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

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

Plaintiff,

v.

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

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

Defendants.

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

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I. Introduction and Summary

The Patient Protection and Affordable Care Act ("ACA") was enacted in 2010 to guarantee access to health insurance to all Americans regardless of preexisting condition or health status. Yet the promise of access was illusory without affordability. Access and affordability in turn required an additional element: competition. Without a robust market of health insurance issuers competing and innovating to cut costs, consumers would be at the mercy of one or two dominant carriers.

To help spur competition, the ACA created the Consumer Operated and Oriented Plan Program (the "CO-OP" program) through which the federal government loaned billions of dollars to start-up nonprofit carriers to inject new competition into stagnant insurance markets. Plaintiff New Mexico Health Connections ("NMHC") is the CO-OP for New Mexico. NMHC delivered on Congress's goals, offering innovative new products that were substantially less expensive. NMHC has developed an intensive and proactive medical management program in which it focuses on reducing barriers to access primary care and behavioral health care; engaging with members to ensure adherence to prescription drug regimens; and coordinating multiple facets of members' care, including professionals such as social workers and community health workers in treatment plans. These initiatives keep NMHC's members healthier, which is not only a good thing in and of itself but also reduces the high costs that are triggered by deteriorating health, such as increased hospitalizations. Even though NMHC has been issuing policies for little more than three years, it has already signed up tens of thousands of enrollees.

Yet NMHC's success has been threatened by HHS's[1] unlawful, arbitrary, and capricious risk adjustment program. Under the so called "risk adjustment" program, the Secretary of HHS

[1] As all other Defendants are officials or agencies of Defendant United States Department of Health and Human Services, Defendants are referred to collectively as "HHS."

is tasked with creating a methodology in which issuers with above average actuarial risk (that is, sicker membership) in a state will receive a subsidy, and issuers with below average actuarial risk (that is, healthier membership) will make a payment into the program. The theory of risk adjustment is that success in the marketplace should not be based on drawing healthier or sicker members, but rather on the merits of price, quality, and service.

But that is not how HHS has implemented this mandate from Congress. Instead of promoting competition, HHS created a system that penalizes innovative cost-cutting issuers like NMHC and forces them to transfer a substantial portion of their revenue to their higher-priced, less efficient competitors. NMHC was assessed a risk adjustment charge amounting to 21.5% of its premiums for benefit year 2014 and a charge amounting to almost 15% of its premiums for benefit year 2015. *See* Declaration of Martin Hickey, MD (Oct. 5, 2016), NMHC 2018 Comment, Ex. B-1, at ¶¶ 17-18, NMHC000865-66.[2] These punitive assessments are particularly devastating in the health insurance industry, where well-managed, successful companies hope for a margin of between 2%-5% per year. Paying out 14%-22% of premiums in one year can wipe out a carrier's margins for years to come, imposing a huge burden on NMHC and its members. *Id.* at ¶ 19, NMHC000866. As a result of similar charges, many low-priced competitors have either left the public exchanges or been forced out of business. As competition has withered and

[2] On February 22, 2017, HHS filed the Administrative Record. While reviewing the Administrative Record, it came to the Parties' attention that certain materials were inadvertently omitted from the record as-filed. Accordingly, the Parties stipulated that each Party could submit a Bates-stamped supplemental appendix with their briefs to include any materials that would properly be considered part of the Administrative Record, *i.e.*, submissions to HHS via regulations.gov regarding the Notices of Benefit and Payment Parameters governing the risk adjustment methodology that were omitted from the record. *See* Stip. Concerning Admin. R., ECF No. 29. NMHC has filed a supplemental appendix with this brief. Materials cited from this supplemental appendix are labeled with the Bates prefix "NMHC" and are cited throughout the brief with reference to this "NMHC" Bates label. Materials from the incomplete February 22, 2017 Administrative Record contained only numerical stamping, and are referred to throughout this brief as "Rec. at XX."

as the risk adjustment program continues to generate enormous and volatile payment transfers, premiums on the ACA exchanges have skyrocketed.

These perverse results stem from a regulatory scheme that flies in the face of Congress's goals of affordability and competition:

- HHS's formula does not make assessments based on actuarial risk. Instead, after computing how much an issuer's actuarial risk is above or below the state's average, HHS multiplies that differential by the weighted average premium in the state to determine payments and charges. This improperly penalizes any carrier that prices below the statewide average, as its required payment will be artificially inflated to the extent that it is lowering prices below the statewide average.

- HHS does not accurately measure actuarial risk. HHS devised a methodology that focuses on whether patients, after their enrollment, are documented as having specific chronic and/or high-cost conditions, such as diabetes or HIV/AIDS. But HHS systematically underestimates the costs of health care for enrollees lacking a documented diagnosis of this type.

- HHS misses many members with chronic illnesses because the methodology ignores prescription drug data and fails to account for members who are enrolled for only a brief duration and thus may not be diagnosed by a doctor during their short enrollment window.

- Finally, the ACA specifies that insurers will offer four types of health insurance plans identified by metallic level: bronze, silver, gold, and platinum. While the ACA mandated the availability of all four types of coverage, HHS's risk adjustment formula has made low-cost bronze plans economically unviable, essentially forcing out an entire affordable product line that Congress intended to be offered on the ACA exchanges.

HHS has admitted to every one of these problems, but has ignored them or punted the solutions far into the future. As a result, NMHC was forced to bring this action under the Administrative Procedures Act. NMHC respectfully requests that this Court vacate the unlawful, arbitrary, and capricious risk adjustment regulatory scheme.

II. Statement of Facts

A. The Mission of the ACA: Expand Access to Affordable Healthcare

1. Prior to the ACA, insurers could reject high risk individuals and price policies for consumers based on their individual risk factors. This left millions unable to obtain coverage – either because they could not qualify for any plan or because they could not afford the exorbitant premiums charged. The ACA addressed this problem through two provisions: guaranteed issue and community rating. Under guaranteed issue, insurers cannot deny coverage based on preexisting conditions or other factors, such as occupation, that might predict the use of health services. *See* 42 U.S.C. §§ 300gg-1 – 300gg-5. Under community rating, insurers, with very few exceptions, are prohibited from varying premiums within a geographic area. *Id*.

2. The ACA also promoted *affordability* by, for example: creating a public health insurance marketplace, offering subsidies to offset the cost of insurance for those who could not otherwise afford it, and encouraging innovation and competition among insurers. *See* 42 U.S.C. § 18041; 26 U.S.C. § 36B; 42 U.S.C. § 18071; 42 U.S.C. § 18042.

3. By encouraging (and rewarding) competition, the ACA sought to push insurance prices down. *See e.g., Nat'l Fed'n of Indep. Bus. v. Sebelius,* 132 S. Ct. 2566, 2580 (2012) (Congress created ACA to "increase the number of Americans covered by health insurance and decrease the cost of health care.").

B. The Risk Adjustment Program

4. The new rules – particularly guaranteed issue and community rating – represented a seismic shift in the way insurance companies operated. Along with the influx of millions of new enrollees without established health care data, the new rules made it difficult, if not impossible, to accurately predict health care costs, posing a substantial risk of premium volatility. To mitigate this risk, the ACA established three premium stabilization programs,

often referred to as the "3R's": the reinsurance, risk corridors, and risk adjustment programs. Only one of these programs is at issue in this litigation: risk adjustment. The risk adjustment program aims 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. *See* Exh. 1, CMS, *The Three Rs: An Overview* (Oct. 1, 2015).

5. The program seeks 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).

6. The ACA directs that "[t]he Secretary [of HHS], in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section."[3] *Id.* at § 18063(b).

7. HHS did not promulgate one rule to cover all benefit plan years moving forward, but rather it issues a Notice of Benefit and Payment Parameters ("NBPP") for each benefit plan year that sets the annual risk adjustment formula. Each NBPP is a separate notice

[3] If individual states decide not to implement this program, HHS assumes that function. *See* 45 C.F.R. § 153.310(a)(2).

and comment rulemaking proceeding under the Administrative Procedures Act. However, as HHS noted in the index filed to the Administrative Record, these rulemaking proceedings are cumulative: "Subsequent to the [initial] 2014 Benefit Rule, each annual HHS Notice of Benefit and Payment Parameters ('Annual Benefit Rule') was informed by and built on prior Annual Benefit Rules. Therefore, the record for each Annual Benefit Rule incorporates the records for each of the preceding Annual Benefit Rules." *See* Index to the Rulemaking Record, at 3, n. 2, ECF No. 25-1. Below is a chart summarizing the iterative NBPP rulemaking proceedings being challenged in this case:

Benefit Year	**Notice of Proposed Rule**	**Notice of Final Rule**
2014	HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,117 (Dec. 7, 2012), Rec. at 000112	HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,409 (Mar. 11, 2013), Rec. at 000226, *as amended by* Amendments to the HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 65,045 (Oct. 30, 2013), NMHC001597
2015	HHS Notice of Benefit and Payment Parameters for 2015, 78 Fed. Reg. 72,321 (Dec. 2, 2013), Rec. at 004460	HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,743 (Mar. 11, 2014), Rec. at 004532
2016	HHS Notice of Benefit and Payment Parameters for 2016, 79 Fed. Reg. 70,673 (Nov. 26, 2014), Rec. at 005593	HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,749 (Feb. 27, 2015), Rec. at 005681
2017	HHS Notice of Benefit and Payment Parameters for 2017, 80 Fed. Reg. 75,487 (Dec. 2, 2015), Rec. at 007645	HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203 (Mar. 8, 2016), Rec. at 007747
2018	HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61,455 (Sept. 6, 2016), Rec. at 009513	HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94,057 (Dec. 22, 2016), Rec. at 009595

8. While certain features of the formula have evolved over time, at a general level HHS's approach to risk adjustment has stayed the same. Risk adjustment assessments and

payments are based on "risk scores" ascribed to a plan's membership base. Members' risk scores are intended to reflect their anticipated health care costs based on age, gender, and medical diagnoses. An individual with more complex medical needs (and, presumably, higher costs) should be given a higher risk score. A membership base's risk score is then compared with the weighted average risk score within the relevant state. Insurers with higher risk (sicker) individuals should receive risk adjustment payments from HHS, and insurers with lower risk (healthier) members should make payments to HHS. *See generally* 78 Fed. Reg. at 15,430, Rec. at 000247.

