because the cost of having them enrolled exceeds the premiums collected. While Congress wanted to ensure that plans did not discriminate against the most chronically ill individuals, it did not authorize a reverse discrimination against covering everyone else. The Risk Adjustment formula artificially inflates the costs of covering anyone without a severe chronic illness, driving premiums up and making health insurance coverage a less viable option for relatively healthy individuals. But without the participation of healthier individuals, no insurance market can function.

167. On July 15, 2016, Richard Foster submitted a memorandum to CHOICES on this issue, stating "The current HHS-HCC risk adjustment model established by CMS is known to understate risk scores for relatively healthy individuals and to overstate them for those

with significant health conditions." Ex. 32, Memorandum from Richard S. Foster to CHOICES Exec. Comm. (July 15, 2016), at 1, available at http://www.choicescoalition.org/documents/HHS%20HCC%20RA%20model%20bias%20adjustment%20memorandum.pdf.

168. Again, CMS has acknowledged this problem and had announced plans to adjust the model *starting in plan year 2017*. *See id.* This is of little comfort to Minuteman and other insurers who are being arbitrarily flogged by the Risk Adjustment transfer formula now for reasons unrelated to the actual risk of their members.

169. Foster has identified a simple fix to this problem: swapping the risk scores that were used by CMS with risk scores that more accurately represent the *actual* costs associated with the HCCs. These adjustments can be made based on existing data. Foster's analysis shows that this relatively easy fix "would eliminate virtually all of the tendency in the existing risk adjustment model to understate risk scores for healthy individuals and groups and to overstate risk scores for those with significant health conditions." *Id.* at 2.

170. CMS has not only ignored the easy fix proposed by Foster, it has shrugged off this issue entirely, no longer planning to implement *any* fix in 2017 or even 2018.

171. In the 2018 Final Rule, CMS wrote: "Commenters generally supported addressing the underprediction of healthy and low-cost enrollees given that approximately 80 percent of enrollees in the [data] sample do not have HCCs. Commenters stated that this revision to the modeling would mitigate risk selection to avoid low-cost enrollees, and that this could result in slightly lower premiums for all enrollees." HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. at 94,083.

172. Despite consensus from CMS and commenters that there is a need to fix the Risk Adjustment model to correct for understating the actuarial risk of enrollees with low HCC scores and that a fix would lower premiums for all enrollees, HHS and CMS concluded that they will not implement any changes for 2018 "but will consider changes in future years." *Id.* at 94,082.

173. This is a complete abdication of their statutory duty.

174. Adjusting for actuarial risk requires the use of legitimate, actuarially-sound factors. The risk scores associated with HCCs are not that. HHS and CMS know that. And they know how to fix the problem. Yet, they have chosen to not to act. Through their decision to sit on their hands, HHS and CMS have placed insurers like Minuteman at risk and have punished citizens with higher-than-necessary premiums.

175. Congress directed HHS to develop a Risk Adjustment methodology that transfers money based on actuarial risk, not demonstrably faulty assumptions that bear no reasonable relationship to the underlying facts. HHS and CMS have, again, gone outside the bounds of their statutory directive with their arbitrary, capricious, and unlawful use of admittedly false assumptions as opposed to actuarially sound data.

D. The Risk Adjustment Methodology is Arbitrary and Capricious Because it Fails to Measure Actuarial Risk with Reasonable Accuracy

176. The Risk Adjustment methodology developed and implemented by HHS/CMS is arbitrary and capricious because it fails to properly measure actuarial risk. Specifically, the Risk Adjustment formula does not account for partial year enrollees and does not factor in prescription drug data. Failing to include these factors renders the Risk Adjustment methodology actuarially unsound and at odds with the statute.

177. The Risk Adjustment methodology rewards issuers who do not attract partial year enrollees, separate and apart from actuarial risk of the insurer's population. The methodology entirely fails to adequately account for individuals who are enrolled for less than a full year, which is commonly referred to as "partial year enrollment."

178. The risk scores for these individuals often understate their health status and corresponding cost to the insurer. This is because a partial year enrollee, who starts with their baseline risk coefficient based on age and gender, may not receive an HCC diagnosis during the portion of the year in which he/she is enrolled in the health plan. Thus, the issuer lacks full knowledge of the enrollee's health status.

179. This is true even if the enrollee is filling prescriptions or otherwise utilizing health care services related to the un-recorded HCC diagnosis. A common scenario is a diabetic patient who does not receive a diagnosis during his partial year enrollment, but nevertheless is filling prescriptions for insulin. Without the diagnosis, this patient's risk score will not reflect that he has diabetes.

