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

MINUTEMAN HEALTH INC.
38 Chauncy Street
BOSTON, MA 02111

Plaintiff,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES
200 Independence Avenue, SW
Washington, DC 20201

CENTERS FOR MEDICARE AND MEDICAID SERVICES
200 Independence Avenue, SW
Washington, DC 20201

THOMAS E. PRICE
Secretary of the United States Department of Health and Human Services, in his official capacity,
200 Independence Avenue, SW
Washington, DC 20201

And

SEEMA VERMA
Acting Administrator for the Centers for Medicare and Medicaid Services, in her official capacity,
200 Independence Avenue, SW
Washington, DC 20201

Defendants.

Civ. No. 16-cv-11570
(Judge Saylor)

Leave of Court Granted to File on March 13, 2017

Request for Oral Argument

TABLE OF CONTENTS

Page

I. Introduction and Summary 1

II. Statement of Facts 4

A. The Mission of the ACA: Expand Access to Affordable Healthcare 4

B. The Risk Adjustment Program 4

C. The Risk Adjustment Program Destabilizes the ACA Exchanges 8

D. Minuteman Is Severely Harmed by the Risk Adjustment Formula 10

III. Argument 13

A. Standard of Review Under the Administrative Procedures Act 13

B. The Risk Adjustment Formula's Use of the Statewide Average Premium is Contrary to Law and Arbitrary and Capricious 16

1. The Statewide Average Premium Unlawfully Penalizes Price-Cutting 16

2. HHS's Proffered Justifications for the Initial Risk Adjustment Rule Do Not Excuse Its Unlawful Use of the Statewide Average Premium 22

3. HHS Reluctantly Concedes the Problem but Refuses to Fix It 28

C. HHS Underestimates the Costs of Healthier Enrollees 34

D. HHS Fails To Accurately Capture HCC Status 38

1. The Partial Year Enrollee Problem 38

2. The Failure To Utilize Prescription Drug Data 39

3. HHS Ignores Years of Comments 40

4. HHS Finally Addresses the Partial Year Enrollee and Prescription Drug Data Issues but Improperly Delays Its Fixes 42

E. HHS Has *De Facto* Banned Bronze Plans in Violation of the ACA 42

IV. Conclusion 45

TABLE OF AUTHORITIES

Page(s)

CASES

Adirondack Med. Ctr. v. Sebelius, 891 F. Supp. 2d 36 (D.D.C. 2012).....13

Allied Local & Reg'l Mfrs. Caucus v. EPA, 215 F.3d 61 (D.C. Cir. 2000) *cert. denied*, 532 U.S. 1018 (2001).....16, 29, 37

Ameritech Corp. v. McCann, 403 F.3d. 908 (7th Cir. 2005).....26

Barnhart v. Walton, 535 U.S. 212 (2002).....14, 24

Bates v. United States, 522 U.S. 23 (1997).....24

Bedford Cnty. Mem. Hops. v. HHS, 769 F.2d 1017 (4th Cir. 1985).....16, 29, 37, 41

Beverly Hosp. v. Bowen, 872 F.2d 483 (D.C. Cir. 1989).....32

Bowen v. Georgetown Univ. Hosp., 488 U.S. 204 (1988).....32

Camp v. Pitts, 411 U.S. 138 (1973).....15

Castaneda v. Souza, 810 F.3d 15 (1st Cir. 2015).....14

Chao v. Occupational Safety and Health Review Comm'n, 540 F.3d 519 (6th Cir. 2008).....31

Chevron, U.S.A., Inc. v. NRDC, Inc. 467 U.S. 837 (1984).....14, 15, 17

Comm. for Fairness v. Kemp, 791 F. Supp. 888 (D.D.C. 1992).....32

Corley v. United States, 556 U. S. 303 (2009).....44

Crowley's Yacht Yard, Inc. v. Peña, 863 F. Supp. 18 (D.D.C. 1994).....16, 29

Del. Dep't of Nat. Res. & Envtl. Control v. EPA, 785 F.3d 1 (D.C. Cir. 2015).....41

