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

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

Plaintiff,

vs. Civ. Case No. 1:18-cv-00773

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

Defendants.

NEW MEXICO HEALTH CONNECTIONS' MEMORANDUM OF LAW IN SUPPORT OF ITS MOTION FOR SUMMARY JUDGMENT

Pursuant to Rule 56 of the Federal Rules of Civil Procedure and the Local Rules for the United States District Court for the District of New Mexico, Plaintiff New Mexico Health Connections ("NMHC"), by and through its undersigned counsel, respectfully submits the following memorandum of law in support of its Motion for Summary Judgment against HHS[1] in support of its claims that HHS violated the Administrative Procedure Act ("APA") (Count I) and NMHC's due process rights (Count II) by issuing the "Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year" (the "2017 Rule") without public notice and comment.

[1] Defendants include the United States Department of Health and Human Services ("HHS"), the Centers for Medicare and Medicaid Services ("CMS"), Alex M. Azar, Secretary of HHS, and Seema Verma, Administrator of CMS. For ease of reference, Defendants will be collectively referred to as HHS throughout this Memorandum.

I. INTRODUCTION

In keeping with what appears to be becoming the agency's preferred practice, HHS has once again promulgated a rule in blatant disregard of the APA's notice and comment requirements. This is despite the fact that three district courts around the country have struck down HHS's rulemakings in the last two years for failing to comply with the APA's provisions for notice and comment procedures. *See California v. HHS*, 281 F. Supp. 3d 806 (N.D. Cal. 2017); *Pennsylvania v. Trump*, 281 F. Supp. 3d 553 (E.D. Pa. 2017); *Dialysis Patient Citizens v. Burwell*, No. 4:17-CV-16, 2017 U.S. Dist. LEXIS 10145 (E.D. Tex. Jan. 25, 2017).

HHS does not appear to have learned from its past mistakes. Much like its earlier failed attempts to invoke the good cause exception to notice and comment requirements, its most recent attempt – the new 2017 Rule governing the Affordable Care Act's risk adjustment program for benefit year 2017 – falls far short of meeting the narrow good cause exception.

HHS contends that it has good cause to skirt its obligations under the APA because notice and comment would be impracticable, unnecessary, and contrary to public interest. HHS offers three purported justifications: (1) it would be impracticable to proceed with notice and comment because HHS has a self-imposed deadline to make risk adjustment transfers (never mind that HHS could have easily met its deadline had it not dithered for months before issuing the 2017 Rule); (2) HHS speculates that some insurers could suffer some harm and may increase premiums if it does not implement the 2017 Rule immediately, though it cites no evidence to support this; and (3) HHS contends that it previously offered notice and comment so it is unnecessary to do so again. None of these assertions hold water, as HHS should well know. Similar excuses have been rejected by the courts time and again.

Indeed, when reviewing HHS's "good cause" explanation in the 2017 Rule, one might be overwhelmed with a sense of *déjà vu*, and with good reason: HHS provided the *very*

same arguments in support of its prior attempts to bypass notice and comment in other areas, which were all *summarily rejected*. In *California v. HHS*, 281 F. Supp. 3d 806 (N.D. Cal. 2017), the Court evaluated and rejected HHS's timing-related claim that the agency needed to provide immediate guidance, explaining:

> If good cause could be satisfied by an Agency's assertion that normal procedures were not followed because of the need to provide immediate guidance and information . . . then an exception to the notice requirement would be created that would swallow the rule.

Id. at 828 (internal quotations and citations omitted). The United States District Court for the Eastern District of Pennsylvania also rejected HHS's attempt to rely on an alleged timing emergency: "urgency is not sufficient in the absence of a deadline imposed by Congress, the executive, or courts." *Pennsylvania v. Trump*, 281 F. Supp. 3d 553, 573 (E.D. Pa. 2017).

In *Pennsylvania,* the Court further rejected HHS's proffered statements of good cause when they, like here, were wholly speculative and without any evidentiary support. The Court explained that such "speculation, unsupported by the record," or "a single comment" was insufficient. *Id.* at 574. Similarly, in *Dialysis Patient Citizens v. Burwell*, No. 4:17-CV-16, 2017 U.S. Dist. LEXIS 10145 (E.D. Tex. Jan. 25, 2017), HHS tried to claim good cause based on sheer speculation, which the Court rejected outright: "speculation . . . does not provide good cause to bypass notice and comment." *Id.* at *12.

The *Pennsylvania* court also flatly rejected HHS's claim that the opportunity to comment on previous iterations of the rule rendered the opportunity to comment on the new rule "unnecessary": "[HHS] cite[s] no case, and research has not disclosed any, finding that notice and comment is unnecessary where an agency has received ample commentary on its prior interpretations of the same law." 281 F. Supp. 3d at 574. Moreover, in the instant case, HHS's claims that there was prior opportunity to comment ring especially hollow because HHS

explicitly refused to consider comments submitted in response to the previous iteration of the rule.

HHS has once again failed to establish good cause to bypass the APA's notice and comment requirements and the Court should vacate the 2017 Rule. This is a straightforward legal issue that NMHC respectfully submits can and should be readily decided on an expedited basis, and will be fully case dispositive.[2] Should this motion be denied, the parties can proceed to the more record-intensive review necessitated by the substantive attack on the 2017 Rule in Count III of the Complaint.

II. STATEMENT OF FACTS

A. The Risk Adjustment Program

1. At issue in this case are the agency rules regarding the risk adjustment ("Risk Adjustment") program promulgated under the Affordable Care Act ("ACA"). Risk Adjustment was implemented as one of three premium stabilization programs designed to mitigate the risk associated with the ACA's guaranteed issue and community rating requirements, which prohibit insurance issuers from denying coverage or increasing rates based on an individual's health status. *See* ACA, Pub. L. No. 111-148, § 1201 (codified at 42 U.S.C. §§ 300gg-1 – 300gg-5).

2. The guaranteed issue and community rating provisions made it difficult for issuers to accurately predict health care costs. To mitigate against the inherent financial risks associated with insuring this new class of previously uninsured Americans, the ACA established three premium stabilization programs, including the Risk Adjustment program. The other two programs sunset after 2016; only Risk Adjustment was in effect in 2017.

[2] NMHC is not moving for a preliminary injunction because it cannot show irreparable harm. Plaintiff is able to pay its (unlawfully assessed) risk adjustment charge for benefit year 2017.

3. The theory behind Risk Adjustment is fairly straightforward: it is designed to protect carriers from the risk of taking on a sicker-than-anticipated enrollee population by distributing funds to and making assessments against insurers based on the actuarial risk (*i.e.*, the relative health or sickness) of their enrollees.

4. The program is intended to level the playing field among insurers by preventing carriers from making or losing money solely because they draw healthier or sicker enrollees. Specifically, the ACA 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. . . .
>
> 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. . . .

42 U.S.C. § 18063(a)(1)-(2).

5. The ACA directs HHS to establish a Risk Adjustment methodology. While states have the option to operate their own risk adjustment programs, no states did so in 2017. ACA, Pub. L. No. 111-148, § 1343 (codified at 42 U.S.C. § 18063); HHS, Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203, 12,230 (Mar. 8, 2016).

6. HHS issues an annual Notice of Benefit and Payment Parameters ("NBPP") that sets the risk adjustment formula for a specific benefit year. Each NBPP is a separate notice and comment rulemaking proceeding under the APA.

7. While certain features of the Risk Adjustment formula have evolved over time, at a general level HHS's approach to Risk Adjustment has stayed the same. Relevant to

this matter is HHS's decision to use the statewide average premium in the Risk Adjustment methodology.

8. Each year, Risk Adjustment assessments and payments are based on "risk scores" ascribed to a plan's membership base.

9. To determine payments and charges, HHS multiplies the plan's overall average risk score by the (i) weighted statewide average premium and (ii) billable member months in a year.