9. HHS has chosen to operate the risk adjustment program in a budget-neutral manner so that all payments to issuers in a state are funded by charges assessed against other issuers in the same state. *See e.g.*, 81 Fed. Reg. at 94,101, Rec. at 009638.

10. 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. *See* 78 Fed. Reg. at 15,430-34, Rec. at 000247-51; 79 Fed. Reg. at 13,754, Rec. at 004543; 80 Fed. Reg. at 10,771, Rec. at 005703; 81 Fed. Reg. at 12,229-30, Rec. at 007773-74; 81 Fed. Reg. at 94,100, Rec. at 009637.

C. The Risk Adjustment Program Destabilizes the ACA Exchanges

11. There was a significant time lag between the promulgation of the initial 2014 benefit year rules in March 2013 and the publication of the first risk adjustment results (the actual dollar assessments) in late Summer 2015. When the numbers were finally crunched, there were several unpleasant surprises. Many small issuers were forced to pay out well over 10% of their premiums in risk adjustment assessments, even though margins in the health insurance industry are typically, at best, a razor thin 2%-3%. *See* Letter from CHOICES to CMS (Apr. 22, 2016), NMHC 2018 Comment, Ex. E-5, at 2, NMHC001018.

12. Often, one year of risk adjustment assessments was wiping out five plus years of profits. These assessments proved too much for many issuers. For example:

- Excessive risk adjustment assessments forced the closure of most of the twenty-three new CO-OP start-up insurance issuers that the ACA established. *See* NMHC 2018 Comment, at 3 n. 2, NMHC000837; Maj. Staff of H. Comm. on Energy & Com., 114th Cong., *Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program* (Sept. 13, 2016), NMHC 2018 Comment, Ex. C-1, at 19-22, NMHC000910-13; Conn. Ins. Dept., *Insurance Department Places HealthyCT Under Order of Supervision* (July 5, 2016), NMHC 2018 Comment, Ex. G-4, at 1-2, NMHC001351-52; CHOICES, *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs* (Nov. 4, 2015), NMHC 2018 Comment, Ex. E-2, at 11-13, NMHC001000-02.

- Preferred Medical, a longtime issuer in Florida, was whacked with a risk adjustment bill of nearly $100 million, leading to its withdrawal from the exchanges and, eventually, financial collapse. *See* CHOICES (Nov. 4, 2015), at 12, NMHC001001.

- Molina Healthcare is now unsure whether it will participate in the exchanges next year after losing $110 million on its ACA exchange business last year, due to paying $325 million more into risk adjustment than it had anticipated. *See* Exh. 2, Jeff Byers, *Molina Hangs 2016 Income Losses on Poor ACA Market Performance,* Healthcare Dive (Feb. 16, 2017); Exh. 3, Zachary Tracer, *One Insurer Says Obamacare in 'Death Spiral,' Another May Quit,* Bloomberg (Feb. 15, 2017).

13. State insurance commissioners – the primary regulators of health insurance[4] – have increasingly sounded the alarm about risk adjustment. Maryland's Insurance Commissioner testified as follows to Congress:

> Over the past few years, new innovative health insurance plans have been created that are providing enhanced competition and patient care. And it is working. For year-end 2014, CareFirst had a 91% market share of the individual market in Maryland. Today, it is 57%, due in part to a more competitive marketplace. These [new] carriers have the potential to continue, but their ability to do so is severely jeopardized by the adverse and perhaps fatal

[4] HHS has acknowledged the states as the "primary regulators of their insurance markets." *See* Amendments to Special Enrollment Periods and the Consumer Operated and Oriented Plan Program, 81 Fed. Reg. 29,146, 29,152 (May 11, 2016).

> financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs.

Al Redmer, Jr., Written Testimony (Feb. 25, 2016), NMHC 2018 Comment, Ex. G-1, at 1, NMHC001331.

14. New York's Insurance Commissioner wrote that her agency "is concerned that the risk adjustment program has created inappropriately disparate impacts among health insurance issuers in New York" and "I support immediate changes to the risk adjustment program …" Letter from Maria Vullo, NY Superintendent of Financial Services, to Sylvia Burwell, Secretary, HHS & Andrew Slavitt, Administrator, CMS (June 28, 2016), NMHC 2018 Comment, Ex. G-2, at 1-2, NMHC001335-36. The Iowa, Wisconsin, and Washington insurance commissioners have likewise spoken out against the program. *See* NMHC Am. Compl., ¶ 39.

15. The logical result of the excessive financial penalties and diminished competition caused by risk adjustment has been higher prices. A senior HHS official testified that 2017 premiums are on average 22% higher than they were in 2016, with some states seeing increases of 50%.[5] *See* NMHC Am. Compl., ¶ 28.

16. HHS recently 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).

D. NMHC Is Severely Harmed by the Risk Adjustment Formula

17. NMHC, a low-cost, innovative start-up issuer, has been crippled in its growth by the out of control risk adjustment program. NMHC was formed by a group of

[5] BCBS in New Mexico raised its rates for individual insurance products by 93% in 2017. *See* NMHC Am. Compl., ¶ 31.

community advocates in 2011 and then applied for a CO-OP program loan under Section 1322 of the ACA. *See* Hickey Decl., at ¶¶ 25-26, NMHC000867.

18. Congress recognized that individuals and small businesses lacked sufficient affordable alternatives within the existing private insurance market, and that such alternatives were necessary to achieve the goal of near-universal health care coverage for all Americans. *See* Exh. 5, Annie L. Mach & Grant A. Driessen, Cong. Research Serv., R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions* (2016).

19. Congress created the CO-OP program to enhance competition. A CO-OP must use any profits "to lower premiums, to improve benefits, or for other programs intended to improve the quality of health care delivered to its members." 42 U.S.C § 18042(c)(4).

20. Substantially all of the activities of the CO-OP must consist of issuing CO-OP qualified health plans in the individual and small group markets; substantially all of the CO-OP policies likewise must be plans offered in those markets. *Id.* at § 18042(c)(1)(B); 45 C.F.R. § 156.515(c)(1).

21. Congress appropriated billions of dollars to HHS to fund loans for the launch and growth of CO-OPs across the United States. *See* 42 U.S.C. § 18042(g). In order to receive these loans, a CO-OP must offer insurance plans on State "Exchange[s]." 45 C.F.R. § 156.515(c). Thus, from the start, every CO-OP, including NMHC, was obligated to participate in the exchange marketplaces created by the ACA.

22. Loan applicants were required to submit detailed business plans for HHS's review. *See* Exh. 4, HHS, et al., *Amended Announcement: Invitation to Apply*, *Loan Funding Opportunity Number: OO-COO-11-001*, 13-14 (Dec. 9, 2011). These business plans were in turn expressly incorporated into the final loan agreements. *See* Exh. 5, Mach & Driessen, *FAQ* (2016), at 4 n.23.

23. On February 19, 2012, NMHC signed a loan agreement with HHS to fund its initial formation and operation in New Mexico. NMHC began enrolling members in October 2013 for coverage set to go into effect in January 2014, when the ACA exchanges launched in New Mexico. *See* Hickey Decl., at ¶ 27, NMHC000867.

24. NMHC has shaken up New Mexico's long stagnant health insurance sector by reinventing the role of a health insurance company. Instead of being a third-party finance company fighting about medical bills, NMHC is a proactive partner in managing its members' care. 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:

- No co-payments for chronic disease generic drugs and behavioral drugs, thus reducing barriers to adherence to medication that controls and stabilizes health conditions;
- First three visits to primary care and behavioral health providers are free to the enrollee with no copayment, deductible, or co-insurance;
- Personalized outreach to patients to ensure compliance with medication regimens;
- Care coordination, including follow-up visits with primary care providers after a hospitalization;
- Assistance of community health workers and social workers when needed; and
- Intense personalized medical management of high risk individuals.

See id. at ¶ 34, NMHC000868-69.

25. To take but one example of NMHC's approach in practice, NMHC identified over 7,500 new members in the Albuquerque area who had no reported doctor visits, and thus appeared to be falling through the cracks. NMHC partnered with the Davita physician medical group (formerly known as ABQ Health Partners) to develop outreach and scheduling processes that resulted in nearly 30% of those who were reachable being scheduled for a comprehensive assessment visit within 3 months. *See* CHOICES (Nov. 4, 2015), at 8, NMHC000997.

26. These programs work. For example, by the second quarter of 2015, NMHC had reduced hospitalizations per 1,000 enrollees to only 37.3, well below the state average of 70. *See id.* at 7, NMHC000996. Similarly, NMHC's rate of hospital readmissions frequently beats the national benchmarks set by HHS. *Id.* at 7-8, NMHC000996-97.

27. NMHC's relentless focus on improving health care and proactively intervening before enrollees' health status declines has allowed it to save money by avoiding costly hospitalizations and other expensive specialty care, leading in turn to lower premiums. Since its inception, NMHC has offered the lowest cost or second lowest cost plan available in each of New Mexico's five rating regions. *See* Hickey Decl., ¶ 31, NMHC000868.

28. The popularity of NMHC's approach to health insurance is evident in the significant growth NMHC has achieved in each of its three years of existence – from 14,000 members in 2014 to 33,000 members in 2015 to 44,500 members in 2016. *See id.* at ¶ 33, NMHC000868.

29. And it is not just NMHC's enrollees who benefit. At a meeting of the National Association of Insurance Commissioners, the Superintendent of Insurance of New Mexico stated to his colleagues that the entry of NMHC had saved New Mexico health insurance

subscribers over half a billion dollars over the last three years by simply being a new competitor in the market and focusing on care management and cost. *See id.* at ¶ 36, NMHC000869.

30. But the risk adjustment program threatens to stall NMHC in its tracks. For benefit year 2014, NMHC was assessed a risk adjustment charge of $6,666,798.00, representing 21.5% of its premiums. *See id.* at ¶ 17, NMHC000865.

31. NMHC's risk adjustment penalty was paid over to New Mexico's long-time, dominant carrier, Blue Cross Blue Shield of New Mexico ("BCBS"), whose Chicago-based parent has billions of dollars in excess reserves. *See id.* at ¶¶ 17, 43, NMHC000865, NMHC000871.

32. As if the sting from 2014 was not bad enough, NMHC's risk adjustment charge for benefit year 2015 was a whopping $14,569,495.74, which amounts to 14.7% of its premiums. Again, this money will be paid out as a subsidy to BCBS. *See id.* at ¶ 18, NMHC000866.

