IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	)	No. 1:16-cv-00878 JB/JHR

NOTICE

Defendants respectfully file this Notice to inform the Court of additional developments that may bear on the Court's consideration of Defendants' Rule 59(e) motion, ECF No. 57, which have occurred since the Defendants' most recent filing of July 25, 2018, ECF No. 81.

HHS has issued a new Notice of Proposed Rulemaking ("NPRM") concerning the risk adjustment methodology for the 2018 benefit year. *See* Ex. A, Patient Protection and Affordable Care Act: Adoption of the Methodology for the HHS-operated Permanent Risk Adjustment Program for the 2018 Benefit Year Proposed Rule (CMS-9919-P), *available at* https://www.federalregister.gov/documents/2018/08/10/2018-17142/patient-protection-and-affordable-care-act-adoption-of-methodology-for-hhs-operated-permanent-risk. This NPRM proposes to adopt the risk adjustment methodology previously promulgated by the agency for the 2018 benefit year. It also responds to the Court's prior decision by providing additional explanation of the agency's use of statewide average premium in the risk adjustment payment

transfer formula, as well as the risk adjustment program's budget neutral design, and seeks comment on these issues. *See* Ex. A at 7–15.

Defendants also notify the Court that the 2017 benefit year rule previously submitted to the Court, Ex. A to ECF No. 81, has now been published in the Federal Register with an effective date of July 30, 2018. *See* 83 Fed. Reg. 36,456 (July 30, 2018).

As stated in their previous notice concerning the new 2017 benefit year rule, Defendants continue to urge the Court to grant their Rule 59(e) motion in full. Issuance of the new 2017 rule and 2018 NPRM clearly does not moot the motion with respect to the 2014-2016 rules. Moreover, the explanations that HHS provided in connection with the new 2017 rule and 2018 NPRM provide additional reasons for the Court to grant the Rule 59(e) motion in its entirety. Thus, we ask the Court to rule on the motion as soon as possible.

Dated: August 8, 2018

Respectfully submitted,

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Acting Assistant Attorney General

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/s/ James Powers
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CERTIFICATE OF SERVICE

I hereby certify that on August 8, 2018, I caused the foregoing document to be served on counsel for plaintiff by filing with the court's electronic case filing system.

/s/ James Powers
James R. Powers

Exhibit A

[Billing Code: 4120-01-P]

DEPARTMENT OF HEALTH AND HUMAN SERVICES

45 CFR Part 153

[CMS-9919-P]

RIN 0938-AT66

Patient Protection and Affordable Care Act; Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Proposed Rule

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

ACTION: Proposed rule.

SUMMARY: This rule proposes to adopt the risk adjustment methodology that HHS previously established for the 2018 benefit year. In February 2018, a district court vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014 through 2018 benefit years. HHS is proposing to adopt the HHS-operated risk adjustment methodology for the 2018 benefit year as established in the final rules published in the March 23, 2012 **Federal Register** and the December 22, 2016 **Federal Register**.

DATES: To be assured consideration, comments must be received at one of the addresses provided below, no later than 5:00 p.m. on September 7, 2018.

ADDRESSES: In commenting, please refer to file code CMS-9919-P. Because of staff and resource limitations, we cannot accept comments by facsimile (FAX) transmission.

Comments, including mass comment submissions, must be submitted in one of the following three ways (please choose only one of the ways listed):

1. Electronically. You may submit electronic comments on this regulation to http://www.regulations.gov. Follow the "Submit a comment" instructions.

2. By regular mail. You may mail written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9919-P,

P.O. Box 8016,

Baltimore, MD 21244-8016.

Please allow sufficient time for mailed comments to be received before the close of the comment period.

3. By express or overnight mail. You may send written comments to the following address ONLY:

Centers for Medicare & Medicaid Services,

Department of Health and Human Services,

Attention: CMS-9919-P,

Mail Stop C4-26-05,

7500 Security Boulevard,

Baltimore, MD 21244-1850.

For information on viewing public comments, see the beginning of the "SUPPLEMENTARY INFORMATION" section.

FOR FURTHER INFORMATION CONTACT:

Krutika Amin, (301) 492-5153; Jaya Ghildiyal, (301) 492-5149; or Adrianne Patterson, (410) 786-0686.

