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

NEW MEXICO HEALTH CONNECTIONS, a New Mexico Non-Profit Corporation, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, et al., Defendants.	No. 1:16-cv-00878-JB/WPL

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PLAINTIFF'S MEMORANDUM OF LAW IN OPPOSITION TO DEFENDANTS' MOTION TO ALTER OR AMEND JUDGMENT PURSUANT TO RULE 59(E)

I. INTRODUCTION AND STANDARD OF REVIEW

Relief under Rule 59 is reserved for "extraordinary circumstances and not [intended] to offer a second bite at the proverbial apple." *Syntroleum Corp. v. Fletcher Int'l, Ltd.,* No. 08-384, 2009 U.S. Dist. LEXIS 22312, *2 (N.D. Okla. Mar. 19, 2009). Rule 59 motions are inappropriate "vehicles to reargue an issue previously addressed by the court when the motion merely advances new arguments, or supporting facts which were available at the time of the original motion." *United States v. 2002 Pontiac Bonneville SE*, No. 12-0580, 2015 U.S. Dist. LEXIS 164738, *9 (D.N.M. Dec. 7, 2015) (Browning, J.) (denying Rule 59 motion). Nor can Rule 59 be used to "advance arguments that *could have been raised* in prior briefing." *C.S. v. Platte Canyon Sch. Dist. No. 1*, No. 12-3358, 2015 U.S. Dist. LEXIS 107998, *2 (D. Colo. Aug. 17, 2015) (emphasis added).

Rule 59 is only to be used to raise either an intervening change in controlling law, the discovery of new evidence that was not previously available, or to avoid clear error or manifest injustice. *Thymes v. Verizon Wireless, Inc.,* No. 16-66, 2017 U.S. Dist. LEXIS 3846, *6 (D.N.M. Jan. 9, 2017). But HHS[1] presents no change in controlling law (there has not been any). Nor can there be newly discovered evidence to present, because this Court is not engaged in independent fact-finding but reviewing a closed administrative record under the Administrative Procedures Act.

HHS thus must show clear error, *i.e.*, "an arbitrary, capricious, whimsical, or manifestly unreasonable judgment," *id.*, or "manifest injustice," for which "the record presented must be so patently unfair and tainted that the error is manifestly clear to all who view it." *In re*

[1] In keeping with prior practice, Defendants are collectively referred to as "HHS."

Green Goblin, Inc., No. 09-11239, 2012 Bankr. LEXIS 2613, *2 n.2 (Bankr. E.D. Pa. May 31, 2012). It has not and cannot do so. Instead, HHS rehashes arguments that this Court has already considered and rejected, and offers points that it failed to advance during summary judgment even though they *could have* been raised earlier. Unfortunately for HHS, "[a] party's failure to present its strongest case in the first instance does not entitle it to a second chance in the form of a motion to reconsider." *Williams v. HSBC Bank USA, N.A.,* No. 15-9372, 2016 U.S. Dist. LEXIS 99858, *3 (D. Kan. July 29, 2016). The parties have had their full opportunity to be heard and the Court has issued its ruling; it is time to proceed to the next stage. The instant motion should accordingly be denied.

II. ARGUMENT

A. The Court Correctly Set Aside The Agency Action

The Court correctly held that HHS's decision to use the statewide average premium was arbitrary and capricious.[2] As the Court explained, when evaluating agency action, the Court must "determine whether HHS 'examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choices made.'" *See* Dkt. No. 55, Memorandum Opinion and Order (Feb. 28, 2018) (hereafter, "Opinion"), at 64 (citing *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016)). "The agency must give adequate reasons for its decisions," and the Court owes no deference to naked assertions that lack reasoned explanation. *Id.* With these key principles in mind, the Court closely examined the administrative record in order to determine if HHS

[2] Plaintiff respectfully disagrees with the portions of the Court's opinion denying in part its motion for summary judgment and granting in part HHS's cross-motion for summary judgment, and Plaintiff intends to appeal that part of the Court's judgment.

provided "adequate reasons" for its decision to adopt the statewide average premium in lieu of a plan's own premium in the risk adjustment formula. It did not.

The Court's review of the record started with the 2011 white paper, in which HHS first considered whether to use the statewide average premium or a plan's own premium. *Id.* at 64-65. HHS explained that the statewide average premium would ensure budget neutrality, and that under the governing statute, the risk adjustment program was "designed" to be budget neutral. *Id.* at 64. As the Court noted, HHS failed to articulate any independent policy reason for budget neutrality in this white paper, and thus its decision can be afforded no deference. *Id.* at 64, 70.

The Court next reviewed the agency's reasoning set forth in the 2014 Proposed Rule (and the subsequent proposed rules which did not differ substantively), finding that it similarly fell short. In that Proposed Rule, HHS again explained that it considered whether to use a plan's own premium or the statewide average premium. *See id.* at 65-66. It also again referenced, without explanation, its "justification" for selecting the statewide average premium, which involved predictability and budget neutrality. *Id.* Noting that the Court is not permitted to rely on the agency's post-hoc explanations for its decisions, the Court's analysis appropriately focused on the proffered rationale for the statewide average premium *as stated in the administrative record*. *Id.* at 66-67. The primary rationale was budget neutrality, which HHS failed to justify with any "independent policy reason." *Id.* at 67.