III. Argument

A. Standard of Review Under the Administrative Procedures Act

This action arises under the Administrative Procedure Act (the "APA"). Because an agency's power can be no greater than that delegated to it by Congress through an enabling statute, the APA provides that courts must set aside agency action that is in excess of that agency's "statutory jurisdiction, authority, or limitations[.]" 5 U.S.C. § 706(2)(C); *see Lyng v. Payne*, 476 U.S. 926, 937 (1986). Accordingly, agency actions that exceed permissible authority under their enabling statute "are *ultra vires* and should be invalidated." *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 43 (D.D.C. 2012). The APA also requires courts to set aside agency action that is "arbitrary, capricious, an abuse of discretion or otherwise not in accordance with law[.]" 5 U.S.C. § 706(2)(A).

When evaluating claims that agency action is contrary to statutory mandate, the Court employs the familiar two-step *Chevron* analysis. *Chevron, U.S.A., Inc. v. NRDC, Inc.,* 467 U.S. 837 (1984). Under *Chevron*, the Court must first determine whether "Congress has directly spoken to the precise question at issue." *Id.* at 842. "If the intent of Congress is clear, that is the end of the matter" because the Court must "give effect to the unambiguously expressed intent of Congress." *Id.* at 842-43. Importantly, when making this determination, "a statutory provision cannot be read in isolation, but necessarily derives its meaning from the context provided by the surrounding provisions, as well as the broader context of the statute as a whole." *Luminant Generation Co. v. EPA*, 714 F.3d 841, 850 (5th Cir. 2013). If the statute is clear, then the text of that statute will control, and no deference is given to agency interpretation. *Id.*

If, however, the statute is "silent or ambiguous with respect to the specific issue," then the Court embarks on the second step of the *Chevron* analysis. *Barnhart v. Walton*, 535 U.S. 212, 218 (2002) (quoting *Chevron*, 467 U.S. at 843). Under *Chevron* step two, the Court must determine whether the agency's action was "based on a permissible construction of the statute." *Id.* If the agency's interpretation of the statute is unreasonable, the agency's action is not entitled to deference and must be invalidated. While step two is deferential, the Court must still engage in a careful analysis; deference is not "abject deference" and the Court cannot "rubber stamp" agency action that is inconsistent with Congressional intent. *Transp. Union-Ill. Legi. Bd. v. Surface Transp. Bd.*, 169 F.3d 474, 477 (7th Cir. 1999); *see also Castaneda v. Souza*, 810 F.3d 15, 23-24 (1st Cir. 2015).

Agency action that meets statutory requirements may still be invalidated if it is arbitrary and capricious. While the *Chevron* analysis focuses on whether agency action is in line with the statutory mandate, the arbitrary and capricious standard examines the evidence relied upon by the agency and the rationality of its decisions. The Court must conduct a "sufficiently probing

review to ensure that the agency has not relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise." *San Luis & Delta-Mentodota Water Auth. v. Locke*, 776 F.3d 971, 994 (9th Cir. 2014).

At a minimum, the agency must have "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.' In reviewing that explanation, [a reviewing court] must 'consider whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment.'" *Motor Vehicle Mfrs. Assn. of the U.S., Inc. v. State Farm Mutual Automobile Ins. Co.,* 463 U.S. 29, 43 (1983) (citations omitted). The Court is not permitted to supply its own reasoned basis for the agency's action that is not found in the administrative record. *See SEC v. Chenery*, 318 U.S. 80, 87-88 (1943); *Camp v. Pitts*, 411 U.S. 138, 142 (1973); *Sierra Club v. Marsh*, 976 F.2d 763, 769 (1st Cir. 1992).

Agency action is arbitrary and capricious when the agency fails to address alternatives or criticisms suggested by commenters. The agency "must respond to significant points raised during the public comment period." *Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv*., 707 F.3d 462, 471 (4th Cir. 2013) (Where an agency receives "critical commentary" but "add[s] nothing to the final [rule] to respond to it" the agency has failed to "articulate a satisfactory explanation for its action that demonstrates a rational connection between the facts found and the choice made," such action should be struck down as arbitrary and capricious) (internal quotations and citations omitted); *Allied Local & Reg'l Mfrs. Caucus v. EPA*, 215 F.3d 61, 79-80 (D.C. Cir. 2000) *cert. denied*, 532 U.S. 1018 (2001); *Bedford Cnty. Mem. Hosp. v. HHS*, 769 F.2d 1017, 1020 (4th Cir. 1985); *Nat'l Audubon Soc'y v. Evans*, No. 99-1707 (RWR), 2003 U.S. Dist.

LEXIS 23675, at *15 (D.D.C. July 3, 2003); *Crowley's Yacht Yard, Inc. v. Peña*, 863 F. Supp. 18, 21 (D.D.C. 1994); *see Home Box Office, Inc. v. FCC*, 567 F.2d 9, 35 (D.C. Cir. 1977). In *State Farm*, the seminal case governing arbitrary and capricious review, the Court invalidated agency action when the agency completely failed to address alternative methodologies; the agency's "nonexistent" analysis was insufficient because "an agency must cogently explain why it has exercised its discretion in a given manner… ." 463 U.S. at 48.

In developing and implementing the risk adjustment program, HHS exceeded its authority as set forth in the ACA and imposed a scheme that is both contrary to law and arbitrary and capricious.

B. The Risk Adjustment Formula's Use of the Statewide Average Premium is Contrary to Law and Arbitrary and Capricious

1. The Statewide Average Premium Unlawfully Penalizes Price-Cutting

While the statutory direction for risk adjustment is not detailed, it is explicit on one point: an issuer may only be assessed a charge under the program "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… ." 42 U.S.C. § 18063(a)(1) (emphasis added). Congress has thus unambiguously provided that risk adjustment assessments cannot be based on factors other than actuarial risk, and HHS is mandated to follow this clear statutory text. *See Chevron,* 467 U.S. at 842-43; *Dion v. Commissioner Me. Dep't of Human Servs.,* 933 F.2d 13, 15 (1st Cir. 1991); *NRDC v. EPA,* 755 F.3d 1010, 1019 (D.C. Cir. 2014). HHS has failed to comply with this statutory directive. That failure has caused significant and ongoing harm to NMHC.

The problem is the formula that HHS uses to calculate payments into and out of the program. After each plan is scored for the relative health of its enrollees, HHS uses the

statewide average premium and total billable member months as multipliers to calculate each issuer's risk adjustment debit or credit. *See* 78 Fed. Reg. at 15,430-34, Rec. at 000247-51; 79 Fed. Reg. at 13,754, Rec. at 004543; 80 Fed. Reg. at 10,771, Rec. at 005703; 81 Fed. Reg. at 12,229-30, Rec. at 007773-74; 81 Fed. Reg. at 94,100, Rec. at 009637.

But this use of the statewide average premium is an unlawful departure from Congress's mandate that risk adjustment assessments be based solely upon actuarial risk. The statewide average premium is, as its name suggests, a calculation of the average premium charged by all issuers across a given state; it is weighted by plan share of statewide enrollment in the risk pool. *See* 78 Fed. Reg. at 15,430-34, Rec. at 000247-51. Given the weighting by market share, issuers with dominant market positions – such as BCBS in New Mexico – drive the statewide average premium through their own prices, which are typically quite high. *See* Hickey Decl., at ¶¶ 58-67, NMHC000875-76.

Average premium is very different than relative actuarial risk. Premiums are based upon not only whether the population of insureds are healthier or sicker, but also on whether an issuer can control its costs by paying lower prices to hospitals and doctors, by doing a better job managing its members' medical care, by reducing administrative overhead, and by controlling other costs. *See, e.g.,* NMHC 2018 Comment, at 11, NMHC000845; CHOICES (Nov. 4, 2015), at 9*,* NMHC000998; CHOICES (Apr. 22, 2016), at 2-3, NMHC001018-19; David V. Axene & Gregory G. Fann, *Comments on Proposed Rule* (Oct. 5, 2016), Minuteman 2018 Comment, Ex. I-1, at 8-14, NMHC000597-603; NMHC 2017 Comment, at 3, NMHC001454.

This mismatch between premiums and actuarial risk has resulted in devastating and improper assessments against NMHC. For example, in 2015, the statewide average premium was $314.00 per month, while NMHC's individual average premium was only $270.00 per month. *See* Hickey Decl., at ¶ 63, NMHC000875. The use of the statewide average premium

instead of NMHC's own premium has inflated NMHC's risk adjustment assessments by millions of dollars. *See id.* at ¶ 65, NMHC000876.

NMHC does not have lower premiums because it dodges sicker enrollees. NMHC's enrollee population is not healthy. In fact, New Mexico has the highest prevalence of Hepatitis C in the nation (a diagnosis which has almost no risk score credit) and NMHC enrolled a very high proportion of that population. *See* NMHC 2018 Comment, at 19-20, NMHC000853-84. What NMHC has done to lower premiums is make smart investments in its members' care, including: (1) engaging proactively in its members' medical management to ensure that members take their medications; (2) eliminating out of pocket costs for preventive care services; and (3) coordinating its members' care and incorporating non-traditional services, including social work support. *See* Hickey Decl., at ¶¶ 31-35, NMHC000868-69. All of these investments and efforts improve health outcomes and keep overall costs down. By keeping people healthier, NMHC reduced the high costs that are incurred, in connection with long hospital admissions, when an individual's health deteriorates. *Id.* at ¶¶ 14-15, NMHC000865. In addition, NMHC reduced its costs by negotiating lower reimbursement rates (prices for services) from hospitals and doctors than its competitors did. *See* NMHC 2018 Comment, at 19, NMHC000853.

This is competition working: NMHC entered a stagnant, overpriced insurance market as an innovative start-up and created a lower-cost insurance option by being smarter, more nimble, and investing in initiatives that result in better health outcomes. This is a plan that should be rewarded. Instead, the risk adjustment formula has penalized NMHC by making it subsidize higher-priced competitors through assessments based on the use of the statewide average premium. As CHOICES, a coalition of insurance issuers, explained in a white paper prepared with the technical assistance of former CMS Chief Actuary Rick Foster:

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

CHOICES (Nov. 4, 2015), at 9, NMHC000998.

Thus, when NMHC's premium changed from 3% below the individual market average premium to 14% below the market average premium between 2014 and 2015, the adjustment in the percentage in the risk adjustment transfer that is attributable to the use of the market average premium (instead of NMHC's own premium) then increased from 6% in 2014 to 16% in 2015. *See* Hickey Decl., at ¶ 67, NMHC000876.