10. HHS's decision to use the statewide average premium, rather than an insurer's own premium (or other alternatives), in the risk adjustment methodology has proven disastrous for efficient issuers who try to keep their premiums low through innovative plans and efficiencies, like NMHC, because the prices charged by the largest insurers skew the weighted average closer to their actual premium price. This creates a risk adjustment system that is based more on plan size than risk score, which leads to premium adjustment rather than risk adjustment.

11. NMHC, a relatively new market entrant, has been able to keep premiums low through its innovative proactive approach to care management. NMHC's philosophy is to drive better health care outcomes by managing and coordinating care, which not only leads to healthier New Mexicans, but also eliminates the enormous costs incurred when an individual's health deteriorates, requiring lengthy hospitalizations or other costly services. For example, NMHC has pursued the following initiatives:

a. No co-payments for chronic disease generic drugs and behavioral drugs, thus reducing barriers to adherence to medications that control and stabilize health conditions;

b. Personalized outreach to patients to ensure compliance with medication regimens;

c. Care coordination, including follow-up visits with primary care providers after a hospitalization;

d. Assistance of community health workers and social workers when needed;

e. Intense personalized medical management of high risk individuals.

Compl. at ¶ 67.

12. NMHC's relentless focus on improving health care by proactively intervening before an enrollee's health status declines has led to fewer costly hospitalizations and other expensive specialty care. This means lower medical expense costs for NMHC and, in turn, lower premiums for its enrollees. Because of this positive domino effect, in 2017 and 2018, NMHC offered the lowest cost or second lowest cost silver plans in a majority of New Mexico's five rating regions. *Id. at* ¶ 65. NMHC is a model of success. It is providing exactly the type of competition and choice that was contemplated by the ACA.

13. But Risk Adjustment has threatened to undermine NMHC's ability to continue improving the health of New Mexican consumers because, as currently designed, it penalizes low-cost efficient issuers in favor of their higher-cost competitors through its use of the statewide average premium. Each year, NMHC has been ordered to pay millions of dollars in Risk Adjustment to its larger, higher-priced competitors. This is not because NMHC has a healthier population; this is the result of the statewide average premium.

14. The perverse effect of using the statewide average premium is obvious when looking at NMHC's risk adjustment assessment for benefit year 2017. In the small group market in 2017, NMHC's risk score (as measured by HHS) was only 1.1% below the state average – that is, NMHC did not have healthier enrollees than average in any meaningful sense. Yet it was ordered to pay several million dollars of risk adjustment charges in the small group market because its premiums were 22% below the statewide average. The Risk Adjustment

program transferred funds not from low-risk to high-risk plans, but from affordable, low-cost plans to expensive plans. *Id.* at ¶ 96.

B. NMHC Sues HHS over the Risk Adjustment Formula

15. After the first year of Risk Adjustment results were released on June 30, 2015 (for benefit year 2014) and the flaws in the program became apparent, NMHC and others voiced their significant concerns about the Risk Adjustment methodology to HHS, especially the use of the statewide average premium. They did so through the next notice and comment rulemaking process that was conducted, which was for the 2017 NBPP. But these comments were ignored. HHS explicitly refused to address any comments related to the statewide average premium, stating "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).

16. Faced with the agency's refusal to address NMHC's and other stakeholders' concerns, NMHC was forced to seek legal recourse. On July 29, 2016, NMHC filed suit in the United States District Court for the District of New Mexico, challenging the 2014-2017 Risk Adjustment rules on numerous grounds under the APA. *See* No. 16-00878-JB-JHR (D.N.M.) (the "First Lawsuit"). NMHC later amended its Complaint to add a challenge to the 2018 NBPP.

17. On February 28, 2018, after voluminous briefing and lengthy oral argument, the Court sustained NMHC's challenge in part, finding the agency's justifications for using the statewide average premium in the Risk Adjustment formula were arbitrary and capricious. The Court accordingly vacated the Risk Adjustment regulations for benefit years 2014-2018 and remanded the matter back to the agency. *See New Mexico Health Connections v.*

United States Dept. of Health and Human Servs., et al., No. CIV 16-0878 JB/JHR, 2018 U.S. Dist. LEXIS 32908 (D.N.M. Feb. 28, 2018).

18. The Court's ruling gave HHS an opportunity to fix the problems with the Risk Adjustment program by initiating a new rulemaking. Instead, HHS took no action whatsoever during the five-month period between February 28, 2018 and July 24, 2018. It commenced no new rulemaking proceeding, nor did it reach out to NMHC to discuss its concerns. Rather, the agency simply moved for reconsideration of the Court's ruling on March 28, 2018. This motion is still pending.

19. In the meantime, as the motion for reconsideration was briefed and argued, the agency acted as if the Court's ruling did not exist. For months, it provided no statement or guidance about how it intended to act in light of the Court's Order.

C. <u>The Risk Adjustment Suspension and New 2017 Rule</u>

20. Under HHS's standard procedures, it was scheduled to publish 2017 Risk Adjustment calculation results on or before June 30, 2018. However, because it failed to act following the Court's Order, there was no 2017 Risk Adjustment regulation in place on June 30. Accordingly, HHS did not publish its 2017 Risk Adjustment results.

21. On July 7, 2018 – more than four months after the Court's ruling – HHS made its first public statement on the status of risk adjustment, announcing that it was freezing Risk Adjustment payments for 2017 because there was no valid regulation in place. The agency did not announce any plans to initiate a new rulemaking at that time, but simply asserted that it hoped to win its pending motion for reconsideration. Stephanie Armour & Anna Wilde Mathews, *Trump Administration Halts Payments Expected by Health Insurers,* WALL ST. J. (July 7, 2018), https://www.wsj.com/articles/trump-administration-halts-payments-expected-by-health-insurers-1530992052.

22. For two weeks, HHS took no further action. Then, on July 24, 2018, HHS issued the new 2017 Rule. The new 2017 Rule did not correct the flaws that have plagued the risk adjustment formula. Rather, the 2017 Rule simply perpetuated the status quo by reinstating the formula adopted in the original 2017 NBPP. Contrary to the requirements of the APA, HHS did not allow for notice and comment. Instead, the new 2017 Rule was effective immediately upon publication. *See* HHS, Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year (July 24, 2018), at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS-9920-F-7-24-18-final.pdf, *effective upon adoption of* 83 Fed. Reg. 36,456 (July 30, 2018), attached as Exhibit 1.

23. In connection with issuing the 2017 Rule, HHS also issued its "Summary Report On Permanent Risk Adjustment Transfers For The 2017 Benefit Year" ("2017 RA Transfer Report"). According to the 2017 RA Transfer Report, NMHC will be assessed over $5.5M in Risk Adjustment charges for 2017. *See* HHS, 2017 RA Transfer Report, at 20 (July 9, 2018), https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.

24. HHS justified the departure from the normally required procedures of notice and comment by invoking the APA's "good cause exception," which permits an agency to bypass notice and comment when "the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefore in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553.

25. HHS makes three claims in support of its invocation of the good cause exception. First, HHS claims that a self-imposed deadline requiring payments to be issued in October required immediate agency action, making notice and comment impracticable. *See* 83

Fed. Reg. at 36,459 ("[I]t is now less than 2 months until risk adjustment payments for the 2017 benefit year . . . are due to begin.").

26. Second, and relatedly, HHS contends that a short delay to allow for notice and comment could possibly have deleterious effects on the market.

27. Third, HHS claims that notice and comment is "unnecessary" because it previously received and considered comments in issuing the 2017 NBPP and that "parties had the opportunity to comment on HHS's use of statewide average premium in the payment transfer formula under the HHS-operated risk adjustment methodology." 83 Fed. Reg. at 36,460.