Dion v. Commissioner Me. Dep't of Human Servs., 933 F.2d 13 (1st Cir. 1991).....17

Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv., 707 F.3d 462 (4th Cir. 2013).....15, 29, 37, 41, 45

Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117 (2016).....23, 27, 28, 33, 34

Hackwell v. United States, 491 F.3d 1229 (10th Cir. 2007).....33

Hasan v. GPM Invs., LLC, 896 F. Supp. 2d 145 (D. Conn. 2012).....31

Health Republic Insurance v. United States, 129 Fed. Cl. 757 (Jan. 10, 2017) 24, 26

Home Box Office, Inc. v. FCC, 567 F.2d 9 (D.C. Cir. 1977).....16, 29, 38, 45

Judulang v. Holder, 565 U.S. 42 (2011).....23, 27, 28, 33, 34

King v. Burwell, 135 S. Ct. 2480 (2015).....23, 36, 43

Lion Health Servs. Inc. v. Sebelius, 635 F.3d 693 (5th Cir. 2011) 32, 42

Luminant Generation Co. v. EPA, 714 F.3d 841 (5th Cir. 2013) 14

Lyng v. Payne, 476 U.S. 926 (1986) 13

Motor Vehicle Mfrs. Assn. of the U.S., Inc. v. State Farm Mutual Automobile Ins. Co. 16, 23, 27, 28, 33, 34

N.Y. Airways, Inc. v. United States, 369 F.2d 743 (Ct. Cl. 1966).....25

Nat'l Audubon Soc'y v. Evans, No. 99-1707 (RWR), 2003 U.S. Dist. LEXIS 23675 (D.D.C. July 3, 2003).....16, 29

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Slattery v. United States, 635 F.3d 1298 (Fed. Cir. 2011).....25

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United States v. Goodner Bros. Aircraft, Inc., 966 F.2d 380 (8th Cir. 1992).....32

STATUTES

5 U.S.C. § 706 .....13, 14, 33, 34

26 U.S.C. § 36B.....4

42 U.S.C. § 300gg-1 4

42 U.S.C. § 300gg-2 4

42 U.S.C. § 300gg-3 4

42 U.S.C. § 300gg-4 4

42 U.S.C. § 300gg-5 4

42 U.S.C. § 18022 44

42 U.S.C. § 18041 4

42 U.S.C. § 18042 .....4, 11

42 U.S.C. § 18061 24

42 U.S.C. § 18062 24

42 U.S.C. § 18063 .....5, 16, 24, 26

42 U.S.C. § 18071 4

Mass. Gen. Laws ch. 176J § 6(d) 2, 44

OTHER AUTHORITIES

45 C.F.R. § 153.230 26

45 C.F.R. § 153.232 26

45 C.F.R. §153.235 26

45 C.F.R. § 153.310 .....5, 27

45 C.F.R. § 156.515 .....11, 12

70 Fed. Reg. 4194 (Jan. 28, 2005) 26

77 Fed. Reg. 73,117 (Dec. 7, 2012) 6, 22, 23, 27, 40

78 Fed. Reg. 15,409 (Mar. 11, 2013) 6, 7, 17, 23, 24, 28, 34, 40, 41

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79 Fed. Reg. 70,673 (Nov. 26, 2014) 6

80 Fed. Reg. 10,749 (Feb. 27, 2015) 6, 7, 17, 29, 40

80 Fed. Reg. 75,487 (Dec. 2, 2015) 6

81 Fed. Reg. 12,203 (Mar. 8, 2016) 6, 7, 17, 29, 36, 41

81 Fed. Reg. 29,146 (May 11, 2016) 9

81 Fed. Reg. 61,455 (Sept. 6, 2016) 7, 31, 35, 36, 37

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MEMORANDUM OF LAW IN SUPPORT OF MINUTEMAN HEALTH INC.'S MOTION FOR SUMMARY JUDGMENT

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 issuers.