HHS's incorrect assumption that budget neutrality was "a given" "infect[ed] its analysis of the relative merits of using a state's average premium . . . instead of using a plan's own premium." *Id.* at 66-67. The Court explained that while there may have been policy reasons to support a budget neutral design, those reasons were never articulated in the

administrative record, and thus cannot be afforded deference. *Id.* at 68-70. Accordingly, the Court properly "set[] aside and vacate[d] the agency action as to the statewide average premium rules and remand[ed] the case to the agency for further proceedings." *Id.* at 71.

In addition to HHS's failure to identify any rational and adequate explanation for its decision to use the statewide average premium, the agency's action was also arbitrary and capricious for a host of other reasons that the Court did not address, but were raised by NMHC in its Amended Complaint, briefing, and oral argument:

- Risk adjustment should be designed to reflect "actuarial risk." The use of the statewide average premium wrongly sweeps in numerous factors that are wholly unrelated to actuarial risk. *See* Dkt. No. 33, NMHC Opening Brief (Apr. 13, 2017), at 17; Dkt. No. 40, NMHC Reply Brief (July 13, 2017), at 11, 13-14; Dkt. No. 49, Oral Argument Transcript (Jan. 22, 2018), at 13-15.

- The statewide average premium undermines the ACA's goals of promoting competition and innovation because it penalizes insurers who keep premiums low through efficiency and innovation. *See* NMHC Opening Br., at 17-21; NMHC Reply Br., at 11-12; Oral Arg. Tr., at 32-34.

- The agency's proffered justifications for the statewide average premium are neither rational nor supported by sufficient evidence:

    - While HHS claimed that the statewide average premium provides a predictable benchmark for estimating transfers, it provided no evidence for this statement, likely because, in reality, the payment formula proved to be wildly unpredictable for carriers. *See* NMHC Opening Br., at 25-26; NMHC Reply Br., at 15-16; Oral Arg. Tr., at 20-22.

    - Budget neutrality could readily be achieved without using the statewide average premium. *See* Dkt. No. 21, NMHC Amended Complaint (Jan. 12, 2017), at ¶ 131; NMHC Opening Br., at 24-25; NMHC Reply Br., at 15; Oral Arg. Tr., at 27, 30-31.

    - HHS claimed that the statewide average premium reduces incentives for plans to avoid high risk enrollees. But HHS cited no evidence of this actually happening, and there are other provisions of the ACA designed to protect high risk enrollees. *See* NMHC Reply Br., at 14-15; Oral Arg. Tr., at 35-37.

    - HHS's claims of a "gaming" risk are implausible in light of the comprehensive regulation of insurance pricing and the lack of predictability in risk adjustment transfers. *See* Oral Arg. Tr., at 19-22. Moreover, the same

"gaming" risk exists when using the statewide average premium. *See* NMHC Opening Br., at 28-29.

B. NMHC Has Consistently Challenged The Statewide Average Premium And Its Budget Neutral Justification As Arbitrary and Capricious

HHS's Motion is premised on a truly perplexing assertion: that NMHC never challenged HHS's decision to apply risk adjustment in a budget neutral way. According to HHS, the Court "concluded that HHS's decision to design the program in a *budget-neutral* manner was arbitrary and capricious." Dkt. No. 57, HHS Rule 59 Brief (Mar. 28, 2018), at 7 (emphasis added). Under HHS's theory, however, NMHC never specifically challenged *budget neutrality* (as opposed to the statewide average premium) as arbitrary and capricious. This is a misstatement of both the Court's holding and NMHC's claims. The Court's holding was clear: the decision to use the statewide average premium, instead of a plan's own premium, was arbitrary and capricious because the administrative record was devoid of any policy justification to support the decision. *See* Opinion, at 70-71. Absent such justification, the Court could not uphold HHS's decision. *Id*.

NMHC's argument was equally clear. NMHC challenged HHS's use of the statewide average premium in the risk adjustment transfer formula as opposed to an issuer's own premium, and repeatedly attacked HHS's proffered justification of budget neutrality. *See* NMHC Opening Br., at 22-25, 31-32; NMHC Reply Br., at 15; Oral Arg. Tr., at 16, 24-31.

HHS now tries to downplay NMHC's challenge to budget neutrality, saying that it was only mentioned by NMHC "in passing." This is flatly contradicted by HHS's statement at oral argument, which plainly indicates that HHS understood NMHC's challenge to the statewide average premium as being rooted in the budget neutrality justification:

> "***Now, I'd like to discuss this point about budget neutrality, because I think it is largely what NMHC's challenge to statewide premium hinges on***."

Oral Arg. Tr., at 47 (Powers). HHS's belated argument that NMHC never "*directly* challenged" HHS's budget-neutral approach as *independently* arbitrary and capricious, but only attacked the use of the statewide average premium as arbitrary and capricious, is strained to the point of being incredible.

Moreover, HHS's argument is premised on an artificial distinction between the agency action challenged – the use of the statewide average premium instead of an issuer's own premium – and the agency's justification for that action. However, the action engaged in by the agency, challenged by NMHC, and addressed by this Court was the decision to use the statewide average premium instead of a plan's own premium. The agency's justification for its choice - budget neutrality - is not in and of itself an agency action subject to separate challenge under the APA. *See* 5 U.S.C. § 702 (limiting judicial review under the APA to agency action).

C. There Is No Issue Waiver

HHS's next argument is that neither NMHC nor any other commenter ever challenged budget neutrality during the 2014-2017 rulemaking, and thus NMHC is foreclosed from challenging it now. *See* HHS Rule 59 Br., at 9-10. This contention likewise has no merit.