28. All of these assertions fail.

III. STANDARD OF REVIEW

While district courts typically review summary judgment motions under Rule 56 of the Federal Rules of Civil Procedure, reviews of agency action under the APA are treated like appeals that are subject to the Federal Rules of Appellate Procedure. *See New Mexico Health Connections v. Dept. of Health & Human Servs. et al.,* No. CIV 16-0878 JB/JHR, 2018 U.S. Dist. LEXIS 32908, at *67 (D.N.M. Feb. 28, 2018) (citing *Olenhouse v. Commodity Credit Corp.*, 42 F.3d 1560, 1580 (10th Cir. 1994) ("the district court should govern itself by referring to the Federal Rules of Appellate Procedure.")). Thus, rather than seeking to determine whether a "genuine dispute as to any material fact" exists, the Court must "engage in a substantive review of the record." *See id.*, at *3 (citing *Olenhouse*, 42 F.3d at 1580). As this Court has explained, this approach "is importantly different from its summary-judgment approach, because 'judicial review of agency action is normally restricted to the administrative record.'" *Id.*, at *4 n. 2 (quoting *Lee v. U.S. Air Force*, 354 F.3d 1229, 1242 (10th Cir. 2004)); *see Camp v. Pitts*, 411 U.S. 138, 142 (1973) (stating "the focal point for judicial review should be the administrative record already in existence"); *see also* Fed. R. App. P. 16(a) ("The record on review or

enforcement of an agency order consists of . . . the order involved; . . . any findings or report on which it is based; and . . . the pleadings, evidence, and other parts of the proceedings before the agency.").

Because HHS bypassed public notice and comment, here the record consists solely of the 2017 Rule itself and the agency statements contained therein. *See Novelty, Inc. v. Tandy*, No. 1:04-cv-1502-DFH-TAB, 2006 U.S. Dist. LEXIS 57270, at *26 (S.D. Ind. Aug. 15, 2006) (finding that where an agency bypasses notice and comment and engages in no fact-finding, the administrative record is limited to the agency rulemaking action in question).

IV. ARGUMENT

A. HHS Violated Section 553 Of The APA By Failing To Engage in Notice-and-Comment Rulemaking

1. The APA's Notice and Comment Requirements Are a Critical Aspect of Agency Rulemaking

The APA requires an agency seeking to promulgate a substantive rule to do so through notice and comment procedures. 5 U.S.C. § 553. First, an agency must issue a general notice of proposed rulemaking. *Id.* at § 553(b). Second, the agency must give interested persons an opportunity to participate in the rulemaking through submission of written data, views, or arguments. *Id.* at § 553(c). Lastly, after consideration of the relevant matter presented, the agency shall incorporate in the rules adopted a concise general statement of their basis and purpose. *Id.*

The importance of the notice and comment process has long been recognized: "Notice requirements are designed (1) to ensure that agency regulations are tested via exposure to diverse public comment, (2) to ensure fairness to affected parties, and (3) to give affected parties an opportunity to develop evidence in the record to support their objections to the rule and thereby enhance the quality of judicial review." *Int'l Union, United Mine Workers of Am. v.*

MSHA, 407 F.3d 1250, 1259 (D.C. Cir. 2005); *see also Am. Radio Relay League, Inc. v. FCC*, 524 F.3d 227, 236 (D.C. Cir. 2008) (same); *California v. HHS,* 281 F. Supp. 3d at 825 (noting that it "is antithetical to the structure and purpose of the APA for an agency to implement a rule first, and then seek comment later.") (quoting *Paulsen v. Daniels*, 413 F.3d 999, 1005 (9th Cir. 2005)).

2. The Limited Application of the Good Cause Exception to Notice and Comment Requirements

The APA recognizes limited exceptions to the requirement of notice-and-comment rulemaking. Relevant here is the so-called "good cause exception", which provides that an agency need not give notice and entertain public comment in advance of a rulemaking:

> when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest

5 U.S.C. § 553(b)(3)(B).

The "good cause exception," is "essentially an emergency procedure," only to be invoked in very "narrow circumstances in which delay would do real harm." *California v. HHS*, 281 F. Supp. 3d at 825 (internal quotations and citations omitted); *Pennsylvania v. Trump*, 281 F. Supp. 3d at 572 (stating that "[t]he circumstances justifying reliance on the good cause exception are indeed rare and will be accepted only after the court has examined closely proffered rationales justifying the elimination of public procedures.") (internal quotations and citations omitted). While invocation of the exception can be an "important safety valve," it cannot be used "to circumvent the notice and comment requirements whenever an agency finds it inconvenient to follow them." *N. Arapahoe Tribe v. Hodel*, 808 F.2d 741, 751 (10th Cir. 1987). The good cause exceptions "are not 'escape clauses' that may be arbitrarily utilized at the agency's whim." *Am. Fed. of Gov't Employees, AFL-CIO v. Block*, 655 F.2d 1153, 1156 (D.C.

Cir. 1981). Accordingly, agency efforts to avoid the notice and comment procedures by invoking the good cause exception are "closely scrutinized." *Nat'l Women, Infants, & Children Grocers Ass'n v. Food & Nutrition Serv.*, 416 F. Supp. 2d 92, 104 (D.D.C. 2006).

In undertaking this requisite close scrutiny, courts recognize that the good cause exception is to be "narrowly construed and only reluctantly countenanced." *N.J., Dep't of Envtl. Prot. v. U.S. Envtl. Prot. Agency*, 626 F.2d 1038, 1045 (D.C. Cir. 1980); *Mack Trucks, Inc. v. EPA*, 682 F.3d 87, 93 (D.C. Cir. 2012) (same). Accordingly, courts review agency claims of good cause *de novo*. *See NRDC v. Nat'l Highway Traffic Safety Admin.,* Nos. 17-2780 & 17-2806, 2018 U.S. App. LEXIS 17881, *33-*34 (2d Cir. June 29, 2018) ("When reviewing an agency's claim of good cause, which we do *de novo*, . . . we must 'examine closely' the agency's explanation as outlined in the rule[.] . . . The burden is on the agency to establish that notice and comment need not be provided.") (internal citations omitted); *United States v. Ross*, 848 F.3d 1129, 1132 (D.C. Cir. 2017) ("We've said that the 'good cause' exception . . . is to be 'narrowly construed and only reluctantly countenanced.' . . . We review the agency's finding of good cause *de novo*.") (internal citations omitted); *Sorenson Commc'ns Inc. v. FCC*, 755 F.3d 702, 706 (D.C. Cir. 2014) ("Deference to an agency's invocation of good cause—particularly when its reasoning is potentially capacious, as is the case here—would conflict with this court's deliberate and careful treatment of the exception in the past. Therefore, our review of the agency's legal conclusion of good cause is *de novo*."); *Nat'l Venture Capital Ass'n v. Duke*, 291 F. Supp. 3d 5, 15-16 (D.D.C. 2017) ("The Court reviews an agency's finding of good cause *de novo*, and, in doing so, must 'examine closely' the agency's explanation as outlined in the rule.") (citations omitted).