Another CO-OP, Minuteman Health, attached a white paper from Axene Health Partners, an expert actuarial consulting firm, to its comments to the 2018 NBPP. *See generally* Axene Report, NMHC000587. Axene concluded that the risk adjustment formula's use of the statewide average premium penalizes price-cutting by innovative, low-cost insurance issuers:

> The 'premium' nature of the transfer payment i[s] not appropriate. The calculation penalizes efficient issuers with the inclusion of administrative costs in the transfer payment formula. As transfer payments are based on premium amounts rather than claims, low cost issuers pay an inflated amount based upon reasons unrelated to the risk of their enrolled population. Many other risk adjustment methodologies, including Medicare Advantage, appropriately recognize only the claims portion of the costs as risk adjustment coefficients apply only to claim amounts. . . .
>
> [Minuteman] is a case example of these issues. It has a 15% to 25% pricing advantage over the average market rates because it excludes higher cost providers, has better than average care management results, and employs a narrow network approach. However, the statewide average premium acts to offset this with a penalty. The result is that [Minuteman] pays a risk adjustment assessment that is much more than

> its risk relative to the market. This also means that [Minuteman] must price its product higher than the market risk to account for the added burden of the statewide average premium adjustment. The statewide average premium adjustment is totally unrelated to the cost of care and has added over 40% to [Minuteman's] costs.

Id. at 9, 13, NMHC000598, NMHC000602.

As the Axene Report explains, market shifts that have nothing to do with an issuer's actuarial risk can cause large swings in risk adjustment liability because of the use of the statewide average premium. For example, if NMHC's larger competitors simply raised their prices, the statewide average premium would necessarily rise too and thus NMHC's risk adjustment liability would increase – even though the individuals buying insurance from each issuer may stay exactly the same. *Id.* at 11, NMHC000600. Similarly, a migration of insureds from NMHC's lower-priced competitors to its higher-priced competitors – without any change in the composition of NMHC's membership and their actuarial risk – would increase the statewide average premium (which is weighted by enrollment volume) and thus NMHC's risk adjustment liability. *Id.*

HHS's formula perversely rewards price-increasing behavior, even though, as HHS has conceded, one of Congress's goals in enacting the ACA was to make health care more affordable by driving insurance premiums *down*. *See e.g.,* Exh. 6, CMS, *Reducing Costs, Protecting Consumers: The Affordable Care Act on the One Year Anniversary of the Patient's Bill of Rights* (Sept. 23, 2011), at 3-4. As the CHOICES white paper noted, risk adjustment assessments are exaggerated by the percentage that a low-priced competitor undercuts the market average price. Pricing at or above the market average premium is thus rewarded, and pricing below the average is penalized. It is no surprise that, since HHS issued the first risk adjustment assessments in Summer 2015, premiums on the exchange marketplaces have skyrocketed. *See e.g.*, Exh. 7, Antonia Ferrier, *Obamacare: Premium Increases Aplenty,* InsuranceNewsNet (May 16, 2016).

NMHC and others have repeatedly objected to the agency's use of the statewide average premium. *See e.g.,* NMHC 2018 Comment, at 11-13, NMHC000845-47; Minuteman 2018 Comment, at 9-12, NMHC000009-12; CHOICES 2018 Comment, at 5, NMHC001435; NMHC 2017 Comment, at 3, NMHC001454 (attaching CHOICES (Nov. 4, 2015)); Minuteman 2017 Comment, at 6-7, NMHC001442-43; Evergreen 2017 Comment, at 2, Rec. at 009436; Land of Lincoln Health 2017 Comment, at 5, Rec. at 009007. In response, as explained below, the agency has either denied the problem or offered belated half-measures.

2. HHS's Proffered Justifications for the Initial Risk Adjustment Rule Do Not Excuse Its Unlawful Use of the Statewide Average Premium

The earliest detailed discussion of the statewide average premium was in a September 2011 white paper issued by HHS with the title *Risk Adjustment Implementation Issues*, in which the agency discussed how to structure the risk adjustment program in time for the launch of the ACA exchanges in 2014. HHS recognized that Congress had charged it with only adjusting for differences in actuarial risk: "The aim of the risk adjustment methodology is to result in plan premiums that differ due to benefit levels and efficiency, but not the risk of their enrolled population." CCIIO, *Risk Adjustment Implementation Issues* (Sept. 12, 2011), at 13, Rec. at 000659. HHS considered both the option of using the statewide average premium and each issuer's own premium in computing assessments and payments. *Id.* at 14-15, Rec. at 000660-61. HHS's own modeling showed that use of the statewide average premium would penalize low-priced issuers and drive premiums up. *Id*. at 38, Rec. at 000684.

Slightly over a year later, on December 7, 2012, HHS issued its proposed rulemaking for risk adjustment for 2014. *See* 77 Fed. Reg. 73,117, Rec. at 000112. Despite knowing the result would be to penalize low-cost competitors, HHS chose to use the statewide average premium for two reasons: (1) to assure budget neutrality, *i.e.*, that payments in and payments out under the

program would always sum to zero; and (2) "The State average premium provides a straightforward and predictable benchmark for estimating transfers." *Id.* at 73,139, Rec. at 000134. The agency's main point was that use of the statewide average premium would be easy from an administrative standpoint, and the agency could achieve budget neutrality without having to make further adjustments or calculations. The agency did not focus on whether this approach was consistent with the ACA or on whether this approach would have harmful effects on the low-cost providers that emerged under the CO-OP program.

In a later phase, in response to public comments that the statewide average premium improperly sweeps in non-risk related administrative costs, HHS added two other cryptic comments: (3) "use of a plan's own premium may cause unintended distortions in transfers"; and (4) "both claims and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium." 78 Fed. Reg. at 15,432, Rec. at 000249.

HHS never coherently confronted the requirements of the ACA, and never offered any justification for developing a methodology driven by factors unrelated to actuarial risk:

First, there is no statutory requirement that risk adjustment be budget neutral. In fact, HHS has never explained why it believes the program must be budget neutral. This Court owes no deference to naked assertions by agencies that lack reasoned explanation. *See e.g., Encino Motorcars, LLC v. Navarro,* 136 S. Ct. 2117, 2125 (2016)*; Judulang v. Holder,* 565 U.S. 42, 55 (2011)*; State Farm,* 463 U.S. at 43. Indeed, HHS has no specialized expertise in budgeting and appropriations, and thus its views on budget neutrality are entitled to no deference. *See King v. Burwell,* 135 S. Ct. 2480, 2489 (2015).

There is no language in Section 1343 of the ACA, which created the program, requiring budget neutrality. *See generally* 42 U.S.C. § 18063. If anything, the structure of the statute suggests the contrary. As HHS has recognized repeatedly, risk adjustment is one of the three

interrelated premium stabilization programs set out in Sections 1341-1343 of the ACA and referred to as the "3 R's." *See e.g.,* Exh. 1, CMS, *The Three Rs: An Overview*; Exh. 8, CMS, *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (Mar. 2012). In one of the three R's – the reinsurance program – Congress expressly made payments out subject to issuers' payments in. *See* 42 U.S.C. § 18061(b)(1)(B). The lack of such a budget neutrality provision in the risk adjustment provision of the ACA strongly suggests that Congress intentionally omitted it and meant for the programs to be administered differently. *See Bates v. United States*, 522 U.S. 23, 29-30 (1997) ("Where Congress includes particular language in one section of a statute, but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposefully in the disparate inclusion or exclusion.") (internal citations omitted); *Barnhart,* 545 U.S. at 438-40.

The third "R" – the risk corridors program[6] – also contained no language mandating budget neutrality. *See generally* 42 U.S.C. § 18062. In March 2013, HHS thus took the position that the risk corridors program was *not* budget neutral. *See* 78 Fed. Reg. at 15,473, Rec. at 000290. In 2014, certain members of Congress asked the U.S. Government Accountability Office ("GAO") whether there was an appropriation to fund payments owed out under the risk corridors program. In response, the GAO opined that the general appropriation to HHS for carrying out its "other responsibilities" would be available for risk corridors program liabilities, in addition to any payments made by issuers into the program. See Exh. 9, GAO, B-325630, *HHS – Risk Corridors Program* (Sept. 30, 2014), at 3-4. Although Congress later restricted the

[6] The risk corridors program generally provided that if an issuer's losses exceeded a certain target, it would be partially made whole by the government, and if an issuer's gains exceeded a certain target, it would pay a portion of those excess gains into the program. *See Health Republic Insurance v. United States,* 129 Fed. Cl. 757, 761-62 (2017).

use of HHS's annual appropriation as to the risk corridors program,[7] it has never placed similar restrictions on risk adjustment. Thus, presumably, HHS has remained free to fund the risk adjustment program from its general program appropriations.

In the most recent rulemaking for the 2018 benefit year, HHS largely admitted that the risk adjustment program need not be budget neutral: "In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner. . . ." 81 Fed. Reg. at 94,101, Rec. at 009638. In other words, there is no mandate of budget neutrality, but the agency asserts (without analysis) that it would potentially lack enough funds to pay its obligations. But if HHS's agency budget lacked sufficient appropriations, underpaid issuers could sue in the Court of Federal Claims and recover any unpaid monies from the Judgment Fund. *See Slattery v. United States*, 635 F.3d 1298, 1316-17 (Fed. Cir. 2011); *N.Y. Airways, Inc. v. United States*, 369 F.2d 743, 748 (Ct. Cl. 1966).

Even assuming for the sake of argument that risk adjustment must be budget neutral, it still does not follow that HHS had authority to use the statewide average premium and assess charges based on factors other than actuarial risk. HHS's statements about risk adjustment assume that budget neutrality requires a formula in which it will be mathematically impossible for payments in and out to ever be imbalanced. But that is not how the agency has administered the other two R's. HHS's reinsurance program regulations provide that, if payments in for a year are insufficient to fund payments out, then it will make a *pro rata* reduction in payments out. *See* 45 C.F.R. § 153.230(d); 45 C.F.R. § 153.232(e); 45 C.F.R. §153.235(a). Similarly, after Congress restricted HHS's ability to pay risk corridors liabilities from its annual appropriation,

[7] *See* Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, § 227; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, § 225. As a result of these restrictions, HHS has not had funds available to pay its risk corridors obligations. NMHC is one of many issuers suing in the Court of Federal Claims for monies owed under the risk corridors program.