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 issuers to inject new competition into stagnant insurance markets. Plaintiff Minuteman Health, Inc. ("Minuteman") is the CO-OP for Massachusetts and New Hampshire. Minuteman delivered on Congress's goals, offering innovative new products that were substantially less expensive. Minuteman has pursued a strategy of partnering with high-quality, low-cost health care providers like Tufts Medical Center and diverting its members' care away from more costly hospitals. Minuteman passes on these cost savings in the form of lower premiums. Even though Minuteman has been issuing policies for little more than three years, it has already signed up tens of thousands of enrollees.

Yet Minuteman'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 is tasked with creating a methodology in which issuers with above average

[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."

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 price-cutting issuers like Minuteman and forces them to transfer a substantial portion of their revenue to their higher-priced competitors. In 2014, Minuteman was required to disgorge 71% of its premium revenue in risk adjustment assessments. *See* CHOICES, *Technical Issues with ACA Risk Adjustment and Risk Corridors Programs,* (Nov. 4, 2015), Minuteman 2018 Comment, Ex. E-2, at 11, MH000177.[2] In 2015, Minuteman's risk adjustment assessment amounted to 40% of its premiums. *See* Minuteman 2018 Comment, at 5, MH000005. These punitive assessments are particularly devastating in the health insurance industry, where issuers target 2-3% operating margins, and where statutes prohibit issuers from rebuilding capital because of limits on retaining profits above certain thresholds. Mass. Gen. Laws ch. 176J § 6(d). 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 as the risk adjustment program

[2] On February 16, 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. Minuteman has filed a supplemental appendix with this brief. *See* Stip. Concerning Admin. R. ECF No. 46. Materials cited from this supplemental appendix are labeled with the Bates prefix "MH" and are cited throughout the brief with reference to this "MH" Bates label. Materials from the incomplete February 16, 2017 Administrative Record contained only numerical stamping, and are referred to throughout this brief as "Rec. at XX."

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 issuer 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 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 issuers 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 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. Minuteman has raised these defects and offered solutions, but its pleas have fallen on deaf ears. As a result, Minuteman was forced to bring this action under the Administrative Procedures Act. Minuteman 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

Prior to the ACA, issuers 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, issuers 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, issuers, with very few exceptions, are prohibited from varying premiums within a geographic area. *Id*.

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 issuers. *See, e.g.*, 42 U.S.C. § 18041; 26 U.S.C. § 36B; 42 U.S.C. § 18071; 42 U.S.C. § 18042. 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

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 issuers from the risk of taking on a sicker-than-anticipated enrollee population by distributing funds to and making assessments against issuers 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), available at https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-1.html. The program seeks to level the playing field among issuers by preventing issuers 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).

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] 42 U.S.C. § 18063(b). 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")

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

for each benefit plan year that sets the annual risk adjustment formula. Each NBPP is a separate notice 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. 41-1. 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[4]	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), MH001597
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

[4] All record documents cited in the "Statement of Facts" are consolidated as one exhibit, Exhibit 2. Because these documents are also found in the administrative record, Minuteman has only attached the relevant excerpts in Exhibit 2.

Benefit Year	Notice of Proposed Rule	Notice of Final Rule
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

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. Issuers with higher risk (sicker) individuals should receive risk adjustment payments from HHS, and issuers with lower risk (healthier) members should make payments to HHS. *See generally* Exh. 2, 78 Fed. Reg. at 15,430, Rec. at 000247.

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.*, Exh. 2, 81 Fed. Reg. at 94,101, Rec. at 009638. 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* Exh. 2, 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

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* Exh. 3, Letter from CHOICES to CMS (Apr. 22, 2016), Minuteman 2018 Comment, at 2, MH000195. 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* Exh. 13, Minuteman 2018 Comment, at 6 n. 3, MH000006; Exh. 4, 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), Minuteman 2018 Comment, at 19-22, MH000085-88; Exh. 5, Conn. Ins. Dept., *Insurance Department Places HealthyCT Under Order of Supervision* (July 5, 2016), Minuteman 2018 Comment, at 1-2, MH000528-29; Exh. 6, CHOICES (Nov. 4, 2015), at 11-13, MH000177-79 .

- 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* Exh. 6, CHOICES (Nov. 4, 2015), at 12, MH000178.