3. HHS Fails To Meet Its Burden To Establish Good Cause for Bypassing Notice and Comment

1. A Self-Inflicted Timing Problem Does Not Constitute Good Cause

HHS's primary proffered rationale for bypassing notice and comment in promulgating the 2017 Rule is a so-called timing problem. According to HHS, notice and comment is impracticable because "it is now less than 2 months until risk adjustment payments for the 2017 benefit year . . . are due to begin." 83 Fed. Reg. at 36,459. In relying on this self-imposed deadline, which HHS is only struggling to meet due to its *own inaction* for months following the Court's February 28 ruling, HHS falls far short of meeting its heavy burden to demonstrate good cause. *See Nat'l Venture Capital Ass'n*, 291 F. Supp. 3d at 16 (stating that "[a]n agency faces an uphill battle to meet [its] burden" to demonstrate good cause). The mere existence of a deadline in and of itself does not constitute good cause. *See U.S. Steel Corp. v. U.S. Envtl. Prot. Agency*, 595 F.2d 207, 213 (5th Cir. 1979) (noting "the mere existence of deadlines for agency action, whether set by statute or court order, does not in itself constitute good cause" for bypassing notice and comment). Rather, "the agency must still show the impracticability of affording notice and comment." *Id.*

Moreover, if the agency's inability to meet a deadline is a result of its own dilatoriness, then good cause will not be found. Indeed, "[g]ood cause cannot arise as a result of an agency's own delay, because otherwise, ***an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory, judicial, or administrative deadline, then raise up the good cause banner and promulgate rules without following APA procedures.***" *NRDC*, 2018 U.S. App. LEXIS 17881, *36 (emphasis added and internal quotation omitted) (citing *Council of S. Mountains, Inc. v. Donovan*, 653 F.2d 573, 581 (D.C. Cir. 1981)). As courts have explained, "[w]e cannot agree . . . that an emergency of [the agency's] own making can constitute good cause." *Id.* (citation omitted)*; Wash. Alliance of*

Tech. Workers v. U.S. Dep't of Homeland Sec., 202 F. Supp. 3d 20, 26 (D.D.C. 2016) (noting that an agency's "own delay in initiating rulemaking" "did not come close to establishing a bona-fide emergency").

To that end, agency delay only amounts to good cause when the delay was imposed by factors *outside the agency's control*. *See Nat'l Venture Capital Ass'n*, 291 F. Supp. 3d at 16 (citing cases that repeatedly rejected good cause arguments when the agency delayed implementing its decision); *Council of S. Mountains*, 653 F.2d at 581 (allowing agency to dispense of notice and comment requirements where "we do not believe [agency] tarried . . . and then postponed the implementation date at the eleventh hour," but rather "the circumstances that ultimately forced [the agency] to postpone implementation of the regulations were beyond the agency's control").

Here, the so-called timing problem is *entirely of HHS's own creation* and thus does not constitute good cause to bypass notice and comment. The only deadline at issue is one imposed by the agency itself to make risk adjustment payments by October 2018. HHS's inability to meet this agency-imposed deadline can be attributed to nothing other than its own failure to act in the *five months* following the Court's February 2018 decision vacating the prior risk adjustment regulations. Quite tellingly, HHS proffers no explanation for its failure to take any action during that five-month period.

Moreover, HHS's claim that it would be unable to meet its self-imposed deadline had it allowed for notice and comment cannot withstand scrutiny. As a threshold matter, HHS made no findings about how long notice and comment would take and how long the alleged delay would be. This failure, in and of itself, justifies overturning the agency's good cause finding.

In past years, HHS has provided just less than a month for the public to submit comment on proposed Risk Adjustment rules. *See e.g.*, HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,673 (Nov. 26, 2014). Thus, if HHS followed past practice, it could have conducted a comment period from July 24, 2018 to August 20, 2018. Presumably, HHS could then issue a final rule, with the benefit of public comments, in September 2018 and restart Risk Adjustment payments and charges in October and November 2018. This would have resulted in a month delay at most – hardly a delay that warrants disregarding the requirements of the APA.

To permit HHS to exclude the public from its rulemaking process by purposefully delaying the 2017 Rule for months and then waving the "good cause banner" would undermine the importance of the notice and comment requirements and the exception itself. Accordingly, the Court should reject HHS's attempt to claim good cause based on its manufactured timing emergency.

2. HHS's Unsupported Claims about Potential Market Effects Do Not Constitute Good Cause

To try to bolster its claim that meeting its self-imposed October payment deadline constitutes good cause, HHS contends that prompt Risk Adjustment payments are imperative for market stability and predictability. 83 Fed. Reg. at 36,459. Specifically, HHS contends that prompt payments are necessary: 1) to maintain issuer confidence in the risk adjustment program; and 2) to ensure issuer solvency. According to HHS, a payment delay: 1) "*could* lead to higher premiums;" 2) "*could"* cause consumers to see a "significant premium increase;" 3) might result in an issuer exiting the market, which "*could* lead to significant, involuntary coverage losses;" and 4) "*could* impact the solvency of plans." *Id.* (emphasis added).

These unsupported "*could"* statements, which are offered without a shred of evidentiary support or citation, do not amount to good cause. As the D.C. Circuit has explained,

while fiscal threats may support good cause, speculation regarding such threats, without factual findings to support the reality of the threat, cannot properly be considered good cause. *Sorenson*, 755 F.3d at 706 ("The Commission cited . . . the threat of impending fiscal peril as cause for waiving notice and comment. Curiously, however, there were no factual findings supporting the reality of the threat. Instead, the agency speculatively stated 'absent Commission action, there *could* be insufficient funds available.'").

In *Sorenson*, the Court explained, "though no particular catechism is necessary to establish good cause, something more than an unsupported assertion is required." *Id.* at 707. Where, as here, HHS's proffered justification for bypassing notice and comment reflects nothing more than speculation and conjecture, the justification falls far short of the good cause standard. Indeed, fear a problem "could" occur might prompt a "cause for concern," but "hardly" demonstrates a crisis sufficient to bypass notice and comment. *Id.* at 702. Moreover, when the agency's proffered good cause consists of a "purely economic" risk, good cause does not exist. *See Dialysis Patient Citizens*, 2017 U.S. Dist. LEXIS 10145, at *12 ("[R]isk [that] is purely economic . . . does not supply good cause"); *Mack Trucks*, 682 F.3d at 94 (treating economic injury as sufficient to support good cause "would give agencies 'good cause' under the APA every time a [party] in a regulated field felt a new regulation imposed some degree of economic hardship").

The record here is devoid of a single evidentiary finding. Rather, HHS's good cause statement consists solely of unsupported "could" statements. HHS's failure to point to evidentiary support for its speculative claims is likely due to the fact that there is none. The hypothetical market effects HHS attempts to invoke are wholly illogical. First, HHS asserts that the lack of a Risk Adjustment rule for 2017 interfered with settled expectations. But this Court issued its judgment in the First Lawsuit on February 28, 2018; after that date, no issuer had any

reasonable expectation that the Risk Adjustment program would simply continue as previously promulgated because this Court had vacated the agency's regulations.

HHS further claimed that any alleged delay in finalizing the 2017 Rule would create uncertainty for rate filings and market participation for benefit year 2019. But there is an already finalized Risk Adjustment rule, which went through notice and comment, for the 2019 benefit year. HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16930 (April 17, 2018). Because the 2019 Risk Adjustment rule was not finalized until after judgment was entered in the First Lawsuit, it was not subject to this Court's earlier judgment.

In a final gasp, HHS makes the extraordinary claim that taking the time for notice and comment would have threatened the solvency of some unnamed insurance companies. This remarkable assertion is supported by no evidence whatsoever: there is not one insurance company named, nor any solvency or financial analysis cited. Indeed, HHS's newfound solicitude for the solvency of issuers is also deeply ironic. It is not a lack of Risk Adjustment payments that threatens issuer solvency. Rather, past out-of-control Risk Adjustment charges have rendered numerous issuers insolvent – a development that HHS indifferently shrugged off at the time. Compl. at ¶ 153.

Absent any findings of fact, backed by actual evidence, to support its speculative claims regarding market stability, HHS has not sufficiently established the requisite good cause to bypass notice and comment. *See Pennsylvania v. Trump*, 281 F. Supp. 3d at 574 (stating that hypothesizing, without factual support, is "merely speculation, unsupported by the record," and cannot constitute good cause).

3. The Agency Did Not Previously Consider Comments on the Statewide Average Premium for the 2017 Risk Adjustment Methodology

HHS's final justification for bypassing notice and comment is that it is "unnecessary" because:

> HHS has received and considered comments in issuing the 2014 through 2017 Payment Notices. In each of these rulemaking processes, parties had the opportunity to comment on HHS's use of the statewide average premium in the payment transfer formula . . .

83 Fed. Reg. at 36,460.

At the outset, this assertion is patently false. HHS *explicitly refused* to address comments on the statewide average premium when it first issued the 2017 NBPP, stating: "We did not propose changes to the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking." 81 Fed. Reg. at 12,230.