HHS operated a system where it reduced payments out on a *pro rata* basis to account for any shortfall of payments in. *See Health Republic Ins.,*129 Fed. Cl. at 768. In its 2011 white paper, HHS expressly recognized it could do the same thing in risk adjustment – base assessments and payments on each issuer's own premium, and make any necessary *pro rata* adjustments if there is a shortfall of payments in. CCIIO, *Risk Adjustment Implementation Issues*, at 15, Rec. at 000661.[8]

In sum, budget neutrality is not required and does not itself require the use of the statewide average premium. There is no justification for HHS's failure to follow the plain language of the statute that risk adjustment assessments be based solely on actuarial risk.[9]

Second, HHS claims that "[t]he State average premium provides a straightforward and predictable benchmark for estimating transfers." 77 Fed Reg. at 73,139, Rec. at 000134. To begin with, there is no explanation or backup data for this statement, and it is accordingly entitled to no deference. *See e.g., State Farm,* 463 U.S. at 43; *Judulang,* 565 U.S. at 53; *Encino Motorcars,* 136 S. Ct. at 2125-26. Furthermore, HHS wrongly assumes the statewide average premium is easily knowable and predictable. The statewide weighted average may be knowable for issuers with large market shares, because their pricing decisions will drive the statewide average. But it is a black box for smaller issuers like NMHC. NMHC must set its premiums for

[8] While the risk adjustment statute does direct HHS to look to the risk adjustment programs under Medicare Parts C and D, *see* 42 U.S.C. § 18063(b), that is no help here: risk adjustment under Part C is not budget neutral, while risk adjustment under Part D is budget neutral. *See* Exh. 10, CMS, *Report to Congress: Alternative Payment Models & Medicare Advantage*, at 13; Exh. 11, CBO, *Reconciliation Recommendations of the S. Comm. on Finance* (Oct. 27, 2005), at 9; HHS, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194 (Jan. 28, 2005).

[9] The Congressional Budget Office has stated, in the past, that the risk adjustment program is budget neutral. *See* Exh. 12, CBO, *The Budget and Economic Outlook: 2014 to 2024* (Feb. 2014), at 59. But the CBO's discussion contains no analysis or citation on this point, and it is unclear if it is simply referring to the budget neutral regulatory scheme implemented by HHS, as opposed to any statutory requirement. Regardless, the CBO's views do not excuse HHS from failing to follow the plain text of the ACA limiting risk adjustments to relative actuarial risk. *See Ameritech Corp. v. McCann,* 403 F.3d. 908, 913 (7th Cir. 2005) ("[T]he CBO's view – on which the Congress did not vote, and the President did not sign – cannot alter the meaning of enacted statutes.").

a given benefit year in the previous calendar year, so that, for example, it had to finalize 2015 premiums in 2014. *See e.g.,* Exh. 14, New Mexico Office of Superintendent of Insurance, *Qualified Health Plan Submission Information*. NMHC does not learn of its risk adjustment liability until well into the following year; for example, it learned of its risk adjustment liability for 2015 on June 30, 2016 – by which time it had already set premiums for 2016 and 2017. *See* 45 C.F.R. § 153.310. There is nothing predictable here at all.

These concerns are real and pervasive. In February 2016, Milliman, a leading actuarial consulting firm, published a white paper that assessed, *inter alia*, just how well issuers were able to predict the outcome of HHS's risk adjustment formula. *See* Daniel J. Perlman & David M. Liner, *Financial Analysis of ACA Health Plan Issuers,* Milliman (Feb. 2016), NMHC 2018 Comment, Ex. E-3, NMHC001005. Milliman made two key findings. First, in 2014 over half of all issuers predicted their risk adjustment payment/assessment to be $0, a result that Milliman largely attributed to plan actuaries throwing their hands up in the air at their inability to predict the outcome of the formula. *Id.* at 3, NMHC001007. Second, while the minority of issuers who did predict either an assessment or payment tended to be directionally correct as to whether they would be creditors or debtors, the predictions of the magnitude of payments and assessments were wildly off. *Id.* In fact, in New Mexico, every carrier assumed in its rate filings for 2017 that it would incur a risk adjustment charge – although that is mathematically impossible under the budget neutral formula and can only be explained by insurers feeling unable to predict the formula's outcome and thus needing to protect against contingent risk. *See* Hickey Decl., at ¶¶ 53-54, NMHC000873-74.

Third, HHS claimed that "use of a plan's own premium may cause unintended distortions in transfers." 78 Fed. Reg. at 15,432, Rec. at 000249. But HHS nowhere explained what these "distortions" are. Once again, the agency's naked say-so, without any supporting explanation

and data, is not entitled to any deference. *See e.g., State Farm,* 463 U.S. at 43; *Judulang,* 565 U.S. at 53; *Encino Motorcars,* 136 S. Ct. at 2125-26; *Sorenson Communs. v. FCC*, 567 F.3d 1215, 1220-21 (10th Cir. 2009).

Fourth, HHS asserted that "both claims and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium." 78 Fed. Reg. at 15,432, Rec. at 000249. Once again, this statement came with no supporting data and explanation, and thus is entitled to no deference. *See e.g., State Farm,* 463 U.S. at 43; *Judulang,* 565 U.S. at 53; *Encino Motorcars,* 136 S. Ct. at 2125-26; *Sorenson Communs.*, 567 F.3d at 1220-21. HHS further ignores the fact that issuers can, as NMHC did, reduce claims costs by improving their members' health care outcomes and by negotiating lower prices with health care providers.

The statement is also exaggerated, as many administrative costs have nothing to do with risk selection. For example, if Insurer A is in a low-cost area and insurer B is in a high-cost area, Insurer A may be able to pay lower wages to its employees.

3. HHS Reluctantly Concedes The Problem But Refuses To Fix It

Despite the flimsy justifications put forward for the 2014 rule, NMHC and other issuers tried to make the system work. The first risk adjustment results, for benefit year 2014, were published by HHS on June 30, 2015. *See* Exh. 13, HHS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (June 30, 2015). By then, HHS had already promulgated regulations governing risk adjustment for 2015 and 2016, maintaining the same use of the statewide average premium. *See* 79 Fed. Reg. at 13,754, Rec. at 004543; 80 Fed. Reg. at 10,771, Rec. at 005703.

These results made clear that the system is broken. In response to HHS's December 2, 2015 publication of proposed rulemaking for the 2017 benefit year, NMHC and numerous others

submitted voluminous comments attacking the agency's use of the statewide average premium, noting that it penalized low-cost issuers who drove down costs through more efficient operations and innovative offerings. *See e.g.,* NMHC 2017 Comment, at 3, NMHC001454 (attaching CHOICES (Nov. 4, 2015)); Minuteman 2017 Comment, at 6-7, NMHC001442-43; Evergreen Health 2017 Comment, at 2, Rec. at 009436; Land of Lincoln Health 2017 Comment, at 5, Rec. at 009007.

The agency published its response on March 8, 2016: "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, Rec. at 007774. This refusal to respond to detailed, reasoned comments from stakeholders is the very epitome of arbitrary and capricious behavior. *See e.g., Allied Local,* 215 F.3d at 79-80; *Bedford Cnty. Mem. Hosp.,* 769 F.2d at 1020; *Dow AgroSciences LLC,* 707 F.3d at 471; *Nat'l Audubon Soc'y,* 2003 U.S. Dist. LEXIS 23675, at *15; *Crowley's Yacht Yard, Inc.,* 863 F. Supp. at 21; *see Home Box Office, Inc.,* 567 F.2d at 35.

At the end of March 2016, HHS held a public meeting regarding risk adjustment, in connection with which it published a lengthy white paper. HHS continued to defend its use of the statewide average premium. It cited, again without supporting analysis, the same canard about alleged need for budget neutrality. *See* CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016), NMHC 2018 Comment, Ex. F-1, at 83, NMHC001158. HHS also claimed that "[u]sing the Statewide average premium minimizes issuers' ability to manipulate their transfers by adjusting their own plan premiums." *Id.* This comment was not accompanied by any analysis or data showing a risk of such "gaming," nor even much in the way of explanation. And with good reason: the same gaming risk exists in the system created by HHS using the statewide average premium. As Axene demonstrated in its white paper, any issuer can increase its premiums to increase the magnitude

of risk adjustment transfers because every issuer's premium – and especially issuers with larger market share – impacts the calculation of the statewide average premium. *See* Axene Report, at 11, NMHC000600.

Still, there were glimmers of hope. HHS conceded it was assessing charges against issuers for reasons other than actuarial risk:

> We are also investigating whether the risk adjustment methodology appropriately addresses plan differences not fully captured by aspects of the current risk adjustment methodology. For example, although a number of sources of premium variation – such as metal level, age, and geographic cost factors – are explicitly addressed in the transfer equation, others – such as network differences, plan efficiency, or effective care coordination or disease management – are not. We are exploring a number of ways of addressing such plan differences in our methodology, including through potentially modifying the transfer equation, perhaps by modifying the equation using a plan's own premium . . . .

CMS (Mar. 24, 2016), at 93, NMHC001168. HHS admitted the "Statewide average premium embeds an average level of efficiency" and thus "[a]ll plans receive a risk adjustment payment or charge sufficient for a plan with average efficiency", even if they have competed hard and innovated to achieve superior efficiency; HHS gives every issuer a C even if some studied hard and deserve A's. *See id.* at 83, NMHC001158.

HHS next published its proposed new rulemaking for the 2018 benefit year on September 6, 2016, proposing to continue using the statewide average premium but nevertheless stating that "[w]e are continuing to evaluate the impact of administrative expenses on risk adjustment transfers, and seek comment on removing a portion of administrative expenses from the Statewide average premium for the 2018 benefit year or for future benefit years." 81 Fed. Reg. at 61,488, Rec. at 009546. NMHC and others again submitted comments detailing how the use of the statewide average premium violates the terms of the ACA and wrongly penalizes innovative, low-cost competitors. *See e.g.,* NMHC 2018 Comment, at 11-13, NMHC000845-47;

Minuteman 2018 Comment, at 9-12, NMHC000009-12; CHOICES 2018 Comment, at 5, NMHC001435.