- 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. 7, Jeff Byers, *Molina Hangs 2016 Income Losses on Poor ACA Market Performance,* Healthcare Dive (Feb. 16, 2017), http://www.healthcaredive.com/news/molina-hangs-2016-income-losses-on-poor-aca-market-performance/436300/; Zachary Tracer, *One Insurer Says Obamacare in 'Death Spiral,' Another May Quit,* Bloomberg (Feb. 15, 2017), https://www.bloomberg.com/news/articles/2017-02-15/molina-plunges-after-obamacare-plans-lead-to-surprise-loss.

State insurance commissioners – the primary regulators of health insurance[5] – 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 financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs.

Exh. 8, Al Redmer, Jr., Written Testimony (Feb. 25, 2016), Minuteman 2018 Comment, at 1, MH000508. 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 …" Exh. 9, Letter from Maria Vullo, NY Superintendent of Financial Services, to Sylvia Burwell, Secretary, HHS & Andrew Slavitt, Administrator, CMS (June 28, 2016), Minuteman 2018 Comment, at 1-2, MH000512-13. The Iowa, Wisconsin, and Washington insurance commissioners have likewise spoken out against the program. *See* Exh. 18, Minuteman Am. Compl., ¶ 37; *see also* Exh. 15-17, Exhibits (11-13) to Minuteman Am. Compl.

The logical result of the excessive financial penalties and diminished competition caused by risk adjustment has been higher prices. Senior HHS officials have testified that 2017 premiums are on average 22% higher than they were in 2016, with some states seeing increases of 50%. *See* Exh. 18, Minuteman Am. Compl., ¶ 30; *see also* Exh. 14, Exhibit (5) to Minuteman

[5] 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).

Am. Compl. 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. Minuteman Is Severely Harmed by the Risk Adjustment Formula

Minuteman, a low-cost, innovative start-up issuer, has been crippled in its growth by the out of control risk adjustment program. Minuteman focuses on the individual and small group segments. *See* Exh. 10, Policelli Decl., Minuteman 2018 Comment, at ¶¶ 12, 24, MH000040; MH000043. It entered the Massachusetts market in 2014 and New Hampshire in 2015.[6] *Id.* at ¶ 31, MH000045.

For years, both states have suffered from out of control healthcare costs. *See id.* at ¶¶ 13-20, MH000040-43. For example, in 2014, premiums in New Hampshire and Massachusetts were more expensive than premiums in over 45 other states. *Id. at* ¶ 13, MH000040. These high premiums were the result of a small number of high-priced brand name teaching hospitals, particularly in Boston, driving health care costs to unsustainable levels. *See id.* at ¶¶ 13-20, MH000040-43.

Minuteman was formed to offer an affordably-priced alternative. A group of high-quality, low-cost Massachusetts health care providers, including Tufts Medical Center, New

[6] At all times HHS has administered the risk adjustment program for New Hampshire. Massachusetts operated its own state risk adjustment program, subject to HHS approval, for 2014-2016, although it will be subject to the HHS program beginning in 2017. Because Massachusetts administered its own risk adjustment program until 2016, Minuteman also raised its objections to the flawed methodology with Massachusetts state officials. In response, the Connector (the responsible state agency) replied it had no authority to vary its formula because its hands were tied by HHS, which refused to provide any regulatory flexibility. *See* Exh. 19, Exhibit (25) to Minuteman Am. Compl., at 5. The state-based program was, in reality, a federally designed and implemented methodology merely administered at the state level. If this Court overturns HHS's rules, HHS should also be directed to authorize the Commonwealth of Massachusetts to fix the state formula for 2014-2016.

England Quality Care Alliance, and Vanguard Health Systems, came together to sponsor the creation of a new insurance issuer that would focus on driving down costs and steering patients to providers committed to bending the health care cost curve. *Id.* at ¶ 21, MH000043. Minuteman set out to offer affordable health care coverage by securing low reimbursement rates (prices for services) from a select network of health care providers. *Id.* at ¶ 25, MH000044. Minuteman excludes high-priced hospital systems from its network and instead directs its members' care to lower-cost, high-quality health care providers. *Id.* Minuteman then passes those savings on through lower insurance premiums. *Id.* at ¶ 26, MH000044.