180. The problem with partial year enrollment is purely one of timing – if the enrollee visits a doctor and receives an HCC diagnosis that is properly transmitted to the issuer, the enrollee's risk score will be adjusted to reflect the HCC. However, if the enrollee does not receive the diagnosis from his or her 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.

181. This timing problem becomes obvious when looking at the risk adjusted medical loss ratio of patients compared to their duration of enrollment. Minuteman's 2015 New Hampshire data starkly show the impact of enrollment duration on Risk Adjusted medical loss ratio:

Enrollment Duration of Member	Risk Adjusted MLR
Under 6 months	122.1%
Over 6 months	90.4%

CMS's Risk Adjustment methodology fails to account for a factor – partial year enrollment – which results in issuers being penalized for the duration of their members' enrollment, a penalty which is wholly unrelated to actuarial risk. In developing this methodology, CMS and HHS have acted in flagrant disregard of their limited authority and the directions expressly given by Congress.

182. In the 2018 Final Rule, CMS acknowledged that actuarial risk tends to be under-predicted for adult enrollees with short enrollment periods and over-predicted for adult enrollees with full enrollment periods. *See id.* at 94,072. To correct for this, CMS will implement adjustments to the Risk Adjustment formula beginning for benefit year 2017. Specifically, CMS will use "additional risk factors by number of enrollment months that decrease monotonically as the number of months of enrollment increases…" *Id.*

183. Having identified the problem with the way the Risk Adjustment methodology treats partial year enrollees and a solution to fix that problem, there can be no doubt that the manner in which the Risk Adjustment methodology was implemented for benefit years 2014-2016 was wrong. CMS should apply the fix to *all* benefit years and should correct past Risk Adjustment assessments accordingly.

184. Similarly, the Risk Adjustment methodology fails to include prescription drug information, thereby distorting relative risk scores and rendering the methodology actuarially unsound.

185. Consider the diabetes patient used as an example above: he has been managing his diabetes with insulin, but has not been to a physician recently and thus has no HCC code.

186. The insulin prescription plainly indicates that he is a diabetic, but that is of no consequence. The Government's Risk Adjustment methodology does not consider prescription drug data, even though it is readily available and often a reliable source of information regarding an individual's health status.

187. The Government's failure to consider prescription drug data results in understated risk scores that do not accurately reflect real actuarial risk.

188. This issue has been raised *ad nauseum* with CMS. Though CMS has acknowledged the incomplete picture that results from ignoring prescription drug data and the resulting inaccurate risk score, CMS does not plan to do anything about it until 2018.

189. In the 2018 Final Rule, CMS conceded the necessity of using prescription drug utilization data to better calculate an enrollees' actuarial risk rather than relying solely on diagnosis codes to identify medical conditions for each enrollee. *See id.* at 94,076. Thus, CMS will implement a hybrid drug-diagnosis Risk Adjustment model that factors in limited prescription drug utilization data beginning in benefit year 2018. *See id*. Use of the prescription drug utilization data not only will lead to more accurate assessment of health risk but also further correct the understated risk for partial year enrollees. As CMS describes it, this is a "major change" to the Risk Adjustment methodology. *Id.*

190. Where, as here, CMS has identified a gap in the Risk Adjustment methodology and a corrective measure, it needs to make the correction *now* and it needs to make carriers whole for imposing on them an improper methodology in past years. Past Risk

Adjustment assessments as well as the future calculations for 2016 and 2017 should be revised to reflect inclusion of the drug utilization data, which CMS has finally recognized as a necessary factor in calculating actuarial risk. By promising to fix the broken system *in 2 years*, CMS is effectively admitting that it is flouting its statutory obligations to adjust for actuarial risk and fully intends to continue doing so. It is not within CMS's authority to knowingly operate a Risk Adjustment model that does not properly adjust for actuarial risk. Minuteman and the other insurers who have been wrongfully penalized by the flawed Risk Adjustment methodology should be made whole, and any future Risk Adjustment calculations should be based on a formula that does its job – *i.e.* adjusts for actuarial risk.

E. Minuteman Has Repeatedly Raised its Objections to the Risk Adjustment Formula to No Avail

191. To the extent that Minuteman was subject to a requirement to exhaust administrative remedies, it has clearly done so.

192. As noted *supra*, the government's failure to include prescription drug data in its Risk Adjustment formula has been raised *ad nauseum* with CMS to no avail. But, prescription drug data is not the only methodological flaw that has been raised *ad nauseum* to no avail. Minuteman has consistently (and persistently) objected to and informed CMS of methodological flaws in its Risk Adjustment methodology.