To begin with, this argument is inappropriately raised in a Rule 59 motion because it was, in fact, raised during oral argument and also could have been raised in HHS's briefing. During oral argument, counsel for HHS told the Court "it does not appear from the record that the agency's decision back in the 2014 rule to treat this as a self-funded program was seriously challenged by commenters." Oral Arg. Tr., at 51-52. That HHS failed to give this argument more air time at oral argument or in its prior briefing does not excuse HHS from the fact that it is simply rehashing arguments that were made or could have been made based on facts that have been before them since the inception of this case. *See Williams,* 2016 U.S. Dist. LEXIS 99858, *3 ("A party's failure to present its strongest case in the first instance does not

entitle it to a second chance in the form of a motion to reconsider."); *Platte*, 2015 U.S. Dist. LEXIS 107998, *2 (Rule 59 cannot be used to "advance arguments that *could have been raised* in prior briefing.").

Even if this argument could properly be made at this stage, it fails because all of the core issues were raised and considered by HHS. According to HHS, before the 2018 rulemaking, neither NMHC nor any other commenter independently challenged budget neutrality as opposed to challenging the statewide average premium. *See* HHS Rule 59 Br., at 9-10. Again, this confuses the agency action being challenged with the proffered justification for the action. There can be no dispute that NMHC and other commenters challenged the agency's decision to use the statewide average premium instead of an issuer's own premium in both the 2017 and 2018 rulemaking periods. *See e.g. CHOICES 2017 Comment*, at 9, NMHC000998 ("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."); *NMHC 2017 Comment*, at 3, NMHC001454 ("use of the statewide market average premium in the risk transfer formula again further punishes efficient and effective plans with lower premiums"); *Minuteman 2017 Comment*, at 6-7, NMHC001442-43; *Evergreen 2017 Comment*, at 2, Rec. '9436; *Land of Lincoln Health 2017 Comment*, at 5, Rec. '9007; *NMHC 2018 Comment*, at 11-13, NMHC000845-47 ("HHS and CMS cannot flout the Risk Adjustment statute to create a budget neutral formula. Instead, … HHS and CMS should adopt the recommendation of CHOICES and use a plan's own average premium in the transfer formula rather than the statewide average premium."); *Minuteman 2018 Comment*, at 9-12, NMHC000009-12; *CHOICES 2018 Comment*, at 5, NMHC001435.

Moreover, that commenters may not have squarely addressed the issue during the 2014-2016 rulemakings is immaterial because the agency considered the issues on its own initiative. If an agency considered the issue *sua sponte*, the Court will not invoke the waiver rule because the agency had the opportunity to consider the issue and apply its expertise. *See Portland Gen. Elec. Co. v. Bonneville Power Admin.*, 501 F.3d 1009, 1024 (9th Cir. 2007) (waiver rule inapplicable if "the issue was considered sua sponte by the agency"); *Glacier Fish Co. LLC v. Pritzker*, 832 F.3d 1113, 1120, n.6 (9th Cir. 2016) (same); *NRDC v. EPA,* 824 F.2d 1146, 1151 (D.C. Cir. 1987) (en banc) ("This court has excused the exhaustion requirements for a particular issue when the agency has in fact considered the issue."), *vacated on other grounds*, 707 F. Supp. 3 (1989). Moreover, parties are not required to challenge "key assumptions" used to justify the agency's rule. *See NRDC v. EPA*, 755 F.3d 1010, 1023 (D.C. Cir. 2014) ("even if a party may be deemed not to have raised a particular argument before the agency, EPA retains a duty to examine key assumptions as part of its affirmative burden of promulgating and explaining a nonarbitrary, non-capricious rule"); *see also Nat'l Lime Assoc. v. EPA,* 627 F.2d 416, 433-34 (D.C. Cir. 1980).

Similarly, issue waiver is inapplicable when the problems underlying the claim are "obvious" to the agency. *See Zen Magnets, LLC v. Consumer Prod. Safety Comm'n,* 841 F.3d 1141, 1151, n. 11 (10th Cir. 2016) ("Claims not raised before an agency are not waived if the problems underlying the claim are 'obvious.'"). Finally, the Court may excuse waiver in "exceptional circumstances." *See Portland*, 501 F.3d at 1024.

Here, the agency considered both the issues of statewide average premium versus an issuer's own premium *and* budget neutrality *sua sponte,* and budget neutrality was the "key assumption" used to justify the use of the statewide average premium. As highlighted in the

Court's opinion, in 2011 HHS published a white paper titled "Risk Adjustment Implementation Issues." *See* Opinion, at 64 (citing Rec. '4367). That white paper addressed the very issue that NMHC challenges, that is the use of the statewide average premium versus an issuer's own premium, and articulated that risk adjustment was designed to be budget neutral. *Id.* at 64-65 (citing Rec. '4370, '4380). In subsequently issuing the proposed rule that adopted the statewide average premium, HHS noted, without explanation, that it did so because it produced a budget neutral result. *Id.* at 65-66 (citing 2014 Proposed Rule, 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (Rec. '134)).

Given that HHS, as early as 2011, considered these issues directly, it is irrelevant whether all of these points were covered again in comments to the agency. Moreover, exceptional circumstances exist given the structure of the risk adjustment payment schedule. Carriers were not able to see the dire effects of the agency's decision until the first charges were assessed in Summer 2015, by which time the 2014-2016 rulemakings had already been completed. *See* NMHC Opening Br., at 6 (setting out timelines for rulemaking proceedings).