The vehicle through which Minuteman was launched was the CO-OP Program created by the ACA. *See id.* at ¶¶ 28-30, MH000044-45. Congress recognized the market reality 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. 11, Annie L. Mach & Grant A. Driessen, Cong. Research Serv., R44414, *Consumer Operated and Oriented Plan (CO-OP) Program: Frequently Asked Questions* (2016), https://fas.org/sgp/crs/misc/R44414.pdf. 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). 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).

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 Minuteman, was obligated to participate in the exchange marketplaces created by the ACA.

Loan applicants were required to submit detailed business plans for HHS's review. *See* Exh. 12, HHS, et al., *Amended Announcement: Invitation to Apply, Loan Funding Opportunity Number: OO-COO-11-001*, 13-14 (Dec. 9, 2011), *available at* https://apply07.grants.gov/apply/opportunities/instructions/oppOO-COO-11-001-cfda93.545-instructions.pdf. These business plans were in turn expressly incorporated into the final loan agreements. *See* Exh. 11, Mach & Driessen, *CO-OP Program: FAQ* at 4 n.23.

HHS approved Minuteman's select-network business plan and on August 13, 2012, Minuteman signed a loan agreement with HHS to fund its initial formation and operation in Massachusetts. *See* Exh. 10, Policelli Decl., at ¶ 28, MH000044. It signed an amendment to the loan agreement in November 2013 for additional funding to enter the New Hampshire market. *Id.*

Minuteman has delivered on its promise to offer an affordable, low-priced alternative to beleaguered consumers in Massachusetts and New Hampshire:

- In 2015, in the individual market for the "bronze" tier plans often preferred by cost-conscious consumers, Minuteman's lowest monthly premiums ranged from $196-$232 while Blue Cross/Blue Shield of Massachusetts's ("BCBS") monthly premiums for its bronze product ranged from $348-$392. Similarly, in "silver" products, Minuteman's monthly premiums ranged from $241-$285 while BCBS charged monthly premiums from $384 to $433. *Id.* at ¶ 32, MH000045.

- In 2015, Minuteman's bronze premium for a non-smoker in New Hampshire was only $188 per month, compared to $224 per month for Anthem, $238 per month for Harvard Pilgrim, $260 per month for Maine Community Health Options, and nearly $400 per month for Assurant. *Id.* at ¶ 33, MH000045.

- Likewise for silver plans for non-smokers in New Hampshire in 2015, Minuteman set a monthly premium of only $238, compared to $283 for Anthem, $295 for Harvard Pilgrim, $304 for Maine Community Health Options, and $474 for Assurant. *Id.* at ¶ 34, MH000045.

Consumers have reacted positively. In just over three years, Minuteman has enrolled tens of thousands of members. *Id.* at ¶ 35, MH000045.

But the risk adjustment program threatens to stall Minuteman in its tracks. Minuteman discovered in June 2015 that it owed risk adjustment transfer charges for 2014 equal to ***71%*** of its gross premium revenues. *See* Exh. 6, CHOICES (Nov. 4, 2015), at 11, MH000177. HHS assessed Minuteman a 2015 risk adjustment payment in New Hampshire of more than $10 million, amounting to a whopping 40% of its members' premiums. *See* Exh. 10, Policelli Decl., at ¶ 9, MH000039. Massachusetts imposed a charge of $6,110,676, 39% of Minuteman premiums in that state. *Id.* These numbers are all the more shocking in light of Minuteman's small market share. For example, in New Hampshire, despite having only 19% of the on-exchange market share for individual policies, Minuteman is responsible for paying 90% of the risk adjustment charges in that state. *Id.* This is not a function of adjusting for actuarial risk, but the result of a broken methodology that penalizes small, innovative, and low-cost issuers.

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.'" *Id*. at 43 (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. *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. Hops. 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 *Motor Vehicle Mfrs. Assn. of the U.S., Inc. v. State Farm Mutual Automobile Ins. Co.*, 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. 29, 48 (1983).