Even if HHS had properly considered and addressed comments related to the statewide average premium during the original 2017 NBPP rulemaking process, this would not justify bypassing notice and comment pursuant to the "unnecessary" prong of the good cause exception. To invoke this prong, HHS must show that the notice and comment procedures were "unnecessary ***so far as the public is concerned***, as would be the case if a minor or merely technical amendment in which the public is not particularly interested were involved." *N. Arapahoe Tribe*, 808 F.2d at 751 (emphasis added) (quoting S. Rep. No. 752, 79th Cong., 1st Sess. 14 (1945)). Indeed, the unnecessary prong of the exception "is confined to those situations in which the administrative rule is a ***routine determination, insignificant in nature and impact, and inconsequential to the industry and to the public***." *Utility Solid Waste Activities Grp. v. EPA*, 236 F.3d 749, 755 (D.C. Cir. 2001) (emphasis added) (internal quotations omitted).

Accordingly, courts have not excused agencies from complying with the notice and comment requirements under the unnecessary prong where, as here, the action at issue

concerned a matter of public interest. *Id.*; *see Mack Trucks,* 682 F.3d at 94 (finding notice and comment for EPA interim rule was not "unnecessary" because it was a rule "about which these members of the public [the petitioners] were greatly interested"). HHS's own statements that its Risk Adjustment methodology affects "billions of dollars" and is "imperative" to the "stability" of the insurance markets belie any claim that notice and comment on the 2017 Rule is insignificant or inconsequential such as to be deemed "unnecessary." 83 Fed. Reg. at 36,456; 36,459.

This is not the first time HHS has unsuccessfully tried to substitute proper rulemaking with past notice and comment procedures. In *Pennsylvania v. Trump*, 281 F. Supp. 3d at 574, the court rejected HHS' similar arguments about relying on past notice and comment for an interim final rule, concluding:

> Defendants cite no case, and research has not disclosed any, finding that notice and comment is unnecessary where an agency has received ample commentary on its prior interpretations of the same law. In fact, the significance of this issue and the outpouring of public comments reflect the opposite: the overwhelming public interest demonstrates that notice and comment is critical.

Accordingly, far from being "unnecessary," public notice and comment on the 2017 Rule is "critical."[3]

[3] Moreover, given the market developments that have occurred in the two years since the original 2017 NBPP was promulgated, HHS's failure to consider updated comments, based upon current conditions, renders its action arbitrary and capricious. Where an agency chooses to ignore new data without reasoned explanation, its conduct is arbitrary and capricious. *See e.g., Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d 1141, 1149 (10th Cir. 2016) (vacating agency's safety standard for magnets where agency, without reasoned explanation, ignored data showing "significant market changes triggered by" the agency's earlier regulatory efforts); *Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv*., 707 F.3d 462, 472-73 (4th Cir. 2013) (agency opinion on pesticides was arbitrary and capricious where agency, without adequate explanation, ignored "more recent available data" showing reductions in pesticides due to EPA regulation); *Sierra Club v. EPA*, 671 F.3d 955, 968 (9th Cir. 2012) (agency's approval of an environmental plan was arbitrary and capricious where plan was based on old data from an outdated model); *Maine Assoc. of Interdependent Neighborhoods v. Petit*, 659 F. Supp. 1309, 1322-23 (D. Me. 1987) (HHS' rule was arbitrary and capricious where HHS relied on old data that was no longer accurate and HHS "offered no evidence" to show that its rule was still reasonable; HHS was also arbitrary and capricious because it "completely failed to address" comments pointing out flaws of the old data).

4. The Court Must Vacate the 2017 Rule

As HHS lacked good cause to bypass notice and comment, the Court must vacate the 2017 Rule. When a court concludes that agency action is unlawful, "the practice of the court is ordinarily to vacate the rule." *Ill. Pub. Telecomms. Ass'n v. FCC*, 123 F.3d 693, 693 (D.C. Cir. 1997). "[D]eficient notice is a 'fundamental flaw' that almost always requires a vacatur." *Allina Health Servs. v. Sebelius*, 746 F.3d 1102, 1110 (D.C. Cir. 2014) (quoting *Heartland Reg'l Med. Ctr. v. Sebelius*, 566 F.3d 193, 199 (D.C. Cir. 2009)). Accordingly, "[w]hen notice-and-comment is absent, [courts have] regularly opted for vacatur." *In re Long-Distance Tel. Serv. Fed. Excise Tax Refund Litig.*, 853 F. Supp. 2d 138 , 144 (D.D.C. 2012); *see also CropLife Am. v. EPA*, 329 F.3d 876, 879 (D.C. Cir. 2003) (vacating regulation issued without notice and comment); *Mendoza v. Perez*, 72 F. Supp. 3d 168 , 175 (D.D.C. 2014) (vacating rule when agency failed to "engage in notice and comment," as error was "a fundamental procedural" one); *AFL-CIO v. Chao*, 496 F. Supp. 2d 76 , 91 (D.D.C. 2007) (noting that "failure to comply with the APA's notice-and-comment requirements is unquestionably a 'serious' deficiency").

B. In Bypassing Notice and Comment, HHS Has Deprived NMHC of Its Property in Violation of the Due Process Clause of the Constitution

In addition to violating the APA, HHS's decision to bypass notice and comment in promulgating the 2017 Rule has deprived NMHC of its property in violation of the Due Process Clause of the Fifth Amendment. The Fifth Amendment provides that "no person shall . . . be deprived of life, liberty, or property, without due process of law." U.S. Const. Amend. V. "The first inquiry in any due process challenge is whether the plaintiff has been deprived of a protected interest in property or liberty." *Am. Mfrs. Mut. Ins. Co. v. Sullivan,* 526 U.S. 40, 59 (1999) (internal citations omitted). Here, NMHC's property interest is the $5.5 million it has

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In addition, commenters were not given an opportunity to weigh in on the impact of this Court's opinion in the First Lawsuit.

been assessed under the 2017 Rule which it will be forced to pay to the federal government. *See* HHS, 2017 RA Transfer Report, at 20 (July 9, 2018), https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.

The second inquiry is whether the procedures surrounding the deprivation of the property interest were constitutionally sufficient. Due Process requires that NMHC be afforded some meaningful opportunity to be heard before its property is taken. *See generally LaBaron v. United States,* 989 F.2d 425, 428 (10th Cir. 1993). Because HHS has decided that it will not entertain any comments on the 2017 Rule, even after the effective date, NMHC has no opportunity to be heard at any time and thus its Due Process rights have been violated. *Cf. Hawaii Helicopter Operators Ass'n v. Federal Aviation Admin.*, 51 F.3d 212, 215 (9th Cir. 1995) (rejecting Due Process claim where agency agreed to receive and consider comments submitted after emergency rule went into effect).

V. CONCLUSION

For all the reasons set forth herein, NMHC respectfully requests that the Court grant its motion for summary judgment on Counts I and II of the Complaint and vacate, set aside, declare unlawful, and enjoin the 2017 Rule.

Dated: August 13, 2018

Respectfully submitted:

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Exhibit 1

■ 25. Section 257.105 is amended by adding paragraph (h)(14) to read as follows:

§ 257.105 Recordkeeping requirements.

* * * * *

(h) * * *

(14) The demonstration, including long-term performance data, supporting the suspension of groundwater monitoring requirements as required by § 257.90(g).

* * * * *

■ 26. Section 257.106 is amended by adding paragraph (h)(11) to read as follows:

§ 257.106 Notification requirements.

* * * * *

(h) * * *

(11) Provide the demonstration supporting the suspension of groundwater monitoring requirements specified under § 257.105(h)(14).

* * * * *

■ 27. Section 257.107 is amended by adding paragraph (h)(11) to read as follows:

§ 257.107 Publicly accessible internet site requirements.