193. CMS issues the Risk Adjustment methodology every year in its Notice of Benefit and Payment Parameters. On December 7, 2012, CMS issued its Proposed Rule regarding Notice of Benefit and Payment Parameters and outlining the 2014 Risk Adjustment formula, and issued its Final Rule outlining the 2014 Risk Adjustment formula on March 11, 2013. HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,117 (proposed Dec. 7, 2012); HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409

(Mar. 11, 2013), *as amended by* Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 65,045 (Oct. 30, 2013). On December 2, 2013, CMS issued its Proposed Rule regarding Notice of Benefit and Payment Parameters and outlining the 2015 Risk Adjustment formula, and issued its Final Rule outlining the 2015 Risk Adjustment formula on March 11, 2014. HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,321 (proposed Dec. 2, 2013); HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,743 (Mar. 11, 2014). On November 26, 2014, CMS issued its Proposed Rule regarding Notice of Benefit and Payment Parameters and outlining the 2016 Risk Adjustment formula, and issued its Final Rule outlining the 2016 Risk Adjustment formula on February 27, 2015. HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,673 (proposed Nov. 26, 2014); HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,749 (Feb. 27, 2015). On December 2, 2015, CMS issued its Proposed Rule regarding Notice of Benefit and Payment Parameters and outlining the 2017 Risk Adjustment formula, and issued its Final Rule regarding the 2017 Risk Adjustment formula on March 8, 2016. HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75,487 (proposed Dec. 2, 2015); HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203 (Mar. 8, 2016). On March 24, 2016, CMS issued its Discussion Paper regarding the Risk Adjustment methodology, and held a public conference to collect commentary regarding the Risk Adjustment program on March 31, 2016. *See* Ex. 1, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016); Ex. 29, CMS, *HHS-Operated Risk Adjustment Methodology Meeting* (Mar. 31, 2016). On September 6, 2016, CMS published its Proposed Rule regarding Notice of Benefit and Payment Parameters for 2018 and issued its Final Rule regarding the 2018 Risk Adjustment Formula on December 22, 2016. HHS Notice of

Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61,455 (proposed Sept. 6, 2016); HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94,057 (Dec. 22, 2016).

194. Minuteman objected to the Risk Adjustment methodology set forth in these Notices of Benefit and Payment Parameters in docketed comments as well as in letters, phone calls and in person meetings, in the years that it was affected.

195. Minuteman submitted comments (which were docketed) to CMS articulating the numerous flaws in the Risk Adjustment methodology during the open comment period for each proposed rule after initially receiving its first Risk Adjustment assessment. On December 21, 2015, Minuteman submitted a comment to CMS explaining that the Risk Adjustment formula has "serious technical and methodological flaws which adversely impact new, rapid-growth, value-driven insurance plans." Ex. 33, Minuteman Health, *Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2017 (CMS-9937-P)* (Dec. 21, 2015), at 4, available at https://www.regulations.gov/document?D=CMS-2015-0128-0385. Further, "[a]s HHS is well aware, these programmatic flaws have driven the withdrawal or outright failure of a number of marketplace plans." *Id.* Minuteman specifically called out the failure of the methodology to capture partial year enrollees, and the need to recalculate the weights assigned to HCCs. *Id.* Minuteman also submitted the CHOICES white paper which clearly articulated the numerous flawed aspects of the methodology.

196. The December 21, 2015 comment and attached white paper specifically explained the problems created by the use of the Statewide Average Premium. As explained in this submission, the use of this premium penalizes efficient low-cost issuers because they offer

less expensive premiums. *Id.* at 6. The submission further explained that reconstructing the formula based on a plan's own average premium would ameliorate the problem. *Id.* at 7.

197. On July 5, 2016, Minuteman submitted another comment articulating the various problems in the Risk Adjustment methodology, including the use of the Statewide Average Premium, and its penalization of issuers that have created high-value products through reduced administrative costs. *See* Ex. 34, Minuteman Health, *Amendments to the Risk Adjustment Program, Special Enrollment Periods, and the Consumer Operated and Oriented Plan Program CMS-9933-IFC* (July 5, 2016), available at https://www.regulations.gov/document?D=CMS-2016-0070-0015. Minuteman also submitted the CHOICES white paper again with this comment, thus noting its continued objection to the Risk Adjustment methodology and its use of the Statewide Average Premium.

198. On October 6, 2016, Minuteman submitted comments, along with the Axene analysis and other voluminous appendices, explaining why the Proposed Notice of Benefit and Payment Parameters for 2018 was not sufficient to correct the problems with the Risk Adjustment methodology.