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. *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). It has not done so. That failure has caused significant and ongoing harm to Minuteman.

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 Massachusetts and Anthem in New Hampshire – drive the statewide average premium through their own prices, which are typically quite high. *See* Policelli Decl., at ¶¶ 13-20, 53-68, MH000040-43, MH000049-52.

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.,* CHOICES (Nov. 4, 2015), at 9, MH000175; CHOICES (Apr.

22, 2016), at 2-3, MH000195-96; David V. Axene & Gregory G. Fann, *Comments on Proposed Rule* (Oct. 5, 2016), at 8-14, Minuteman 2018 Comment, Ex. I-1, MH000597-603.

This mismatch between premiums and actuarial risk has resulted in devastating and improper assessments against Minuteman. Minuteman's business strategy – as laid out in its CO-OP program loan application that HHS approved – was to inject new price competition into Massachusetts and New Hampshire. Minuteman achieved this goal:

- The 2014 statewide average premium in Massachusetts was $435 per month while Minuteman's average premium was $254 per month.
- The 2015 statewide average premium in Massachusetts was $418 per month, while Minuteman's average premium was $255 per month.
- The 2015 statewide average premium in New Hampshire for individual plans was $379 per month while Minuteman's average premium was $283.

Policelli Decl., at ¶¶ 58-59, MH000050-51.

Minuteman did not achieve these results by dodging sicker enrollees and setting premiums based upon having a healthier population. As Minuteman CEO Tom Policelli explained in a sworn Declaration attached to Minuteman's comments to the 2018 NBPP:

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

Id. at ¶ 56, MH000050.

Minuteman lowered premiums by purchasing health care services differently. Both Massachusetts and New Hampshire have experienced spiraling health care cost inflation because of the high prices of certain brand name hospitals. *See id.* at ¶¶ 13-16, MH000040-42. Minuteman refused to contract with these higher-priced facilities, in favor of steering its members to equally high quality but lower-priced options like Tufts Medical Center and Lahey. *See id.* at ¶¶ 21-26, MH000043-44; Minuteman 2018 Comment, at 10, MH000010. The same person with the same health condition costs Minuteman less because it sends that individual to a more efficiently run, lower-priced hospital, and Minuteman then passes those savings on in the form of lower premiums. *See* Policelli Decl., at ¶ 26, MH000044; Minuteman 2018 Comment, at 10, MH000010. While these cost savings from smarter shopping among hospitals have a big impact on premiums, they have nothing to do with relative actuarial risk.

This is competition working: Minuteman entered stagnant, overpriced insurance markets as an innovative start-up and created a lower-cost insurance option by being smarter and more nimble. Yet the risk adjustment formula then penalized Minuteman 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, MH000175.

Minuteman's comments to the 2018 NBPP attached a white paper from Axene Health Partners, an expert actuarial consulting firm. *See generally* Axene Report, MH000587. 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, MH000598, MH000602.

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 Minuteman's larger competitors simply raised their prices, the statewide average premium would necessarily rise too and thus Minuteman's risk adjustment liability would increase – even though the individuals buying insurance from each issuer may stay exactly the same. *Id.* at 11, MH000600. Similarly, a migration of insureds from Minuteman's lower-priced competitors to its higher-priced competitors – without any change in

the composition of Minuteman's membership and their actuarial risk – would increase the statewide average premium (which is weighted by enrollment volume) and thus Minuteman's risk adjustment liability. *Id.*

Unsurprisingly, of the roughly $19.7 million in risk adjustment assessments against Minuteman in 2014 and 2015, roughly $5.8 million – 30% of the total – was due to HHS's use of the statewide average premium instead of Minuteman's own premiums. *See* Policelli Decl., at ¶ 64, MH000051. This almost perfectly tracks the fact that Minuteman's premiums were between 25%-40% below the relevant statewide averages. *See id.* Instead of adjusting for actuarial risk, HHS is adjusting for premiums and imposing large-scale financial penalties on innovative issuers that are finding ways to bend the cost curve in health care.