SUPPLEMENTARY INFORMATION:

Inspection of Public Comments: All comments received before the close of the comment period are available for viewing by the public, including any personally identifiable or confidential business information that is included in a comment. We post all comments received before the close of the comment period on the following website as soon as possible after they have been received: http://www.regulations.gov. Follow the search instructions on that website to view public comments.

Comments received timely will also be available for public inspection as they are received, generally beginning approximately 3 weeks after publication of a document, at the headquarters of the Centers for Medicare & Medicaid Services, 7500 Security Boulevard, Baltimore, Maryland 21244, Monday through Friday of each week from 8:30 a.m. to 4 p.m. To schedule an appointment to view public comments, phone 1-800-743-3951.

I. Background

A. Legislative and Regulatory Overview

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

so. For the 2018 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia.

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

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

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

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

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

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

In the November 2, 2017 **Federal Register** (82 FR 51042), we published a proposed rule outlining the Federally certified risk adjustment methodology for the 2019 benefit year, and to

further promote stable premiums in the individual and small group markets. We proposed updates to the risk adjustment methodology and amendments to the risk adjustment data validation process (proposed 2019 Payment Notice). We published the 2019 Payment Notice final rule in the April 17, 2018 **Federal Register** (83 FR 16930). We published a correction to the 2019 risk adjustment coefficients in the 2019 Payment Notice final rule in the May 11, 2018 **Federal Register** (83 FR 21925). On July 27, 2018, consistent with 45 CFR 153.320(b)(1)(i), we updated the 2019 benefit year final risk adjustment model coefficients to reflect an additional recalibration related to an update to the 2016 enrollee-level EDGE dataset.[1]

In the July 30, 2018 **Federal Register** (83 FR 36456), we published a final rule that adopted the 2017 benefit year risk adjustment methodology in the March 23, 2012 **Federal Register** (77 FR 17220 through 17252) and in the March 8, 2016 **Federal Register** (81 FR 12204 through 12352). In light of the court order described below, this final rule sets forth additional explanation of the rationale supporting the use of statewide average premium in the HHS-operated risk adjustment payment transfer formula for the 2017 benefit year, including the reasons why the program is operated in a budget neutral manner. This final rule permitted HHS to resume 2017 benefit year program operations, including collection of risk adjustment charges and distribution of risk adjustment payments. HHS also provided guidance as to the operation of the HHS-operated risk adjustment program for the 2017 benefit year in light of publication of this final rule.[2]

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[1] See, Updated 2019 Benefit Year Final HHS Risk Adjustment Model Coefficients. July 27, 2018. Available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2019-Updtd-Final-HHS-RA-Model-Coefficients.pdf.

[2] See, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2017-RA-Final-Rule-Resumption-RAOps.pdf.

B. The New Mexico Health Connections Court's Order

On February 28, 2018, in a suit brought by the health insurance issuer New Mexico Health Connections, the United States District Court for the District of New Mexico (the district court) vacated the use of statewide average premium in the HHS-operated risk adjustment methodology for the 2014, 2015, 2016, 2017, and 2018 benefit years. The district court reasoned that HHS had not adequately explained its decision to adopt a methodology that used statewide average premium as the cost-scaling factor to ensure that amounts collected from issuers equal the amount of payments made to issuers for the applicable benefit year, that is, a methodology that maintains the budget neutrality of the program for the applicable benefit year.[3] The district court otherwise rejected New Mexico Health Connections' arguments. HHS's motion for reconsideration remains pending with the district court.

II. Provisions of the Proposed Rule

This rule proposes to adopt the HHS-operated risk adjustment methodology that was previously published at 81 FR 94058 for the 2018 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the risk adjustment program. This rule does not propose to make any changes to the previously published HHS-operated risk adjustment methodology for the 2018 benefit year.