* * * * *

(h) * * *

(11) The demonstration supporting the suspension of groundwater monitoring requirements specified under § 257.105(h)(14).

* * * * *

[FR Doc. 2018–16262 Filed 7–27–18; 8:45 am]

BILLING CODE 6560–50–P

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS–9920–F]

RIN 0938–AT65

Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year

AGENCY: Centers for Medicare & Medicaid Services (CMS), Department of Health and Human Services (HHS).

ACTION: Final rule.

SUMMARY: This final rule adopts the risk adjustment methodology that HHS previously established for the 2017 benefit year. In February 2018, a district court vacated the use of statewide average premium as a basis for the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. Accordingly, HHS is issuing this final rule to allow charges to be collected and payments to be made for the 2017 benefit year. We hereby adopt the final rules set out in the publication in the **Federal Register** on March 23, 2012 and the publication in the **Federal Register** on March 8, 2016.

DATES: These provisions of this final rule are effective on July 30, 2018.

FOR FURTHER INFORMATION CONTACT: Abigail Walker, (410) 786–1725; Adam Shaw, (410) 786–1091; Jaya Ghildiyal, (301) 492–5149; or Adrianne Patterson, (410) 786–0686.

SUPPLEMENTARY INFORMATION:

I. Background

A. Legislative and Regulatory Overview

The Patient Protection and Affordable Care Act (Pub. L. 111–148), was enacted on March 23, 2010; the Health Care and Education Reconciliation Act of 2010 (Pub. L. 111–152) was enacted on March 30, 2010. These statutes are collectively referred to as "PPACA" in this final rule. Section 1343 of the PPACA established an annual permanent risk adjustment program under which payments are collected from health insurance issuers that enroll relatively low-risk populations, and payments are made to health insurance issuers that enroll relatively higher-risk populations. Consistent with section 1321(c)(1) of the PPACA, the Secretary is responsible for operating the risk adjustment program on behalf of any state that elected not to do so. For the 2017 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

HHS sets the risk adjustment methodology that it uses in states that elect not to operate the program in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately (45 CFR 153.320; 76 FR 41930, 41932 through 41933; 81 FR 94058, 94702 (explaining the importance of setting rules ahead of time and describing comments supporting that practice)).

In the July 15, 2011 **Federal Register** (76 FR 41929), we published a proposed rule outlining the framework for the risk adjustment program. We implemented the risk adjustment program in a final rule, published in the March 23, 2012 **Federal Register** (77 FR 17219) (Premium Stabilization Rule). In the December 7, 2012 **Federal Register** (77 FR 73117), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2014 benefit year and other parameters related to the risk adjustment program (proposed 2014 Payment Notice). We published the 2014 Payment Notice final rule in the March 11, 2013 **Federal Register** (78 FR 15409). In the June 19, 2013 **Federal Register** (78 FR 37032), we proposed a modification to the HHS-operated methodology related to community rating states. In the October 30, 2013, **Federal Register** (78 FR 65046), we finalized the proposed modification to the HHS-operated methodology related to community rating states. We published a correcting amendment to the 2014 Payment Notice final rule in the November 6, 2013 **Federal Register** (78 FR 66653) to address how an enrollee's age for the risk score calculation would be determined under the HHS-operated risk adjustment methodology.

In the December 2, 2013 **Federal Register** (78 FR 72321), we published a proposed rule outlining the Federally certified risk adjustment methodologies for the 2015 benefit year and other parameters related to the risk adjustment program (proposed 2015 Payment Notice). We published the 2015 Payment Notice final rule in the March 11, 2014 **Federal Register** (79 FR 13743). In the May 27, 2014 **Federal Register** (79 FR 30240), the 2015 fiscal year sequestration rate for the risk adjustment program was announced.

In the November 26, 2014 **Federal Register** (79 FR 70673), we published a proposed rule outlining the proposed Federally certified risk adjustment methodologies for the 2016 benefit year and other parameters related to the risk adjustment program (proposed 2016 Payment Notice). We published the 2016 Payment Notice final rule in the February 27, 2015 **Federal Register** (80 FR 10749).

In the December 2, 2015 **Federal Register** (80 FR 75487), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2017 benefit year and other parameters related to the risk adjustment program (proposed 2017 Payment Notice). We published the 2017 Payment Notice final rule in the March 8, 2016 **Federal Register** (81 FR 12204).

In the September 6, 2016 **Federal Register** (81 FR 61455), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2018 benefit year and other parameters related to the risk adjustment program (proposed 2018 Payment Notice). We published the 2018 Payment Notice final rule in the December 22, 2016 **Federal Register** (81 FR 94058).

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the benefit and payment parameters for the 2019 benefit year, and to further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925).

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used the statewide average premium as the cost-scaling factor to ensure that amounts collected from issuers equal payments made to issuers for the applicable benefit year, that is, a methodology that maintains the budget neutrality of the program for the applicable benefit year.[1] The district court otherwise rejected New Mexico Health Connections' arguments. HHS's reconsideration motion remains pending with the district court.

HHS recently announced the collection and payment amounts for the 2017 benefit year as calculated under the HHS-operated risk adjustment methodology that uses the statewide average premium.[2] However, without this administrative action (that is, issuing this final rule), HHS would be unable to make those collections or distribute the payments for the 2017 benefit year, which total billions of dollars.[3] Uncertainty and delay in the distribution of those payments, which issuers anticipated when they set premiums for the 2017 benefit year, could add uncertainty to the market, as issuers are now in the process of determining the extent of their market participation and the rates and terms of plans they will offer for the 2019 benefit year.

II. Provisions of the Final Rule

This final rule adopts the HHS-operated risk adjustment methodology previously published at 81 FR 12204 for the 2017 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the program. This rule does not make any changes to the previously published HHS-operated risk adjustment methodology for the 2017 benefit year.

The risk adjustment program provides payments to health insurance issuers that enroll higher risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to structure their plan benefit designs or marketing strategies in order to avoid these enrollees and lessening the potential influence of risk selection on the premiums that issuers charge. Instead, issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual or small group markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.[4] In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with § 153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a Federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the Federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate the program is based on the premise that premiums for this market should reflect the differences in plan benefits, quality, and efficiency—not the health status of the enrolled population.[5] HHS developed the risk adjustment payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan's enrollees and the revenues that a plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS chose to use statewide average premium and normalize the risk adjustment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each state market risk pool. Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget neutral manner. This approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees. Such incentives could arise if HHS used each issuer's plan's own premium in the risk adjustment payment transfer formula, instead of statewide average premium.

As explained above, the district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years on the ground that HHS did not adequately explain its decision to adopt that aspect of the risk adjustment methodology. The district court recognized that use of statewide average premium maintained the budget neutrality of the program, but concluded that HHS had not adequately explained the underlying decision to adopt a methodology that kept the program budget neutral, that is, that ensured that amounts collected from issuers would equal payments made to issuers for the applicable benefit year. Accordingly, HHS is providing additional explanation herein.

[1] *New Mexico Health Connections* v. *United States Department of Health and Human Services et al.*, No. CIV 16–0878 JB/JHR (D.N.M. 2018).

[2] See, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*, available at *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.*

[3] See, July 7, 2018 *United States District Court Ruling Puts Risk Adjustment On Hold*, available at *https://www.cms.gov/Newsroom/MediaReleaseDatabase/Press-releases/2018-Press-releases-items/2018-07-07.html* and the July 9, 2018, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.* Also see the CMS Memo: *Implications of the Decision by United States District Court for the District of New Mexico on the Risk Adjustment and Related Programs* (July 12, 2018), available at *https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Implications-of-the-Decision-by-United-States-District-Court-for-the-District-of-New-Mexico-on-the-Risk-Adjustment-and-Related-Programs.pdf.*

[4] See the definition for "risk adjustment covered plan" at 45 CFR 153.20.

[5] See 78 FR 15409 at 15417.