199. As noted *supra*, Minuteman did not enter the New Hampshire market (a market with a federally run Risk Adjustment program) until 2015, and Massachusetts opted to run its own Risk Adjustment program prior to 2017. Accordingly, prior to 2015, Minuteman lodged its objections to Risk Adjustment with Massachusetts state officials who were administering the Massachusetts Risk Adjustment program.

200. Minuteman repeatedly and forcefully raised its concerns about Risk Adjustment to the Connector, in both written and oral communications. For example, Minuteman sent letters articulating its concerns on January 30, 2015 and March 23, 2015. *See*

Ex. 35, Letter from Thomas D. Policelli, CEO, Minuteman, to Edward DeAngelo, GC, Commonwealth Health Ins. Connector Auth. (Jan. 30, 2015); Ex. 36 , Letter from Thomas D. Policelli, CEO, Minuteman, to Edward DeAngelo, GC, Commonwealth Health Ins. Connector Auth. (Mar. 23, 2015). In its March 2015 letter, Minuteman specifically noted the problematic use of the Statewide Average Premium in lieu of a carrier's own average premium, explaining that the use of this premium penalizes low-cost carriers and creates a disincentive to provide low premiums. *See id.* at 5, 7-8.

201. Despite Minuteman raising these issues, Massachusetts has been unable to do anything to fix them, explaining that their hands are tied by the federal government.

202. Minuteman also raised its concerns with the Risk Adjustment methodology through letters, calls and meetings with HHS staff. On June 22, 2015, Minuteman wrote to Kevin Counihan at CMS requesting a waiver in Massachusetts from the federal Risk Adjustment program. *See* Ex. 37, Letter from Thomas D. Policelli, CEO, Minuteman, to Kevin Counihan, Dir. & Marketplace CEO, Minuteman (June 22, 2015). This letter articulated the destabilizing effects that implementation of the federal program would have in Massachusetts. In this letter, Minuteman yet again raised the problematic use of the Statewide Average Premium, explaining its unfair penalization of narrow network plans.

203. On April 22, 2016, the CHOICES coalition (of which Minuteman is a member) sent a letter to HHS, again explaining, among other things, the flaws in the use of the Statewide Average Premium and the failure to account for prescription drugs. *See* Ex. 38, Letter from CHOICES to CMS (Apr. 22, 2016). Regarding the Statewide Average Premium, CHOICES explained that the use of this premium is unreliable and that its failure to incorporate

differences in efficiency among plans "can result in overcompensating inefficient, higher priced plans, and conversely, disproportionately hurt efficient, lower priced ones." *Id.* at 3.

204. On May 31, 2016, Minuteman sent a letter to CMS identifying the adverse impact Risk Adjustment had on CO-OPs. *See* Ex. 39, Minuteman Health, *Impact of ACA 'Risk Adjustment' Program on COOPs and Their Valuation* (May 31, 2016). Minuteman then discussed this letter during an in-person meeting on June 2, 2016.

205. Minuteman also repeatedly brought up the flaws in regularly-scheduled agency calls. Specifically, Minuteman raised the flawed aspects and their harm on Minuteman during calls on February 23, 2015; April 20, 2015; May 18, 2015; June 24, 2015; July 20, 2015; August 17, 2015; September 21, 2015; October 22, 2015; November 9, 2015; November 23, 2015; November 30, 2015; December 7, 2015; December 21, 2015; January 4, 2016; January 11, 2016; January 25, 2016; February 1, 2016; February 22, 2016; February 29, 2016; March 7, 2016; March 21, 2016; April 4, 2016; April 11, 2016; April 25, 2016; May 2, 2016; May 9, 2016; June 6, 2016; June 13, 2016; and June 20, 2016.

206. In addition to the back-and-forth described above, CMS also held public meetings and discussions regarding Risk Adjustment at which Minuteman and others detailed the flaws with the methodology. For example, CMS hosted a conference following publication of the March 2016 white paper. In the 2018 Final Rule, CMS acknowledged the input it received at that conference: "We received numerous thoughtful and substantive comments to the White Paper and at the conference, which directly informed the policies in this Payment Notice." HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. at 94,070.

207. Despite the abundant notice that the methodology runs afoul of the Risk Adjustment statute and produces results that are anathema to the purpose of the ACA, CMS has

failed to take corrective action. In fact, based on the 2018 Final Rule, it is plain that CMS does not intend to fix its arbitrary and capricious Risk Adjustment methodology in the foreseeable future. Accordingly, Minuteman has been forced to seek relief from this Court.