D. The Court Did Not Misapprehend HHS's Position On Budget Neutrality And HHS's Post-Hoc Justifications For Budget Neutrality Are Owed No Deference

HHS next claims that the Court misapprehended its position regarding budget neutrality, which "led it to overlook binding principles of constitutional and appropriations law". HHS Rule 59 Br., at 13. According to HHS, the Court's singular focus was whether the text of the ACA mandated budget neutrality, which caused the Court to overlook what it alleges are "fundamental" principles of constitutional and appropriations law in two respects. First, HHS contends that principles of constitutional law required budget neutrality because "Congress designed the risk adjustment program to be implemented by states . . . [y]et nothing in the text of section 1343 requires states to spend their own funds for risk-adjustment payments or allows

HHS to impose such a requirement." *Id.* Second, HHS claims that "fundamental appropriations law principles" required budget neutrality when HHS operated the program on behalf of states because "the ACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in". *Id.* at 14-15. Not only are these arguments both groundless, they are also wholly inappropriate for Rule 59 review because they both clearly were, *or could have been,* raised during summary judgment.

1. The Court Did Not Misapprehend HHS's Position

At the outset, HHS claims that the Court's analysis is flawed because it supposedly myopically focused only on whether the text of the ACA required budget neutrality. *See id*. at 12. While the Court did (*correctly*) explain that the ACA does not mandate budget neutrality, this was not, as HHS implies, what drove the holding that the use of the statewide average premium was arbitrary and capricious. Rather, the Court's crucial finding was that HHS failed to articulate an independent policy reason for requiring budget neutrality outside of its incorrect assertion that it was mandated by the ACA. In the Court's words:

- In short, HHS assumed that the ACA requires budget neutrality, and HHS does not give an independent policy reason for requiring budget neutrality.
- Again, HHS gives no policy reason for requiring budget neutrality.
- The proposed rule does not, however, provide a policy rationale for budget neutrality.
- HHS articulates no independent policy reason for requiring budget neutrality.
- That HHS, in designing its risk adjustment methodology, never considered whether budget neutrality was sound public policy means that HHS cannot now appeal to budget neutrality's public policy benefits to justify its decision.

Opinion, at 64-69.

2. HHS's Post-Hoc Justifications For Budget Neutrality Are Owed No Deference And Are Not Properly Raised In A Rule 59 Motion

The failure to identify any policy reason in the record for budget neutrality still plagues HHS despite its attempts to justify it now (and in its prior briefing) through post-hoc arguments rooted in alleged "fundamental" principles of constitutional and appropriations law. During the 2014-2017 rulemakings, HHS admits to being silent on the issue. *See* HHS Rule 59 Br., at 12 (noting that it first "clarified" its reasoning for budget neutrality in the 2018 rulemaking). In the 2018 rulemaking, HHS, for the first time, noted without any further explanation that its decision to operate the program in a budget neutral manner was based on the "absence of additional funding for the HHS-operated risk adjustment program". 2018 Final Rule, 81 Fed. Reg. 94,058, 94,101 (Dec. 22, 2016) (Rec. '9638). But this bare bones statement, even if accurate, is not a policy justification for designing the program to be inherently budget neutral. If anything, it implies the opposite – if only the agency had the funds, it would scrap budget neutrality.

Lacking any justification in the administrative record, HHS's litigation counsel now raise two post-hoc justifications why the lack of a specific appropriation required budget neutrality: (1) in the event a state elected to operate its own risk adjustment program, HHS would not be able to require it to spend its own funds; and (2) in the event HHS runs the program on behalf of a state, it lacked appropriations or authorization to make payments out in excess of payments in. *See* HHS Rule 59 Br., at 13-18. As these are post-hoc justifications concocted by counsel in litigation filings, they cannot be considered by this Court. *See* Opinion, at 66; *see also SEC v Chenery Corp.*, 318 U.S. 80, 92-95 (1943). Nevertheless, even if the Court could entertain these improper arguments under the APA, they fail.

a. NMHC Is Not Challenging A State-Run Risk Adjustment Program

HHS's first argument – that it cannot bind state budgets – was raised numerous times during summary judgment. *See* Dkt. No. 35, HHS Opening Brief (June 1, 2017), at 22, n. 4 ("NMHC does not contend that a state must use its general appropriations to make risk adjustment payments, and nothing in the statute directs the Department to do so."); Dkt. No. 41, HHS Reply Brief (Aug. 17, 2017), at 7, n. 2 ("But [NMHC] cannot deny that Congress established the program as a system of monetary transfers that could be operated by states without the necessity for external funding."); Oral Arg. Tr., at 51 ("Congress, in the first instance, assumed that states would appropriate these risk adjustment programs. And so it would be quite strange to think that Congress was obligating states to pay out of their treasuries to make up the shortfall or difference in payments and transfers."). This is thus a rehash of previously raised issues that is inappropriate under Rule 59. *See e.g., Syntroleum*, 2009 U.S. Dist. LEXIS 22312, *7-*8.

This argument also fails substantively. NMHC is not challenging a state-run program, but the federal HHS program that has always applied in New Mexico.

b. The Lack Of A Specific Line Item Appropriation Does Not Compel Budget Neutrality

HHS's arguments related to the lack of specific appropriations for the federal risk adjustment program are equally unavailing. Again, this argument has already been addressed by both parties, making it inappropriate to rehash in a Rule 59 motion. In its opening brief, HHS explained its position that "the ACA did not appropriate or authorize any external source of funding for the risk adjustment program. … Accordingly, since 2011, HHS has treated risk adjustment as a self-funded program under which monies collected from low actuarial risk plans are the sole source of funding for payments to high actuarial risk plans." HHS Opening Br., at 9;

see also HHS Reply Br., at 7 ("NMHC's alternative suggestion that the government pick up the tab for any shortfall . . . ignores the lack of any appropriation for that purpose"). That HHS chose to mention the issue in passing rather than devote pages to the purported "fundamental" appropriations law principles it now invokes does not justify Rule 59 relief. *See e.g., Williams*, 2016 U.S. Dist. LEXIS 99858, *3 ("A party's failure to present its strongest case in the first instance does not entitle it to a second chance in the form of a motion to reconsider.").