First, Congress designed the risk adjustment program to be implemented and operated by states if they choose to do so. Nothing in section 1343 of the PPACA requires a state to spend its own funds on risk adjustment payments or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funding on the program if they voluntarily chose to do so, HHS could not have required additional funding within the HHS-operated risk adjustment methodology.

Second, while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget-neutral manner, it also does not proscribe designing the program in a budget-neutral manner. In fact, although the statutory provisions for many other PPACA programs appropriated or authorized amounts to be appropriated from the U.S. Treasury, or provided budget authority in advance of appropriations,[6] the PPACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, nor authorized HHS to obligate itself for risk adjustment payments in excess of charges collected.[7] Indeed, unlike the Medicare Part D statute, which expressly authorizes the appropriation of funds and provides budget authority in advance of appropriations to make Part D risk-adjusted payments, the PPACA's risk adjustment statute makes no reference to additional appropriations whatsoever.[8] Because Congress omitted from the PPACA any provision appropriating independent funding or creating budget authority in advance of an appropriation for the risk adjustment program, HHS could not—absent another source of appropriations—have designed the risk adjustment program in a way that required payments in excess of collections consistent with binding appropriations law. Thus, as a practical matter, Congress did not give HHS discretion to implement a program that was not budget neutral.

Furthermore, if HHS had elected to adopt a HHS-operated risk adjustment methodology that was contingent on appropriations from Congress in the annual appropriations process that would have created uncertainty for issuers in the amount of risk adjustment payments they could expect. That uncertainty would undermine one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a high risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure. Moreover, relying on the possibility in each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year.[9] Without the adoption of a budget-neutral framework, HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with one of the overall goals of the risk adjustment program—to reduce incentives for issuers to avoid enrolling individuals with higher than average actuarial risk.

In light of the budget-neutral framework discussed above, HHS also chose not to use a different parameter for the payment transfer formula under the HHS-operated methodology, such as each plan's own premium, that would not have automatically achieved equality between risk adjustment payments and charges in each benefit year. As set forth in prior discussions,[10] use of the plan's own premium or some similar parameter would have required the application of a balancing adjustment in light of the program's budget neutrality—either reducing payments to issuers owed a payment, increasing charges on issuers due a charge, or splitting the difference in some fashion between issuers owed payments and issuers assessed charges. Such adjustments would have impaired the risk adjustment program's goals, discussed above, of encouraging issuers to rate for the average risk in the applicable risk pool and avoiding the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid higher-risk enrollees. Use of an after-the-fact balancing adjustment is also less predictable for issuers than a methodology that can be calculated in advance of a benefit year. Such predictability is important to serving the risk adjustment program's goals of premium stabilization and reducing issuer incentives to avoid enrolling higher-risk populations. Additionally, using a plan's own premium to scale transfers may provide additional incentive for plans with high-risk enrollees to increase premiums in order to receive additional risk adjustment payments. As noted by commenters to the 2014 Payment Notice proposed rule, transfers may be more volatile from year to year and sensitive to anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. Scaling the risk adjustment transfers by the statewide average premium promotes premium stabilization by encouraging pricing to average risk in a risk pool, and results in a calculation of equal payments and charges.

In the risk adjustment methodologies applicable to the 2018 and 2019 benefit years, HHS has adjusted statewide average premium by reducing it by 14 percent to account for an estimated proportion of administrative costs that do not vary with claims. HHS is not applying this adjustment retroactively to the 2017 benefit year, but is instead

[6] For examples of PPACA provisions appropriating funds, *see* PPACA secs. 1101(g)(1), 1311(a)(1), 1322(g), 1323(c). For examples of PPACA provisions authorizing the appropriation of funds, *see* PPACA secs. 1002, 2705(f), 2706(e), 3013(c), 3015, 3504(b), 3505(a)(5), 3505(b), 3506, 3509(a)(1), 3509(b), 3509(e), 3509(f), 3509(g), 3511, 4003(a), 4003(b), 4004(j), 4101(b), 4102(a), 4102(c), 4102(d)(1)(C), 4102(d)(4), 4201(f), 4202(a)(5), 4204(b), 4206, 4302(a), 4304, 4305(a), 4305(c), 5101(h), 5102(e), 5103(a)(3), 5203, 5204, 5206(b), 5207, 5208(b), 5210, 5301, 5302, 5303, 5304, 5305(a), 5306(a), 5307(a), 5309(b).

[7] *See* 42 U.S.C. 18063.

[8] *Compare* 42 U.S.C. 18063 (failing to specify source of funding other than risk adjustment charges), *with* 42 U.S.C. 1395w–116(c)(3) (authorizing appropriations for Medicare Part D risk adjusted payments); 42 U.S.C. 1395w–115(a) (establishing "budget authority in advance of appropriations Acts" for risk adjusted payments under Medicare Part D).

[9] It has been suggested that the annual lump sum appropriation to CMS for program management was potentially available for risk adjustment payments. The lump sum appropriation for each year was not enacted until after the applicable rule announcing the methodology to calculate payments for the applicable benefit year. Moreover, HHS does not believe that the lump sum is legally available for risk adjustment payments. As the underlying budget requests reflect, the lump sum is for program management expenses, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the PPACA's insurance market reforms—not for the program payments themselves. CMS would have elected to use the lump sum for these important program management expenses even if CMS had discretion to use all or part of the lump sum for risk adjustment payments.

[10] See, *e.g.*, September 12, 2011, *Risk Adjustment Implementation Issues* White Paper, available at: *https://www.cms.gov/CCIIO/Resources/Files/Downloads/riskadjustment_whitepaper_web.pdf.*

maintaining the definition of statewide average premium previously established for the 2017 benefit year. As discussed above, HHS has repeatedly stressed the importance of providing a risk adjustment methodology in advance of the benefit year to which it applies to provide issuers the opportunity to price their plans accordingly.[11] To protect the settled expectations of issuers that have structured their pricing and offering decisions in reliance on the previously promulgated 2017 benefit year methodology, this rule maintains for the 2017 benefit year the description of statewide average premium set forth in the 2017 Payment Notice.

Therefore, for the 2017 benefit year, we are issuing this final rule that adopts the HHS-operated risk adjustment methodology previously established for the 2017 benefit year in the **Federal Register** publications cited above, including use of statewide average premium. As set forth in reports previously issued, HHS has completed final risk adjustment calculations for the 2017 benefit year, but has not yet collected or paid risk adjustment amounts to issuers of risk adjustment covered plans. The provisions of this final rule adopt the methodology that applies to collection and payment of risk adjustment amounts for the 2017 benefit year. Because this final rule does not alter any previously announced risk adjustment methodology, the amounts previously calculated by HHS have not changed by virtue of this rule's issuance.

HHS will begin collection of the 2017 benefit year risk adjustment charge amounts announced in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year*[12] through netting pursuant to 45 CFR 156.1215(b) and subsequently issuing invoices if an amount remains outstanding in the September 2018 monthly payment cycle. HHS will begin making the 2017 benefit year risk adjustment payments outlined in the *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* as part of the October 2018 monthly payment cycle, continuing on a monthly basis as collections are received. Under this timeline, issuers would receive invoices on or about September 11–13, 2018 and payments would begin to be made around October 22, 2018.

[11] See 76 FR 41930, 41932–33. Also see 81 FR 94058, 94702.

[12] *https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.*

III. Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act

This rule adopts the final rules set out in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). For the 2017 benefit year, in states where HHS is operating the risk adjustment program under section 1343 of the PPACA, HHS will use the criteria and methods as specified in the publication in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and publication in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352).