COUNT ONE
(Violations of Section 1343 of the ACA and the APA, 5 U.S.C. § 706)

208. Minuteman incorporates by reference all preceding paragraphs of this Complaint.

209. Section 1343 of the ACA directs the Secretary, in consultation with the States, to "establish criteria and methods" to effectuate Risk Adjustment by charging health insurance issuers with "less than the average actuarial risk of all enrollees in all plans or coverage" in a given state and making payments to health insurance issuers with "greater than average actuarial risk of all enrollees in all plans and coverage" in that state.

210. The Risk Adjustment methodology developed and implemented by CMS, at the direction of HHS, as set forth in 78 Fed. Reg. 15,409, 78 Fed. Reg. 65,045, 79 Fed. Reg. 13,743, 80 Fed. Reg. 10,749, 81 Fed. Reg. 12,203, and 81 Fed. Reg. 94,057 does not effectuate the mandate of § 1343. It acts outside the mandate by transferring money based on relative premiums and other factors that have no bearing on actuarial risk.

211. The Risk Adjustment methodology developed and implemented by CMS, at the direction of HHS, as set forth in 78 Fed. Reg. 15,409, 78 Fed. Reg. 65,045, 79 Fed. Reg. 13,743, 80 Fed. Reg. 10,749, 81 Fed. Reg. 12,203, and 81 Fed. Reg. 94,057 does not effectuate the goal of Congress to stabilize the health insurance marketplace.

212. The Risk Adjustment methodology developed and implemented by CMS, at the direction of HHS, as set forth in 78 Fed. Reg. 15,409, 78 Fed. Reg. 65,045, 79 Fed. Reg.

13,743, 80 Fed. Reg. 10,749, 81 Fed. Reg. 12,203, and 81 Fed. Reg. 94,057 does not effectuate the goals of the ACA to expand access to affordable health care.

213. Nor does the Risk Adjustment methodology developed and implemented by CMS, at the direction of HHS, effectuate the goals of the ACA's CO-OP program, through which Minuteman obtained start-up and solvency funds. The ACA's CO-OP program was designed to support new market participants who would increase competition, provide innovative health care delivery models, and offer low cost premium options.

214. The Risk Adjustment methodology does not adjust for actuarial risk, does not promote stability in the markets, and does not promote access to affordable health care. Rather, it severely penalizes Minuteman and other small, innovative insurers for reducing premiums based on costs unrelated to actuarial risk, for offering Bronze plans to cost-conscious consumers, and by inaccurately measuring actuarial risk.

215. The Risk Adjustment methodology developed and implemented by CMS, at the direction of HHS, is arbitrary, capricious, and unlawful. It flouts Congressional intent and the express mandate of the Risk Adjustment statute. HHS and CMS have gone beyond the bounds of their statutory directive, injecting unauthorized factors into the Risk Adjustment methodology, and failing to create a methodology that effects the directive of Congress. Accordingly, the methodology, as developed and implemented by HHS and CMS violates Section 1343 of the ACA and also violates the APA, 5 U.S.C. § 706.

PRAYER FOR RELIEF

WHEREFORE, Plaintiff respectfully asks this Court to enter judgment in its favor and against Defendants and to:

1. Declare that the Risk Adjustment methodology applied to Minuteman for benefit years 2014 and 2015 and intended to be applied going forward is arbitrary, capricious, and contrary to law, in violation of the APA and Section 1343 of the ACA;

2. Declare that the Risk Adjustment methodology must be revised to comply with the express language and intent of Section 1343 of the ACA;

3. Enjoin further application of the unlawful and improper Risk Adjustment methodology;

4. Enjoin the Government from implementing the 2018 Final Rule.

5. To the extent any adjustments are made to the Risk Adjustment methodology, declare that such adjustments must be applied for all benefit years from 2014 forward. This includes but is not limited to CMS's plans to (a) make adjustments for partial year enrollees beginning in benefit year 2017, (b) utilize prescription drug utilization data beginning in benefit year 2018, (c) reduce the Statewide Average Premium by 14% beginning in benefit year 2018.

4. Enjoin the Government from imposing on or collecting from Minuteman a Risk Adjustment assessment until such time as the methodology has been revised to comply with the express language and intent of Section 1343 of the ACA;

5. To the extent permitted, award Minuteman costs and attorneys' fees; and

6. Award Minuteman such other relief as this Court may deem necessary and appropriate.

Dated: January 12, 2017

Respectfully submitted:

/s/ *William M. Taylor*

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CERTIFICATE OF SERVICE

I hereby certify that this document filed on January 12, 2017 through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on the date of electronic filing.

/s/ *William M. Taylor*
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