In the final rule, HHS conceded that the use of the statewide average premium is improper: "Based on comments received, HHS will reduce the Statewide average premium in the risk adjustment transfer formula by 14 percent to account for the proportion of administrative costs that do not vary with claims beginning for the 2018 benefit year."[10] 81 Fed. Reg. at 94,099-100, Rec. at 009636-37. This 14% figure was the agency's calculation of the "mean administrative cost percentage" independent of claims costs. *Id.* at 94,100, Rec. at 009637.

This is too little and too late. To start with, too late: HHS has now admitted that it was inflating risk adjustment assessments in 2014 and 2015 – and will do so again for 2016 and 2017 – by not applying this 14% adjustment. At a minimum, if the agency has determined that its formula was overstating actuarial risk by a calculated percentage, then that correction must be made for all years of the program.[11] *See e.g., Natural Fuel Gas Supply Corp. v. F.E.R.C.,* 59 F.3d 1281 (D.C. Cir. 1995) (holding that a court's invalidation of a regulation should be given

[10] The 14 percent reduction was not set forth in the proposed rulemaking, and there was no opportunity for the public to comment. Thus, this portion of the 2018 rulemaking is not entitled to the deference afforded to notice and comment rulemaking under the APA. *Chao v. Occupational Safety and Health Review Comm'n*, 540 F.3d 519, 526-27 (6th Cir. 2008); *Hasan v. GPM Invs., LLC*, 896 F. Supp. 2d 145, 149 (D. Conn. 2012).

[11] Such a correction is an appropriate form of relief here. While the Supreme Court has explained that an *agency's* power to promulgate a retroactive rule is limited, *see Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204 (1988), such limitation is inapplicable here where NMHC is not challenging a retroactive rule promulgated by HHS. *See Beverly Hosp. v. Bowen,* 872 F.2d 483, 485-86 (D.C. Cir. 1989) (noting that *Georgetown* prohibits retroactive agency *rulemaking* but leaves room for "retroactive corrective adjustments"). Rather, NMHC is requesting that the Court invalidate a series of rules. When a *Court* invalidates a rule, if there are any retroactive effects, that is an inevitable by-product of judicial review. *See e.g.*, *Lion Health Servs. Inc.*, 635 F.3d 693. Moreover, in this case, any modification to a prior risk adjustment assessment resulting from this Court's ruling can be implemented by HHS giving future credits (rather than retroactive payments); this is HHS's standard process when assessments are challenged based on agency calculation errors. *See* 79 Fed. Reg. at 13,768-69, Rec. at 004557-58; *see also* HHS, *Bulletin on the Risk Adjustment Program: Proposed Operations by the DHSS* (May 1, 2012), at 9, Rec. at 000642 ("HHS does not intend to make retroactive adjustments to prior years' payments and charges based on data validation error results. More specifically, the risk score error results based on the data validation for benefit year 2014 would apply prospectively during the risk score and payments and charges calculation processes for benefit year 2015"). Awarding credits for use in future years would be prospective relief and would eliminate any potential concern over retroactive relief.

retroactive effect); *United States v. Goodner Bros. Aircraft, Inc.,* 966 F.2d 380 (8th Cir. 1992) (same); *Beverly Hosp. v. Bowen,* 872 F.2d 483, 486 (D.C. Cir. 1989) (same; court has a duty to "make certain that the agency does not accomplish by indirection what the court's invalidation *ab initio* decrees the agency cannot directly do."); *Lion Health Servs. Inc. v. Sebelius,* 635 F.3d 693 (5th Cir. 2011) (invalidating agency regulation for all years – prior, past, and future – and ordering a recalculation of refunds owed to plaintiffs); *Comm. for Fairness v. Kemp*, 791 F. Supp. 888 (D.D.C. 1992) (ordering recalculation of funds under a regulation for prior years). NMHC should not be made to suffer unnecessary harm because it took the agency years to acknowledge its own mistake.

It is also too little. Once more, HHS refuses to recognize that competition and innovation are real factors that impact upon premiums. The 14% figure is a "mean"; like any average, it underestimates the high performers who work hard to be more efficient. The 14% reduction also ignores that there are factors driving premium levels that are not either risk selection or administrative costs, such as NMHC's innovative medical management that improves health outcomes and cuts costs and NMHC's success in securing lower prices from hospitals and doctors. HHS is therefore still assessing charges based on factors other than actuarial risk, but simply doing so at a lower rate.

It is in each issuer's own premium that these factors are controlled for. But HHS continues its opposition to using each issuer's own premium:

> We have considered the use of a plan's own premium instead of the Statewide average premium. However, our analysis determined that this approach is likely to lead to substantial volatility in transfer results and even higher transfer charges for low-risk low-premium plans. Under such an approach, high-risk, high-premium plans would require even greater transfer payments; thus, low-risk, low-premium plans would be required to pay in an even higher percentage of their plan-specific premiums in risk adjustment transfer charges. In other words, the use of a plan's own premium does not reduce risk adjustment charges for low-

> cost and low-risk issuers, given the budget neutrality of the risk adjustment program.

81 Fed. Reg. at 94,100, Rec. at 009637.

There is no explanation or supporting data for the asserted "substantial volatility", so the Court need not linger over that red herring. *See e.g., State Farm,* 463 U.S. at 43; *Judulang,* 565 U.S. at 53; *Encino Motorcars,* 136 S. Ct. at 2125-26; *Sorenson Communs.,* 567 F.3d at 1220-21. Instead, HHS once again falls back on the view that the program's supposed budget neutrality ties its hands. But, as explained above, that contention is without merit. *See supra*, at 22-25.

In sum, HHS's use of the statewide average premium is a clear violation of the plain text of the ACA's risk adjustment provision and should be invalidated and declared illegal as contrary to law. *See* 5 U.S.C § 706(2)(C); *Hackwell v. United States,* 491 F.3d 1229, 1233 (10th Cir. 2007) (invalidating agency regulation that was "contrary to the [statute's] plain language"); *NRDC*, 755 F.3d at 1019 (vacating agency regulation that contradicted the "plain intent" of Congress). In the alternative, to the extent that the matter is not settled by the clear statutory language, HHS's actions have been arbitrary and capricious in violation of the APA. *See* 5 U.S.C § 706(2)(A); *State Farm,* 463 U.S. at 43; *Judulang,* 565 U.S. at 53; *Encino Motorcars,* 136 S. Ct. at 2125-26; *Sorenson Communs.*, 567 F.3d at 1220-21.

C. HHS Underestimates the Costs of Healthier Enrollees

Not only does the risk adjustment formula improperly assess charges based on factors unrelated to actuarial risk, it also fails to measure actuarial risk accurately in the first place. To assess relative actuarial risk, HHS's risk adjustment formula begins by calculating a risk score for each enrollee. The risk score is intended to reflect the relative health status and, correspondingly, the predicted costs of care for that individual. *See* 78 Fed. Reg. at 15,419, Rec. at 000236. The calculation begins with a coefficient based only on age and gender. That

coefficient will be increased if the enrollee has been diagnosed with one or more hierarchal condition categories ("HCCs"), such as diabetes or HIV/AIDS, that is documented during the plan year. Each HCC has a corresponding coefficient, with higher values intended to represent more serious and costly health conditions. HCC coefficients are added to the age/gender coefficient to calculate an enrollee's overall risk score. The risk score is ultimately a prediction of relative future health care costs for an individual. HHS calculates risk scores based on data submissions from issuers.

However, HHS severely underpredicts the costs of enrollees who do not qualify for an HCC. For example, an individual without an HCC may:

- Utilize preventive care services.
- Get sick during the year, such as with a severe flu.
- Experience catastrophic injury, fracture, or trauma.
- Suffer from chronic low back pain.
- Need joint replacement surgery.
- Be at risk for developing a condition covered by an HCC code, such as Type 2 diabetes, and need aggressive clinical intervention to prevent the onset of such a chronic condition. Perversely, the risk adjustment formula financially penalizes such efforts to stop the onset of a chronic illness.

See Hickey Decl., at ¶¶ 83-88, NMHC000882-83; Declaration of Thomas Policelli (Oct. 6, 2016), Minuteman 2018 Comment, Ex. B-1, at ¶¶ 85-91, NMHC000058-59; NMHC 2018 Comment, at 9, NMHC000843; Mary van der Heijde & Jordan Paulus, *Risk Adjustment: Overview and Opportunity* (Aug. 25, 2015), NMHC 2018 Comment, Ex. E-1, at 3, NMHC000984.

For these reasons, the HHS formula underestimates health care costs for enrollees without an HCC by 10%-35%. *See* Memorandum from Richard S. Foster to CHOICES Exec.

Comm. (July 15, 2016), NMHC 2018 Comment, Ex. E-8, at 1, 7, NMHC001042, NMHC001048; *see also* CHOICES (Nov. 4, 2015), at 4-5, NMHC000993-94. Though healthier enrollees should be profitable and thus balance out losses from sicker enrollees, that is not the case. After application of risk adjustment, NMHC and other issuers actually ***lose*** money on enrollees without an HCC. *See e.g.,* Hickey Decl., at ¶ 87, NMHC000883; Policelli Decl., at ¶¶ 89-90, NMHC000059; Molina Healthcare 2018 Comment, at 3, Rec. at 0011555.

This dynamic is particularly perverse for NMHC. By engaging with its members and encouraging them to monitor and maintain their health by utilizing certain health care services, NMHC is doing its best to prevent its members from developing HCC-qualifying conditions in the first place. But by improving its members' health so that they do not develop, for example, Type 2 diabetes, the risk adjustment system guarantees that NMHC loses money on such members, as they lack an HCC. If NMHC neglected its members' medical management, though, and simply let their conditions deteriorate, its members may then qualify for an HCC classification and be profitable. This absurd result – that carriers are given financial incentives ***not*** to improve health outcomes – cannot be what Congress wanted.

Issuers have raised this flaw with HHS from the outset of the program. *See e.g.,* BCBSA 2014 Comment, at 5, Rec. at 004330; NMHC 2017 Comment, at 2, NMHC001453; Minuteman 2017 Comment, at 4-6, NMHC001440-42; Health New England 2017 Comment, at 5, 7, Rec. at 008487, 008489; NMHC 2018 Comment, at 9-10, NMHC000843-44; Minuteman 2018 Comment, at 13-14, NMHC000013-14; Molina Healthcare 2018 Comment, at 3, Rec. at 0011555; Emblem 2018 Comment, at 2, Rec. at 011232. HHS has reluctantly admitted to this estimation bias flaw. 81 Fed. Reg. 61,472, Rec. at 009530.