The risk adjustment program provides payments to health insurance issuers that enroll higher-risk populations, such as those with chronic conditions, thereby reducing incentives for issuers to structure their plan benefit designs or marketing strategies to avoid these enrollees and lessening the potential influence of risk selection on the premiums that issuers charge. Instead,

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

issuers are expected to set rates based on average risk and compete based on plan features rather than selection of healthier enrollees. The program applies to any health insurance issuer offering plans in the individual or small group markets, with the exception of grandfathered health plans, group health insurance coverage described in 45 CFR 146.145(c), individual health insurance coverage described in 45 CFR 148.220, and any plan determined not to be a risk adjustment covered plan in the applicable Federally certified risk adjustment methodology.[4] In 45 CFR part 153, subparts A, B, D, G, and H, HHS established standards for the administration of the permanent risk adjustment program. In accordance with §153.320, any risk adjustment methodology used by a state, or by HHS on behalf of the state, must be a Federally certified risk adjustment methodology.

As stated in the 2014 Payment Notice final rule, the Federally certified risk adjustment methodology developed and used by HHS in states that elect not to operate the program is based on the premise that premiums for that state market should reflect the differences in plan benefits, quality, and efficiency – not the health status of the enrolled population.[5] HHS developed the risk adjustment payment transfer formula that calculates the difference between the revenues required by a plan based on the projected health risk of the plan's enrollees and the revenues that a plan can generate for those enrollees. These differences are then compared across plans in the state market risk pool and converted to a dollar amount based on the statewide average premium. HHS chose to use statewide average premium and normalize the risk adjustment transfer formula to reflect state average factors so that each plan's enrollment characteristics are compared to the state average and the total calculated payment amounts equal total calculated charges in each

[4] See the definition for "risk adjustment covered plan" at 45 CFR 153.20.
[5] See 78 FR 15409 at 15417.

state market risk pool. Thus, each plan in the risk pool receives a risk adjustment payment or charge designed to compensate for risk for a plan with average risk in a budget neutral manner. This approach supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high-risk enrollees.. Such incentives could arise if HHS used each issuer's plan's own premium in the payment transfer formula, instead of statewide average premium.

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

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

Second, while the PPACA did not include an explicit requirement that the risk adjustment program be operated in a budget neutral manner, it also did not prohibit HHS from designing the

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

Furthermore, if HHS elected to adopt a risk adjustment methodology that was contingent on appropriations from Congress through the annual appropriations process, that would have created uncertainty for issuers regarding the amount of risk adjustment payments they could

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

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

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

expect for a given benefit year. That uncertainty would have undermined one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a higher-risk population compared to other issuers in the state market risk pool. The budget-neutral framework spreads the costs of covering higher-risk enrollees across issuers throughout a given state market risk pool, thereby reducing incentives for issuers to engage in risk-avoidance techniques such as designing or marketing their plans in ways that tend to attract healthier individuals, who cost less to insure.

Moreover, relying on each year's budget process for appropriation of additional funds to HHS that could be used to supplement risk adjustment transfers would have required HHS to delay setting the parameters for any risk adjustment payment proration rates until well after the plans were in effect for the applicable benefit year. Any later-authorized program management appropriations made to CMS, moreover, were not intended to be used for supplementing risk adjustment payments, and were allocated by the agency for other, primarily administrative, purposes.[9] Without the adoption of a budget-neutral framework, HHS would have needed to assess a charge or otherwise collect additional funds, or prorate risk adjustment payments to balance the calculated risk adjustment transfer amounts. The resulting uncertainty would have conflicted with the overall goals of the risk adjustment program – to stabilize premiums and to

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

reduce incentives for issuers to avoid enrolling individuals with higher than average actuarial risk.

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

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

anomalous premiums if they were scaled to a plan's own premium instead of the statewide average premium. In the 2014 Payment Notice final rule, we noted that we received a number of comments in support of our proposal to use statewide average premium as the basis for risk adjustment transfers, while some commenters expressed a desire for HHS to use a plan's own premium. HHS addressed those comments by reiterating that we had considered the use of a plan's own premium instead of statewide average premium and chose to use statewide average premium, as this approach supports the overall goals of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to employ risk-avoidance techniques.