Even if HHS's argument were appropriately raised now, it fails. The lack of a specific appropriation does not, in fact, compel use of the statewide average premium. To begin with, if HHS used each carrier's own premium instead of the statewide average, and there was an imbalance between payments in and out, HHS can make a pro rata reduction in the amount of payments out to account for the shortfall – which is exactly the approach it adopted in the interrelated risk corridors and reinsurance programs. *See* NMHC Opening Br., at 24-25.

Moreover, in the event of a shortfall in payments out, any underpaid carriers can sue for damages in the Court of Federal Claims and recover under the Judgment Fund. It is well-established that a payment obligation of the United States is not defeated merely by the lack of a specific appropriation. *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966); *see also United States v. Langston*, 118 U.S. 389, 393-94 (1886); *Prairie Cnty., Mont. v. United States*, 782 F.3d 685, 689-90 (Fed. Cir. 2015); *Greenlee Cnty., Ariz. v. United States*, 487 F.3d 871, 877 (Fed. Cir. 2007); *Gibney v. United States*, 114 Ct. Cl. 38, 50-51 (1949).

These principles have in fact been applied in the case of shortfalls in payment under the ACA's risk corridors program. *See Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436, 458, 461-62 (2017); *Molina Healthcare of Cal., Inc. v. United States*, 133 Fed. Cl. 14, 41 (2017). HHS itself took the initial position (before later flip-flopping without explanation)

that the risk corridors program is not required to be budget neutral despite the lack of specific appropriations. *See* 2014 Final Rule, 78 Fed. Reg. 15,409, 15,473 (Mar. 11, 2013) (Rec. '290) ("The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act").

Finally, as NMHC has pointed out, there are funds available to HHS in its general program management appropriations. *See* NMHC Opening Br., at 23-24. The Government Accountability Office ("GAO") has examined this very point in the context of the closely related risk corridors program, and found that HHS's general program appropriation would be broad enough to cover the risk corridors program:

> [ACA] Section 1342(b)(1) directs the Secretary to make payments to qualified health plans, but that section neither designates nor identifies a source of funds. *The CMS PM appropriation for FY 2014 made funds available to CMS to carry out its responsibilities, which, with the enactment of section 1342, include the risk corridors program.* Consequently, the CMS PM appropriation for FY 2014 would have been available for making the payments pursuant to section 1342(b)(1).

Exh. 9 to NMHC Opening Br., GAO, B-325630, *HHS - Risk Corridors Program* (Sept. 30, 2014), at 4 (emphasis added). Although Congress later specifically restricted the use of HHS's annual appropriations as to the risk corridors program, it never did so for the risk adjustment program.

Without a single reference to the GAO's opinion, HHS argues that the Program Management Appropriation cannot be used for the risk adjustment program because: (1) it is "an appropriation to CMS, which has no authority to transfer such funds to state governments"; and (2) it is "for *program management expenses,* such as administrative costs for various CMS programs . . . not for the program payments themselves, which would vastly exceed the amount

of the lump sum"; and (3) it is enacted each year after the risk adjustment rule. HHS Rule 59 Br., at 16. These arguments carry no weight.

First, NMHC's challenge is not to any state-run risk adjustment program but to the federal program which has been applied in New Mexico and in nearly every state, and thus the availability of the Program Management Appropriation to states is wholly irrelevant. Second, HHS's description of the Program Management Appropriation is entitled to no deference. Not only did HHS fail to present this new theory during the relevant risk adjustment rulemakings, but HHS's theory contradicts the GAO, which is the actual expert agency in the field of government appropriations, whose views are entitled to deference. *See e.g., Int'l UAW et al. v. Donovan*, 746 F.2d 855, 861 (D.C. Cir. 1984); *Nevada v. DOE*, 400 F.3d 9, 16 (D.C. Cir. 2005) (explaining that courts "give special weight to [GAO's] opinions due to its accumulated experience and expertise in the field of government appropriations."); *see also* Oral Arg. Tr., at 26. Indeed, both the *Moda* and *Molina* courts deferred to the GAO opinion, holding that "CMS Program Management funds were available to make risk corridor payments." *Molina*, 133 Fed. Cl. at 33.

Finally, HHS argues in its brief that "the later-enacted lump sum could not have authorized HHS to deviate from the budget-neutral design of the ACA in those Benefit Rules." HHS Rule 59 Br., at 16. But this is backwards: the question before the Court was whether the agency had justified its action in making the budget-neutral design in the first place, not whether it could be deviated from later.

E. The Regulation Is Subject To Judicial Review

In a last gasp, HHS claims for the first time in this Rule 59 motion that its budget neutral reasoning cannot be reviewed by the Court, citing the proposition that the Court should not review the allocation of funds from a lump-sum appropriation. At the outset, this new

argument cannot be raised for the first time on a Rule 59 motion. *See Williams*, 2016 U.S. Dist. LEXIS 99858, *3. It is also a red herring. NMHC is not challenging a decision not to allocate funds. Rather, NMHC challenges the agency's action in adopting a formula using the statewide average premium instead of each issuer's own premium.