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.*, 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, https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/patients-bill-of-rights09232011a.pdf. 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.*, Antonia Ferrier, *Obamacare: Premium Increases Aplenty*, InsuranceNewsNet (May 16, 2016), https://insurancenewsnet.com/oarticle/obamacare-premium-increases-aplenty.

Minuteman and others have repeatedly objected to the agency's use of the statewide average premium. *See e.g.*, Minuteman 2018 Comment, at 9-12, MH000009-12; CHOICES 2018 Comment, at 5, MH001435; Minuteman 2017 Comment, at 6-7, MH001442-43; NMHC 2017 Comment, at 3, MH001454 (attaching CHOICES (Nov. 4, 2015)); 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 Mut. Auto. Ins. Co.*, 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.*, CMS, *The Three Rs: An Overview*; *Reinsurance, Risk Corridors, and Risk Adjustment Final Rule* (Mar. 2012), https://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf. 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[7] – 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

[7] 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 (Jan. 10, 2017).

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. GAO, B-325630, *HHS – Risk Corridors Program* (Sept. 30, 2014), 3-4, http://www.gao.gov/assets/670/666299.pdf. Although Congress later restricted the use of HHS's annual appropriation as to the risk corridors program,[8] 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) 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

[8] *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. Minuteman is one of many issuers suing in the Court of Federal Claims for monies owed under the risk corridors program.

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, 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.[9]

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.[10]

[9] 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* CMS, *Report to Congress: Alternative Payment Models & Medicare Advantage*, at 13, https://www.cms.gov/Medicare/Medicare-Advantage/Plan-Payment/Downloads/Report-to-Congress-APMs-and-Medicare-Advantage.pdf; CBO, *Reconciliation Recommendations of the S. Comm. on Finance* (Oct. 27, 2005), at 9, https://cbo.gov/sites/default/files/109th-congress-2005-2006/costestimate/sfrecon0.pdf; HHS, Medicare Prescription Drug Benefit, 70 Fed. Reg. 4194 (Jan. 28, 2005).

[10] The Congressional Budget Office has stated, in the past, that the risk adjustment program is budget neutral. *See* CBO, *The Budget and Economic Outlook: 2014 to 2024*, at 59, https://www.cbo.gov/sites/default/files/113th-congress-2013-2014/reports/45010-outlook2014feb0.pdf. 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.").

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 Minuteman. Minuteman must set its premiums for a given benefit year in the previous calendar year, so that, for example, it had to finalize 2015 premiums in 2014. *See e.g.*, 211 MASS. CODE REGS. 66.09(2)(a); 211 MASS. CODE REGS. 41.06(1)(c); NHID Bulletin No. INS-14-010 (Apr. 4, 2014), at 2, https://www.nh.gov/insurance/media/bulletins/2014/documents/14-010-ab.pdf. Minuteman 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 July 30, 2016 – by which time it has 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*, (Feb. 2016), Minuteman 2018 Comment, Ex. E-3, MH000181. Milliman made two key findings. First, over half of all issuers predicted 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, MH000184. 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.*

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 Commc'ns, Inc.*, 567 F.3d at 1220-21.

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 Commc'ns, Inc.*, 567 F.3d at 1220-21. HHS further ignores the fact that issuers, like Minuteman, can reduce claims costs by steering their members to lower-priced health care providers.

The statement is also exaggerated, as many administrative costs have nothing to do with risk selection. To take a simple example, if Issuer A is based in Pittsfield, and Issuer B is based in Boston, then Issuer A will have lower administrative costs because Pittsfield has lower wage scales than Boston. This has nothing to do with actuarial risk.

3. HHS Reluctantly Concedes the Problem but Refuses to Fix It

Despite the flimsy justifications put forward for the 2014 rule, Minuteman 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* HHS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year*

(June 30, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RI-RA-Report-Draft-6-30-15.pdf. 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, Minuteman 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.,* Minuteman 2017 Comment, at 6-7, MH001442-43; NMHC 2017 Comment, at 3, MH001454 (attaching CHOICES (Nov. 4, 2015)); 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 & Reg'l Mfrs. Caucus,* 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), Minuteman 2018 Comment, Ex. F-1, at 83, MH000335. 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, MH000600.