IV. Waiver of Proposed Rulemaking and Delay in Effective Date

Under the Administrative Procedure Act (APA) (5 U.S.C. 553), a notice of proposed rulemaking and an opportunity for public comment are generally required before issuing a regulation. We also ordinarily provide a 30-day delay in the effective date of the provisions of a rule in accordance with the APA (5 U.S.C. 553(d)), unless the rule is a major rule and subject to the 60-day delayed effective date required by the Congressional Review Act (5 U.S.C. 801(a)(3)). However, these procedures can be waived if the agency, for good cause, finds that notice and public comment and delay in effective date are impracticable, unnecessary, or contrary to public interest and incorporates a statement of the finding and its reasons in the rule issued. See 5 U.S.C. 553(d)(3); 5 U.S.C. 808(2).

HHS has determined that issuing this rule in proposed form, such that it would not become effective until after public comments are submitted, considered, and responded to in a final rule, would be impracticable, unnecessary, and contrary to the public interest. As discussed above, immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets. It is also consistent with settled expectations in that this rule adopts the risk adjustment methodology previously established for the 2017 benefit year.[13] Under normal operations, risk adjustment invoices for the 2017 benefit year would be issued beginning in August 2018 and risk adjustment payments for the 2017 benefit year would be made beginning in the September 2018 monthly payment cycle. Accordingly, it is now less than 2 months until risk adjustment payments for the 2017 benefit year, expected to total $5.2 billion, are due to begin. Immediate action is also necessary to maintain issuer confidence in the HHS-operated risk adjustment program. Issuers have already accounted for expected risk adjustment transfers in their rates for the 2017 benefit year and uncompensated payments for the 2017 benefit year could lead to higher premiums in future benefit years as issuers incorporate a risk premium into their rates. Issuers file rates for the 2019 benefit year in the summer of 2018, and if a projected $5.2 billion in risk adjustment payments is unavailable or there is uncertainty as to whether payments for the 2018 benefit year will be made, there is a serious risk issuers will substantially increase 2019 premiums to account for the uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. Furthermore, issuers are currently making decisions on whether to offer qualified health plans (QHPs) through the Exchanges for the 2019 benefit year, and, for the Federally-facilitated Exchange (FFE), this decision must be made before the August 2018 deadline to finalize QHP agreements. In states with limited Exchange options, a QHP issuer exit would restrict consumer choice, and put additional upward pressure on Exchange premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. The combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS's failure to make timely risk adjustment payments could impact the solvency of plans providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators determine issuer solvency, any uncertainty surrounding risk adjustment transfers jeopardizes regulators' ability to make decisions that protect consumers and support the long-term health of insurance markets. Therefore, HHS has determined that delaying the effective date of the use of statewide average premium in the payment transfer calculation under the HHS-operated risk adjustment methodology for the 2017 benefit year to allow for

[13] The risk adjustment methodology for those benefit years was published at the February 27, 2015 **Federal Register** (80 FR 10749) and the March 8, 2016 **Federal Register** (81 FR 12203).

proposed rulemaking and comment is impracticable and contrary to the public interest because consumers would be negatively impacted by premium changes should risk adjustment payments be interrupted or confidence in the program undermined.

There is also good cause to proceed without notice and comment for the additional reason that such procedures are unnecessary here. HHS has received and considered comments in issuing the 2014 through 2017 Payment Notices. In each of these rulemaking processes, parties had the opportunity to comment on HHS's use of statewide average premium in the payment transfer formula under the HHS-operated risk adjustment methodology. Because this final rule adopts the same HHS-operated risk adjustment methodology issued in the 2017 Payment Notice final rule, the comments received in those rulemakings are sufficiently current to indicate a lack of necessity to engage in further notice and comment. In the 2014 Payment Notice final rule, we received a number of comments in support of our proposal to use the statewide average premium as the basis for risk adjustment transfers. In subsequent benefit year rulemakings, some commenters expressed a desire for HHS to use a plan's own premium. HHS addressed those comments by reiterating that we had considered the use of a plan's own premium instead of the statewide average premium and chose to use statewide average premium. As this approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees.

V. Collection of Information Requirements

This document does not impose information collection requirements, that is, reporting, recordkeeping, or third-party disclosure requirements. Consequently, there is no need for review by the Office of Management and Budget under the authority of the Paperwork Reduction Act of 1995 (44 U.S.C. 3501, *et seq.*).

VI. Regulatory Impact Analysis

A. Statement of Need

This final rule adopts the HHS-operated risk adjustment methodology for the 2017 benefit year set forth in the 2017 Payment Notice final rule to ensure that the risk adjustment program works as intended to protect consumers from the effects of adverse selection and premium increases due to issuer uncertainty. The Premium Stabilization Rule and previous Payment Notices noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2017 benefit year.

B. Overall Impact

We have examined the impact of this rule as required by Executive Order 12866 on Regulatory Planning and Review (September 30, 1993), Executive Order 13563 on Improving Regulation and Regulatory Review (January 18, 2011), the Regulatory Flexibility Act (RFA) (September 19, 1980, Pub. L. 96–354), section 1102(b) of the Social Security Act, section 202 of the Unfunded Mandates Reform Act of 1995 (March 22, 1995; Pub. L. 104–4), Executive Order 13132 on Federalism (August 4, 1999), the Congressional Review Act (5 U.S.C. 804(2), and Executive Order 13771 on Reducing Regulation and Controlling Regulatory Costs. Executive Orders 12866 and 13563 direct agencies to assess all costs and benefits of available regulatory alternatives and, if regulation is necessary, to select regulatory approaches that maximize net benefits (including potential economic, environmental, public health and safety effects, distributive impacts, and equity). A regulatory impact analysis (RIA) must be prepared for major rules with economically significant effects ($100 million or more in any one year).

OMB has determined that this final rule is "economically significant" within the meaning of section 3(f)(1) of Executive Order 12866, because it is likely to have an annual effect of $100 million in any 1 year. In addition, for the reasons noted above, OMB has determined that this is a major rule under the Congressional Review Act.

This final rule offers a further explanation on budget neutrality and the use of statewide average premium in the risk adjustment payment transfer formula when HHS is operating the permanent risk adjustment program established in section 1343 of the PPACA on behalf of a state for the 2017 benefit year. We note that we previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2017 Payment Notice, and that the provisions of this final rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those final rules. The approximate risk adjustment transfers for the 2017 benefit year are $5.179 billion. As such, we also adopt the RIA in the 2017 Payment Notice proposed and final rules.

Dated: July 23, 2018.

Seema Verma,

Administrator, Centers for Medicare & Medicaid Services.

Dated: July 24, 2018.

Alex M. Azar II,

Secretary, Department of Health and Human Services.

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FEDERAL COMMUNICATIONS COMMISSION

47 CFR Part 1

[MD Docket Nos. 18–175; FCC 18–65]

Assessment and Collection of Regulatory Fees for Fiscal Year 2018

AGENCY: Federal Communications Commission.

ACTION: Final action.

SUMMARY: In this document, the Federal Communications Commission (Commission) makes decisions involving submarine cables, international bearer circuits, and the calculation of cable television subscribers.

DATES: This final action is effective August 29, 2018.

FOR FURTHER INFORMATION CONTACT: Roland Helvajian, Office of Managing Director at (202) 418–0444.

SUPPLEMENTARY INFORMATION: This is a summary of the Commission's *FY 2018 Report and Order* (FY 2018 Report and Order), FCC 18–65, MD Docket No. 18–175 adopted on May 21, 2018 and released on May 22, 2018. The full text of this document is available for inspection and copying during normal business hours in the FCC Reference Center, 445 12th Street SW, Room CY–A257, Portals II, Washington, DC 20554, and may also be purchased from the Commission's copy contractor, BCPI, Inc., Portals II, 445 12th Street SW, Room CY–B402, Washington, DC 20554. Customers may contact BCPI, Inc. via their website, *http://www.bcpi.com,* or call 1–800–378–3160. This document is available in alternative formats (computer diskette, large print, audio record, and braille). Persons with disabilities who need documents in these formats may contact the FCC by email: *FCC504@fcc.gov* or phone: 202–418–0530 or TTY: 202–418–0432.