F. There Is No Reason To Disturb The Court's Use Of The Standard APA Remedy

No doubt sensing its attacks on the merits fall flat, HHS also seeks reconsideration on the remedy ordered by the Court, which was vacatur of the relevant regulations with a remand to proffer a revised justification for the use of the statewide average premium. This is the standard remedy when a Court finds regulatory action to violate the APA. *See e.g., Southeast Alaska Conserv. Council v. U.S. Army Corps of Eng'rs*, 486 F.3d 638, 654 (9th Cir. 2007) ("Under the APA, the normal remedy for an unlawful agency action is to 'set aside' the action.") (citing 5 U.S.C. § 706(2)), *rev'd on other grounds,* 557 U.S. 261 (2009); *St. Lawrence Seaway Pilots Ass'n v. U.S. Coast Guard*, 85 F. Supp. 3d 197, 208 (D.D.C. 2015) ("The typical remedy for an arbitrary and capricious agency action is to vacate the rule."). While HHS argues that this Court committed clear error and manifest injustice in following the normal course, its arguments are again procedurally improper and substantively baseless.

1. There Is No Support For HHS's Argument That The Court Incorrectly Assumed That Vacatur Is The Mandatory Remedy

HHS's first argument is that the Court wrongly assumed that it was required to order vacatur, with no other options. But there is nothing in the Court's opinion suggesting that it operated under the assumption that vacatur is the only possible remedy. HHS argued repeatedly against a vacatur remedy. *See* HHS Opening Br., at 43-44; Oral Arg. Tr., at 138-139. The fact that the Court did not include any detailed discussion of this issue in its opinion does not show that it did not consider and weigh HHS's arguments on alternative remedies.

2. The Court Could Not Have Misapprehended The Law By Applying The "Typical" And "Standard" Remedy

HHS next argues that vacatur was inappropriate when the Court determined that HHS's justifications did not sufficiently support its actions. To begin with, this is a rehash of arguments that HHS previously made and thus is not an appropriate ground for relief under Rule 59. *See* HHS Opening Br., at 43-44; Oral Arg. Tr. at 137-139.

Nor does the contention have any merit. The Court has significant discretion in determining the appropriate remedy. *See e.g. Am. Forest Res. Council v. Ashe*, 946 F. Supp. 2d 1, 45-46 (D.D.C. 2013); *NRDC v. EPA*, 676 F. Supp. 2d 307, 312 (S.D.N.Y. 2009). In exercising that discretion, the Court weighs "the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed." *Allied-Signal, Inc. v. NRC*, 988 F.2d 146, 150-51 (D.C. Cir. 1993). But HHS's position here collapses into incoherence. While HHS characterizes the errors that the Court found as trivial and harmless, it has taken no steps to remedy them. The Court's opinion does not require HHS to change the risk adjustment formula, but rather to reexamine its approach and articulate a legitimate justification if HHS wishes to re-adopt the same regulations. If HHS could readily justify the policies it has followed for the past several years, then there was no reason that HHS could not have commenced a new rulemaking proceeding shortly after this Court issued its judgment to remedy the deficiencies in the administrative record. The fact that it has not done so speaks volumes about its inability to actually provide a valid policy explanation in the rigors of notice and comment rulemaking, not to mention provides further justification for the Court's decision to vacate the regulations. As the Court did not require any changes to the agency's formula if a proper justification were put

forth, any disruptive effect flows solely from the agency's apparent unwillingness to engage in the task that the Court set for it – a purely self-inflicted wound.

3. The Vacatur Order Is Not Manifestly Unjust

a. The Court Should Not Consider The Jeff Wu Declaration

HHS next argues that the vacatur order is manifestly unjust because of the harm that will result to the insurance market, but this argument relies almost entirely on the declaration of Jeffrey Wu (the "Wu Declaration"). However, the Court cannot consider the Wu Declaration.[3]

First, the Wu Declaration should not be considered because it is outside of the administrative record and is thus beyond the scope of materials that a court can consider in determining whether to set aside agency action. *Franklin Sav. Ass'n v. Dir., Office of Thrift Supervision*, 934 F.2d 1127, 1137 (10th Cir. 1991) ("where Congress has provided for judicial review without setting forth the . . . procedures to be followed in conducting that review . . . review shall be confined to the administrative record"); HHS Opening Br., at 8 ("judicial review of agency action [is] generally limited to the administrative record").

Second, the Wu Declaration simply repackages and expands upon on arguments already made, thus making it an inappropriate to rely on for Rule 59 relief. Both parties made arguments as to the proper remedy that the Court should issue if it determined that HHS acted in an arbitrary and capricious manner. *See e.g.,* HHS Opening Br., at 43-44; NMHC Reply Br., at 25. But HHS made the decision at that time not to emphasize the arguments it now makes. Rule 59 is an inappropriate vehicle to "revisit issues already addressed or advance arguments that could have been raised in prior briefing." *The Servants of the Paraclete v. John Does, I-XVI*, 204

[3] NMHC has moved separately to strike the Wu Declaration.

F.3d 1005, 1012 (10th Cir. 2000); *see Syntroleum*, 2009 U.S. Dist. LEXIS 22312, *4 ("arguments that could have been raised in prior briefings are not appropriate grounds for Rule 59(e) motions").