This problem is far from innocuous. The flawed formula penalizes the enrollment of younger and healthier members needed to balance the risk pool and avoid a "death spiral" of

rising medical costs spurring higher premiums that drive everyone but the most acutely ill out of the market. *See King,* 135 S. Ct. at 2486, 2493 (noting that the goal of the ACA is to avoid a "death spiral"). As Anthem, the nation's second largest health issuer, explained in its comments to HHS:

> We agree with the President's recent letter to issuers that stated that the fourth open enrollment period is a critical time for the Affordable Care Act (ACA) and that it is very important that more young and healthy individuals enroll in order to 'improve the risk pool and consequently the affordability of coverage for all enrollees.' Unfortunately, the existing risk adjustment methodology impedes the pursuit of this goal as the revenue for healthy members is insufficient to fund costs after risk adjustment charges, while issuers are being overcompensated for the segment of members who have moderate health conditions. . . .
>
> This imbalance is not in the long-term interest of the risk adjustment program because those incentives create a worsening risk pool that results in higher premiums for consumers.

Anthem 2018 Comment, at 2, 11, NMHC001474, NMHC001483.

Yet HHS took no action to fix this bias before the 2017 rulemaking. Even then HHS only added a factor – to begin in 2017 – to account for the cost of preventive care services. *See* 81 Fed. Reg. at 12,218-19, Rec. at 007762-63. But, as Anthem pointed out, "the impact of this change is relatively small" and "does little to change the relative value of HCC members to non-HCC members." Anthem 2017 Comment, at 8-9, NMHC001528-29. CMS ultimately agreed that "overall this is not a very large effect…." 81 Fed. Reg. 12,218, Rec. at 007762.

In the 2018 rulemaking, HHS proposed several potential solutions to the estimation bias problem. *See* 81 Fed. Reg. at 61,472-73, Rec. at 009530-31. Even though the agency "believe[s] that some of the modeling approaches we considered could improve the model's predictive ability", it nevertheless refused to take any action because "we are still evaluating the tradeoffs that would need to be made in model predictive power among subgroups of enrollees." 81 Fed. Reg. at 94,083, Rec. at 009620.

This handwringing is unnecessary because the estimation bias problem can be easily fixed. As part of its comments to the 2018 proposed rulemaking, NMHC submitted a white paper authored by former CMS Chief Actuary Rick Foster explaining how to eliminate the estimation bias. *See* Foster Memo (July 15, 2016), NMHC001042. Mr. Foster explains that "the pattern of estimation bias shown by the predictive ratio can be approximated closely as a function of the predicted risk score and the actuarial value *(AV)*." *Id.* at 5, NMHC001046. In other words, the HHS formula's prediction of health care costs for a person without an HCC is consistently off in a particular amount from actual health care costs in the data sets. Because the bias has a consistent pattern, Mr. Foster developed a mathematical formula to adjust for it.[12] *See generally id.*

Incredibly, HHS did not respond to Mr. Foster's white paper at all, much less offer any reasoning or data to explain why it was not adopting his detailed proposal.[13] *See* 81 Fed. Reg. 94,082-83, Rec. at 009619-20. Where an agency ignores critical comments to proposed rules, it has acted in an arbitrary and capricious manner. *See e.g., Allied Local*, 215 F.3d at 79-80; *Bedford Cnty. Mem. Hosp.*, 769 F.2d at 1020; *Dow AgroSciences LLC*, 707 F.3d at 471. This is because the protections of notice and comment rulemaking under the APA are meaningless if the

[12] Mr. Foster's proposal preserves the budget neutral approach favored by HHS. *See id.* at 10, NMHC001051.

[13] HHS did note obliquely that it had considered some unspecified methodology "in which we would directly adjust plan liability risk scores outside of the model for these subpopulations. For example, we could make an adjustment to the plan liability risk scores calculated through the HHS risk adjustment models that would adjust for such an underprediction or overprediction in actuarial risk by directly increasing low plan liability risk scores and directly reducing high plan liability risk scores in order to better match the relative risks of these subpopulations." 81 Fed. Reg. at 61,473, Rec. at 009531. HHS expressed concern that "there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well." *Id.* It is unclear what model this refers to and what data or reasoning support the unexplained "risk."

agency were free to simply ignore comments from the public. *Home Box Office, Inc.* 567 F.2d at 35.

D. HHS Fails To Accurately Capture HCC Status

The risk adjustment methodology also fails to accurately identify enrollees who should qualify for an HCC, which is key to calculating risk scores. This is due to two factors: (1) HHS's failure to account for partial year enrollees; and (2) HHS's failure to utilize prescription drug data when ascribing risk scores. Despite receiving over 100 comments on these topics since the initial proposed rulemaking for 2014, HHS idly sat on its hands for years, merely offering vague assurances that it would, at some unspecified point in the future, consider these shortcomings. But when it finally agreed to take corrective action, it delayed implementation of the solutions until 2017 and 2018.

1. The Partial Year Enrollee Problem

Partial year enrollment occurs when a member is not enrolled for the full calendar year. *See* Hickey Decl., at ¶ 93, NMHC000884. If the enrollee has an HCC-qualifying condition but does not receive a formal diagnosis *during his/her enrollment in the plan*, the enrollee's risk score will be understated because the plan cannot report the HCC score. *Id.* at ¶¶ 94-95, NMHC000884-85. Consider a patient with diabetes who switches to a new plan mid-year. If the patient visits a physician *during* his enrollment (late in the calendar year), he will receive an HCC-qualifying diagnosis which will then be reflected in his risk score. But if he only visits a physician during the initial part of the year (when he is not yet enrolled in the plan), his diagnosis will not be recorded while he is enrolled in the new plan. Yet he may incur and seek reimbursement for substantial costs for medical devices and prescription drugs.

The problem with partial year enrollees is also exacerbated by the methodology's assumption that health care costs are distributed evenly throughout the year. But this is not

always the case. For example, labor and delivery costs for a pregnant member would be the same regardless of whether the member was covered for 12 months or 3 months. Nevertheless, the methodology applies greater risk weighting for each month a member is enrolled. Thus, short-term members who have an acute event, such as labor and delivery, do not receive adequate credit under the formula. *Id.* at ¶ 96, NMHC000885.

2. The Failure To Utilize Prescription Drug Data

A related problem is the methodology's failure to consider prescription drug data when assessing member risk scores. The inclusion of prescription drug data is "one of the simplest, most effective, and most reliable indicators of health status… ." CHOICES (Nov. 4, 2015), at 5, NMHC000994. As explained *supra,* individuals may not always receive a documented HCC medical diagnosis during their enrollment periods. Accordingly, relying solely on medical diagnosis codes paints an incomplete picture. But, prescription drug data offers an easy way to complete the brush strokes. Consider the same diabetic patient who did not receive an HCC diagnosis while enrolled in the plan. It is highly likely that this patient is managing his condition by regularly filling his insulin prescriptions. Accordingly, utilizing prescription drug data would accurately capture his otherwise missed diagnosis. *See* Hickey Decl., at ¶ 101, NMHC000887.

Moreover, prescription drug data is more reliable than medical diagnosis coding because "[a] pharmacy prescription represents an actual, unaltered medical decision determined by a prescribing physician, while the practice of coding medical diagnoses is often an after the fact subjective determination." Axene Report, at 17, NMHC000606. Using prescription drug data is also more efficient. *See* Minuteman 2017 Comment, at 4, NMHC001440; Pharmaceutical Care Management Association 2017 Comment, at 5, NMHC001662. Establishing diagnoses from medical claims data requires a doctor visit. In contrast, many chronic conditions can be identified quickly and economically by a patient's routine use of specific prescription drugs. *See*

Axene Report, at 16-19, NMHC000605-08. Such data is readily available, adjudicated electronically, and does not require a review of medical records (which can include deciphering handwritten notes). *Id*. at 17, NMHC000606.[14]

NMHC is particularly hard hit by the exclusion of prescription drug data, because NMHC prevents unnecessary hospital and physician encounters by proactively engaging with its members to take their medications. For instance, if a diabetic member of NMHC fails to fill an insulin prescription, NMHC reaches out directly to him or her and tries to figure out why. *See* Hickey Decl., at ¶¶ 14, 103, NMHC000865, NMHC000887. But if NMHC simply ignored the situation and let the member land in an emergency room, there would be a physician encounter generating a diabetes diagnosis. Once again, HHS penalizes NMHC for improving health outcomes and lowering costs.

3. HHS Ignores Years of Comments

Commenters have been raising these issues *ad nauseum* since HHS issued the first NBPP for 2014. *See e.g*, Pharmaceutical Research and Manufacturers of America 2014 Comment, Rec. at 002765, 002768-70. But, for years, HHS failed to seriously consider the issues.

In issuing the final 2014 NBPP, HHS devoted one sentence to the numerous detailed comments it received on the prescription drug issue: "HHS is finalizing its proposal to exclude prescription drugs . . . but will consider how prescription drugs could be included in future HHS risk adjustment models." 78 Fed. Reg. at 15,419, Rec. at 000236.[15]

[14] Because it is myopically focused on diagnosis coding instead of managing and improving health outcomes, the risk adjustment program also rewards health plans that expend significant resources in administrative work capturing and submitting additional diagnosis codes. This gives the advantage to larger health plans who have deeper pockets for pulling in additional administrative resources for manual and intensive work solely related to increasing their risk score.

[15] In the initial notice of proposed rulemaking, HHS did cite a concern that using prescription drug data would encourage physicians to write unnecessary prescriptions. *See* 77 Fed. Reg. at 73,128, Rec. at 000123. But HHS cited no data to support this speculation. And HHS does not explain why a physician would risk a medical

(continued...)

Commenters continued to press the issue in the following years. In its NBPP for 2015, HHS again provided a one-sentence response: "[W]e do not intend to significantly change the model by including pharmacy utilization, though we continue to consider whether and how to include prescription drug data in future models." 79 Fed. Reg. at 13,753, Rec. at 004542. History repeated itself the next year, with HHS again providing a one-sentence response to commenters' concerns that it would "continue to consider including prescription drug data in future model recalibrations." 80 Fed. Reg. at 10,762, Rec. at 005694.