Although HHS has not yet calculated risk adjustment payments and charges for the 2018 benefit year, immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets. This proposed rule would ensure that collections and payments may be made for the 2018 benefit year in a timely manner. Without this administrative action, the uncertainty related to the HHS-operated risk adjustment methodology for the 2018 benefit year could add uncertainty to the individual and small group markets, as issuers are now in the process of determining the extent of their market participation and the rates and benefit designs for plans they will offer for the 2019 benefit year. Issuers file rates for the 2019 benefit year during the summer of 2018, and if there is uncertainty as to whether payments for the 2018 benefit year will be made, there is a serious risk that issuers will substantially increase 2019 premiums to account for the uncompensated risk associated with high-risk enrollees. Consumers enrolled in certain plans could see a significant premium increase, which could make coverage in those plans particularly unaffordable for unsubsidized enrollees. Furthermore, issuers are currently making decisions on whether to offer qualified

health plans (QHPs) through the Exchanges for the 2019 benefit year, and, for the Federally-facilitated Exchange (FFE), this decision must be made before the August 2018 deadline to finalize QHP agreements. In states with limited Exchange options, a QHP issuer exit would restrict consumer choice, and put additional upward pressure on Exchange premiums, thereby increasing the cost of coverage for unsubsidized individuals and federal spending for premium tax credits. The combination of these effects could lead to significant, involuntary coverage losses in certain state market risk pools.

Additionally, HHS's failure to make timely risk adjustment payments could impact the solvency of plans providing coverage to sicker (and costlier) than average enrollees that require the influx of risk adjustment payments to continue operations. When state regulators determine issuer solvency, any uncertainty surrounding risk adjustment transfers jeopardizes regulators' ability to make decisions that protect consumers and support the long-term health of insurance markets.

In light of the district court's decision to vacate the use of statewide average premium in the risk adjustment methodology on the ground that HHS did not adequately explain its decision to adopt that aspect of the methodology, we offer an additional explanation in this rule and are proposing to maintain the use of statewide average premium in the applicable state market risk pool for the payment transfer formula under the HHS-operated risk adjustment methodology for the 2018 benefit year. Therefore, HHS proposes to adopt the methodology previously established for the 2018 benefit year in the **Federal Register** publications cited above that applies to the calculation, collection and payment of risk adjustment transfers under the HHS-operated methodology for the 2018 benefit year. This includes the adjustment to the statewide average premium, reducing it by 14 percent, to account for an estimated proportion of administrative

costs that do not vary with claims.[11] We seek comment on the proposal to use the statewide average premium. However, in order to protect the settled expectations of issuers that structured their pricing and offering decisions in reliance on the previously promulgated 2018 benefit year methodology, all other aspects of the risk adjustment methodology are outside of the scope of this rulemaking, and HHS does not seek comment on those finalized aspects.

III. Collection of Information Requirements

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

IV. Regulatory Impact Analysis

A. Statement of Need

This rule proposes to maintain statewide average premium as the cost-scaling factor in the HHS-operated risk adjustment methodology and continue the operation of the program in a budget neutral manner for the 2018 benefit year to protect consumers from the effects of adverse selection and premium increases due to issuer uncertainty. The Premium Stabilization Rule, previous Payment Notices, and other rulemakings noted above provided detail on the implementation of the risk adjustment program, including the specific parameters applicable for the 2018 benefit year.

B. Overall Impact

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[11] See 81 FR 94058 at 94099.

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

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

This proposed rule offers further explanation of budget neutrality and the use of statewide average premium in the risk adjustment payment transfer formula when HHS is operating the permanent risk adjustment program established in section 1343 of the PPACA on behalf of a state for the 2018 benefit year. We note that we previously estimated transfers associated with the risk adjustment program in the Premium Stabilization Rule and the 2018 Payment Notice, and that the provisions of this proposed rule do not change the risk adjustment transfers previously estimated under the HHS-operated risk adjustment methodology established in those

final rules. The approximate estimated risk adjustment transfers for the 2018 benefit year are $4.8 billion. As such, we also incorporate into this proposed rule the RIA in the 2018 Payment Notice proposed and final rules.

V. Response to Comments

Because of the large number of public comments we normally receive on **Federal Register** documents, we are not able to acknowledge or respond to them individually. We will consider all comments we receive by the date and time specified in the "DATES" section of this proposed rule, and, when we proceed with a subsequent document, we will respond to the comments in the preamble to that document.

CMS-9919-P

Dated: July 30, 2018.

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Seema Verma,

Administrator,

Centers for Medicare & Medicaid Services.

Dated: August 2, 2018.

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Alex M. Azar II,

Secretary,

Department of Health and Human Services.

[FR Doc. 2018-17142 Filed: 8/8/2018 4:15 pm; Publication Date: 8/10/2018]