Furthermore, had HHS submitted evidence outside of the administrative record, such as the Wu Declaration, in connection with its briefing, NMHC would have sought discovery relating to that evidence, including the deposition of Mr. Wu. If the Court intends to consider the Wu Declaration, NMHC respectfully requests that the Court grant it the opportunity to serve document requests and interrogatories to HHS and to take Mr. Wu's deposition, so that his assertions can be tested through cross-examination. *Cf. Bar MK Ranches*, 994 F.2d at 740 (limited discovery is appropriate when the record may not be complete).

b. The Wu Declaration Fails To Show Manifest Injustice

Even if the Court were to consider the Wu Declaration, HHS has not provided a valid basis to disturb the Court's remedy. The bulk of Mr. Wu's argument is that vacatur upsets settled expectations and reliance interests in the previously issued risk adjustment regulations. But this harm is self-inflicted: the Court has not prohibited HHS from continuing the same risk adjustment formula, but only required it to justify its policy choices in compliance with the APA. Mr. Wu nowhere explains why HHS has not simply commenced a new rulemaking to address the errors found by the Court. The only conclusion is either that the agency does not consider risk adjustment important enough to act upon, in which case the cry of disruption rings hollow, or the agency cannot address the Court's critique, in which case the remedy is wholly appropriate to address a serious deficiency.

In addition, the reliance interests are overstated. The administrative record contains substantial evidence that carriers are unable to predict risk adjustment transfers and thus cannot rely upon them. For example, NMHC's 2018 comments attached a study from the

national actuarial consulting firm Milliman showing that carriers could not predict risk adjustment. *See* Ex. E-3 to NMHC 2018 Comment, NMHC001005 (Daniel J. Perlman & David M. Liner, *Financial Analysis of ACA Health Plan Issuers*, Milliman (Feb. 2016)). In addition, NMHC's 2018 comments pointed out that every carrier in New Mexico built into its 2017 premium the assumption that it would make a risk adjustment payment – a mathematical impossibility under the risk adjustment formula which always has a balance of payments in and out within a state. These rate-setting assumptions can only be explained by the carriers' inability to predict how the formula will work and a desire to have a cushion if the outcome were adverse. *See* Ex. B-1 to NMHC 2018 Comment, NMHC000873-874 (Declaration of Martin Hickey (Oct. 5, 2016)).

Most absurdly, Mr. Wu claims that the Court's remedy will interfere with settled expectations for payment under the risk corridors program. But HHS has defaulted on its risk corridors obligations, leading to massive litigation in the Court of Federal Claims, including a class action. *See generally Molina*, 133 Fed. Cl. 14; *Moda,* 130 Fed. Cl. 436; *Health Republic Ins. Co. v. United States*, 129 Fed. Cl. 757 (2017).

Moreover, contrary to Mr. Wu's picture of a smoothly running status quo, the evidence in the administrative record shows that the risk adjustment program has wreaked havoc, decimating competition and raising premiums. Many small insurers have been forced to pay out well over 10% of their premiums in risk adjustment assessments, even though margins in the health insurance industry are typically only a thin 2-3%. *See* Ex. E-5 to NMHC 2018 Comment, NMHC001018 (Letter from CHOICES to CMS (Apr. 22, 2016)). As a result, one year of risk adjustment assessments can wipe out five plus years of profits.

Risk adjustment has even forced insurers to leave the market, including the closure of many of the CO-OP start-up insurance issuers that the ACA established. *See* NMHC 2018 Comment (Oct. 6, 2016), at NMHC000837; *id.* at Ex. C-1, NMHC000910-13 (H. Comm. on Energy & Com., 114th Cong., *A Review of CMS' Mgmt. of the Failed CO-OP Prog.* (Sept. 13, 2016)); *id.* at Ex. G-4, NMHC001351-52 (Conn. Ins. Dept., *Ins. Dept. Places HealthyCT Under Order of Supervision* (July 5, 2016)); *id.* at Ex. E-2, NMHC001000-02 (CHOICES, *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs* (Nov. 4, 2015)).

Insurers that have remained in the market have been forced to raise premiums to build in a cushion for the risk of extreme, destabilizing risk adjustment penalties. A senior HHS official testified that 2017 premiums were on average 22% higher than they were in 2016, with some states seeing increases of 50%. *See* Am. Compl., ¶ 28. HHS has admitted that "[t]he health and competitiveness of the Exchanges, as well as the individual and small group markets in general, have recently been threatened by issuer exit and increasing rates in many geographic areas." Market Stabilization, 82 Fed. Reg. 10,980, 10,981 (Feb. 17, 2017).

State insurance commissioners have also warned of the harms caused by the risk adjustment rules. Al Redmer, Jr., the insurance commissioner of Maryland, testified that the ability of new carriers to continue in the market "is severely jeopardized by the adverse and perhaps fatal financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs." Ex. G-1 to NMHC 2018 Comment, NMHC001331 (Redmer Written Testimony (Feb. 25, 2016)); *see also* Ex. G-2 to NMHC 2018 Comment, NMHC001335 (Letter from Maria Vullo, NY DFS Superintendent, to CMS (June 28, 2016) ("DFS is concerned that the risk adjustment program has caused inappropriately disparate impacts among health insurance issuers in New York and unintended consequences.")). The Iowa, Wisconsin, and

Washington insurance commissioners have likewise spoken out against the program. *See* Am. Compl., ¶ 39.

c. Evidence Outside Of The Current Record Further Shows That Vacating The Rules Is Not Manifestly Unjust

While it is NMHC's position that the record on this Rule 59 motion should be limited to the administrative record and the record on summary judgment, if the Court is to consider HHS's new evidence outside of that record, it must also consider additional new evidence that provides a more fulsome context and that undermines the Wu Declaration.