The agency's performance was equally poor in addressing the partial year enrollee problem. In the 2014 NBPP rulemaking, the Association for Community Affiliated Plans submitted a detailed comment explaining the way in which partial year enrollees' risk scores would be understated. *See* ACAP 2014 Comment, at 3-4, NMHC001570-71 (attaching ACAP, *Improving Risk Adjustment in Health Insurance Exchanges to Ensure Fair Payment* (Nov. 28, 2012)). In response, HHS offered two justifications for its formula. *See* 78 Fed. Reg. at 15,421, Rec. at 000238. First, "enrollee diagnoses were included from the time of enrollment" instead of the date of diagnosis coding. *Id.* While helpful, this does not address the core problem of individuals with very short enrollment periods who never see a doctor while enrolled. Second, HHS pointed to the fact that it prorated and averaged medical costs over a 12-month period. *Id.* But this exacerbates the problem, because many enrollees – such as a woman giving birth – have their expenses concentrated in a small time period, and thus averaging such expenses over twelve months significantly underestimates the costs of partial year enrollees. *See* Hickey Decl., at ¶ 96, NMHC000885.

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malpractice claim or ethics charge for prescribing unnecessary medications simply to provide a very slight financial gain to some insurance company. *See* Axene Report, at 17-18, NMHC000606-07; NMHC 2018 Comment, at 7, NMHC000841.

HHS next received a number of comments addressing the problem and offering solutions in response to its 2017 NBPP. *See e.g.,* Viva Health 2017 Comment, at 2-3, NMHC001564-65. While HHS noted its "appreciation" for this feedback, it provided no analysis of the issues raised, only noting (in its preferred one-sentence style) that it would "continue to analyze th[e] issue and include [its] findings in the White Paper for discussion at the March 31, 2016 risk adjustment conference." 81 Fed. Reg. at 12,220, Rec. at 007764.

This repeated failure to consider the problems and solutions raised by commenters constitutes arbitrary and capricious conduct. *See Del. Dep't of Nat. Res. & Envtl. Control v. EPA*, 785 F.3d 1, 15 (D.C. Cir. 2015) (holding that EPA's failure to address critical commentary rendered its action arbitrary and capricious); *Dow AgroSciences LLC*, 707 F.3d at 471; *Bedford Cnty. Mem. Hosp.*, 769 F.2d at 1020.

4. HHS Finally Addresses The Partial Year Enrollee And Prescription Drug Data Issues But Improperly Delays Its Fixes

HHS finally addressed these two issues when it held a meeting to discuss the risk adjustment program in Spring 2016. HHS conceded that actuarial risk for partial year enrollees tends to be underpredicted. *See* March 31, 2016 Discussion Paper, Rec. at 009760. HHS also agreed that there were benefits to the consideration of prescription drug data. *Id.*, Rec. at 009764. Following the March 2016 meeting, HHS issued the NBPP for 2018, and finally implemented initial solutions to the partial year enrollee and prescription drug problems. For partial year enrollment, HHS explained that it would recalibrate the model by adding enrollment duration factors. 81 Fed. Reg. at 94,072, Rec. at 009609. HHS also agreed to incorporate prescription drug utilization indicators into the methodology. *Id.* at 94,076, Rec. at 009613.

However, the partial year enrollee fix will not commence until 2017 and the use of prescription drug data will not begin until 2018. But where, as here, agency action should be

invalidated, the correction should apply to all relevant time periods. *See e.g., Natural Fuel Gas Supply Corp.,* 59 F.3d 1281 (holding that the agency was compelled to give retroactive effect to the decision of a court); *Lion Health Servs.*, 635 F.3d 693 (invalidating agency regulation for all years – prior, past, and future – and ordering a recalculation of refunds owed to plaintiffs).

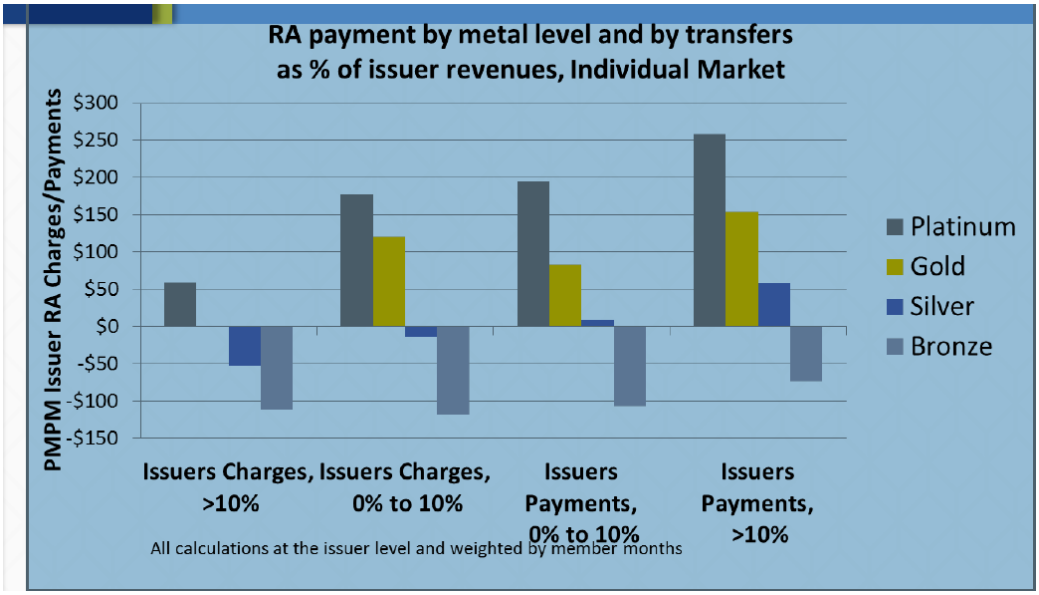
E. HHS Has *De Facto* Banned Bronze Plans in Violation of the ACA

As discussed above, there are numerous flaws in HHS's risk adjustment formula that penalize low-priced health plans and underestimate the cost of enrolling healthier members. These dynamics have had a particularly chilling impact upon "bronze" plans, which are often the preferred health plan option for cost-conscious, healthier enrollees. By wreaking havoc with the economics of bronze plans, HHS's formula is driving these products off the market, in direct contravention of Congress's clear intent that bronze plans be a robust, available option. Without bronze plans, there are fewer attractive options for the healthier enrollees necessary to stabilize the risk pool in the ACA exchanges and avoid a "death spiral" of rising costs and worsening risk selection. *See King,* 135 S. Ct. at 2486.

In the ACA exchanges, there are four types of plans, primarily defined by metallic tier: bronze, silver, gold, and platinum. *See* Hickey Decl., at ¶ 73, NMHC000879. In bronze plans, the issuer must cover 60% of health care costs, while the issuer covers 70% in silver, 80% in gold, and 90% in platinum. *Id.* at ¶ 74, NMHC000879. Bronze plans have the lowest premiums but the highest deductibles. *Id.* Consumers who do not anticipate significant health care needs and/or are price-sensitive tend to purchase bronze or silver products as opposed to gold or platinum products, because of the lower monthly premium expense. *Id.*

Because bronze plans are low-priced and attract a healthier population, the use of the statewide average premium and the underestimation bias against healthier enrollees particularly hammer these products. *See* CHOICES (Apr. 22, 2016), at 3, NMHC001019; Axene Report, at

19, NMHC000608. HHS demonstrated this point itself in Spring 2016, when it published the following chart showing that, under every scenario, bronze plans are always net payors under risk adjustment:



CMS, *HHS-Operated Risk Adjustment Methodology Meeting* (Mar. 31, 2016), at 31, Rec. at 009881.

In an industry with notoriously slim operating margins – often 2-5% at best – this pattern has led NMHC and others to experience steep losses on bronze plans. *See* Hickey Decl., at ¶ 77, NMHC000880; Policelli Decl., at ¶ 77, NMHC000056. Unsurprisingly, issuers around the United States are dropping bronze plans. *See* Policelli Decl., at ¶ 78, NMHC000056-57. This, of course, will further drive away healthier enrollees needed to stabilize the ACA exchange risk pool. *See* Axene Report, at 19, NMHC000608; Policelli Decl., at ¶ 81, NMHC000057.

In other words, the HHS risk adjustment formula makes it extremely difficult for bronze plans to be profitable. However, the ACA expressly provides for bronze plans as an available option in the exchange marketplaces. *See* 42 U.S.C. § 18022(d)(1)(A). Congress thus clearly intended that there must be some viable form of bronze coverage available; otherwise this statutory text would be improperly rendered superfluous. *See e.g., Corley v. United States*, 556

U.S. 303, 314 (2009) ("A statute should be constructed so that effect is given to all of its provisions, so that no part will be inoperative or superfluous, void or insignificant.").

If the agency is not going to end use of the statewide average premium and/or fix the estimation bias in its formula, then it must take some affirmative measure to allow issuers to offer bronze plans without losing money, as Congress intended. For example, bronze plans in a state could be treated as their own risk pool for purposes of risk adjustment so they are not forced to cross-subsidize more expensive plans. HHS has been aware of the potential for discrimination against bronze plans since 2011, long before the exchanges went live in 2014. *See* RTI Letter (Dec. 15, 2011), at 3-4, Rec. at 000811-12. NMHC and others raised this concern during the risk adjustment rulemaking proceedings. *See e.g.* NMHC 2018 Comment, at 14, NMHC000848; Minuteman 2018 Comment, at 12, NMHC000012; CHOICES 2018 Comment, at 5-6, NMHC001435-36. HHS ignored the issue entirely in its rulemaking. A remand to the agency is required in order to have HHS grapple with the question of how the agency can prevent the risk adjustment program from gutting Congress's intent to have viable bronze product offerings. *See e.g., Dow AgroSciences LLC*, 707 F.3d at 475; *Home Box Office, Inc.*, 567 F.2d at 60.

IV. Conclusion

For the foregoing reasons, NMHC respectfully requests that that the Court enter summary judgment in its favor and enter an order vacating HHS's risk adjustment regulations for the years 2014-2018, with instructions to HHS on remand to revise its regulations consistent with this Court's judgment and the express language of the risk adjustment statute.

Dated: April 13, 2017

Respectfully submitted:

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CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of April 13, 2017, I electronically filed the foregoing Memorandum of Law in Support Of New Mexico Health Connections' Motion for Summary Judgment using the Court's CM/ECF system, causing a notice of filing to be served upon all counsel of record.

/s/ Nancy R. Long
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