Attached as Exhibit A is a Declaration from Myja Peterson, Plaintiff's Senior Director of Health Plan Analytics, explaining in detail how neither NMHC nor its competitors in New Mexico have been able to predict the results of the risk adjustment formula – all contrary to Mr. Wu's blithe assumption of a readily predictable formula engendering reliance interests. *See* Ex. A, Declaration of Myja Peterson (Apr. 20, 2018) (the "Peterson Declaration"). In addition, the Peterson Declaration explains in detail how the risk adjustment formula has unfairly penalized New Mexicans with artificially inflated health care premiums.

Moreover, in litigation involving the risk adjustment program in federal court in New York, the State of New York recently filed a Declaration by John Powell, the Director of Rate Review, Health Bureau of the New York State Department of Financial Services ("DFS"), which describes in detail the harm caused by HHS's risk adjustment program. *See* Ex. B, *United Healthcare of New York, Inc. et al. v. Vullo*, No. 17-7694, Declaration of John Powell (S.D.N.Y Feb. 16, 2018) (the "Powell Declaration"). That case involves a challenge by United Healthcare, the nation's largest health insurance company, to New York state insurance regulations designed to mitigate the impact of HHS's program. The Powell Declaration describes the inability of

United – which is number six on the Fortune 500 with over $180 billion in annual revenue[4] – to project its risk adjustment receivables. Powell Decl., at ¶ 35. If a company with such massive resources and sophistication cannot figure out how to predict risk adjustment, one is at a loss to know why Mr. Wu is so certain that there are significant reliance interests in this supposedly predictable formula.

Mr. Powell further explained that the risk adjustment formula, including the use of the statewide average premium, is deeply flawed and driving competition out of the market. *Id.* at ¶¶ 38-41. Accordingly, New York developed its own regulations "to ensure market stability until HHS was able to take action within the ACA-Risk Adjustment methodology to correct for the destabilizing impact." *Id.* at ¶ 40. Most significantly for purposes of HHS's motion, New York contacted Mr. Wu himself to explain its concerns and planned remedial measures. *Id.* at ¶ 42. Mr. Wu did not dispute New York's conclusions. *Id.*

As discussed above, many of the CO-OP insurers have been forced out of business. The legal filings putting those companies into receivership and/or converting them into for-profit entities make it clear that the flawed risk adjustment program was the cause of their demise. Ex. C, *Wade v. HealthyCT, Inc.,* No. 16-6072516, Pet. for Order of Rehabilitation (Conn. Sup. Ct. Nov. 1, 2016), at ¶ 16 ("On July 1, 2016, the Commissioner, pursuant to Conn. Gen. Stat. § 38a-962b, placed HealthyCT under an order of administrative supervision having determined that the imposition of the 2015 risk adjustment by CMS placed HealthyCT in a financial condition such that the continuance of its business would be hazardous to the public or to its insureds."); Ex. D, Evergreen Health, Inc., App. for Conversion of a Nonprofit HMO (May 1, 2017), at 2 (noting that the risk adjustment program disadvantages small, start-up carriers and

[4] *See* Fortune 500, *Full List*, available at http://fortune.com/fortune500/list/ (last visited Apr. 22, 2018).

that Evergreen's 2016 risk adjustment transfer "wip[ed] out all of Evergreen Health's financial gains over the prior two-and-a-half years."); Ex. E, *Comm'r of Ins. v. Minuteman Health, Inc.*, No. SJ-2017-0288, Verified Compl. Requesting Appointment of Liquidator (Mass. Sup. Ct. Mar. 16, 2018), at ¶ 16 (attributing Minuteman's negative financial performance and ultimate demise in part on "the actual risk adjustment payable by MHI in 2017 was approximately $6 million higher than the amount estimated and recorded as of December 31, 2016").

In fact, the CEO's of those COOP's have made clear that, contrary to Mr. Wu's sanguine certainty that risk adjustment is predictable, their companies had been unable to predict the magnitude of the crippling risk adjustment liabilities imposed upon them. *See* Ex. F, Declaration of Kenneth Lalime; Ex. G, Declaration of Peter Beilenson; Ex. H, Declaration of Kathryn Howell.

4. Any Relief Specifically Limited To New Mexico Is Improper

HHS argues for the first time in this Motion that the Court should limit any relief to the State of New Mexico. But HHS should have presented this argument to the Court at summary judgment and it cannot be raised for the first time now. *Platte*, 2015 U.S. Dist. LEXIS 107998, at *2. Additionally, there is no reason to limit the vacatur to New Mexico. The regulations apply nationwide. Courts regularly vacate and enjoin enforcement of nationwide regulations even when challenged by an individual plaintiff. *See e.g. Earth Island Inst. v. Ruthenbeck*, 459 F.3d 954, 966 (9th Cir. 2006), *rev'd on other grounds,* 555 U.S. 488, 500 (2009).

III. CONCLUSION

For the foregoing reasons, NMHC respectfully requests that the Court deny HHS's Motion to Alter/Amend the Judgment.

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Respectfully submitted:

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CERTIFICATE OF SERVICE

I hereby certify that on April 23, 2018, I electronically filed the foregoing Memorandum of Law In Opposition to Plaintiff's Rule 59 Motion using the Court's CM/ECF system, causing a notice of filing to be served upon all counsel of record.

/s/ Nancy R. Long
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