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 [*i.e.*, which hospitals and doctors are included in an insurer's network], 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, MH000345. 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, MH000335.

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. Minuteman 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.*, Minuteman 2018 Comment, at 9-12, MH000009-12; CHOICES 2018 Comment, at 5, MH001435; NMHC 2018 Comment, at 11-13, MH000845-47.

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."[11] 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

[11] 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).

that its formula was overstating actuarial risk by a calculated percentage, then that correction must be made for all years of the program.[12] *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 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). Minuteman 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%

[12] 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 Minuteman is not challenging a retroactive rule promulgated by HHS. *See Beverly Hosp. v. Bowen*, 872 F.2d 483 (D.C. Cir. 1989) (noting that *Georgetown* prohibits retroactive agency *rulemaking* but leaves room for "retroactive corrective adjustments"). Rather, Minuteman 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.

reduction also ignores that there are factors driving premium levels that are not either risk selection or administrative costs, such as Minuteman's strategic steering to lower-priced 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 Commc'ns, Inc.,* 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 23-26.

In sum, HHS's use of the statewide average premium is a clear violation of the plain text of the ACA's risk adjustment statute 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 v. EPA, 755 3d 1010, 1019 (D.C. Cir. 2014) (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 Commc'ns, Inc.*, 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 under-predicts 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 Policelli Decl., at ¶ 82-91, MH000057-59; Declaration of Martin Hickey, M.D. (Oct. 5, 2016), NMHC 2018 Comment, Ex. B-1, at ¶ 80-88, MH000881-83; Mary van der Heijde & Jordan Paulus, *Risk Adjustment: Overview and Opportunity*, Minuteman 2018 Comment, Ex. E-1, at 3, MH000161.

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), Minuteman 2018 Comment, Ex. E-8, at 1, 7, MH000219, MH000225; *see also* CHOICES (Nov. 4, 2015), at 4-5, MH000170-71. Though healthier enrollees should be profitable and thus balance out losses from sicker enrollees, that is not the case. After application of risk adjustment, Minuteman and other issuers actually ***lose*** money on enrollees without an HCC. *See e.g.*, Policelli Decl., at ¶¶ 89-90, MH000059; Hickey Decl., at ¶ 87, MH000883; Molina Healthcare 2018 Comment, at 3, Rec. at 0011555. Issuers have raised this flaw with HHS from the outset of the program. *See e.g.*, BCBSA 2014 Comment, at 5, Rec. at 004330; Minuteman 2017 Comment, at 4-5, MH001440-41; NMHC 2017 Comment, at 2, MH001453; Health New England 2017 Comment, at 5, 7, Rec. at 008487, 008489; Minuteman 2018 Comment, at 13-14, MH000013-14; NMHC 2018 Comment, at 9-10, MH000843-44; 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, as the flawed formula penalizes enrolling 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 (2015) (goal of the ACA to avoid "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, MH001474, MH001483.

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, MH001528-29. 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, Minuteman 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), MH000218. 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, MH000223. 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.[13] *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.[14] *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

[13] Mr. Foster's proposal preserves the budget neutral approach favored by HHS. *See id.* at 10, MH000228.

[14] 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. CMS 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."

meaningless if the 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. Policelli Decl., at ¶ 96, MH000060. If, however, 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 ¶ 99, MH000061. 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.

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. Hickey Decl., at ¶ 96, MH000885.

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, MH000171. 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. Policelli Decl., at ¶ 103, MH000062.

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, MH000606. Using prescription drug data is also more efficient. *See* Minuteman 2017 Comment, at 4, MH001440; Pharmaceutical Care Management Association Comment re: NBPP for 2017, at 5, MH001662. 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, MH000605-608. Such data is readily available, adjudicated

electronically, and does not require a review of medical records (which can include deciphering handwritten notes). *Id*. at 16, MH000606.

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 Comment re: NBPP for 2014, 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]

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

[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. 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 malpractice claim or ethics charge for prescribing unnecessary medications simply to provide a very slight financial gain to some insurance company. Axene Report, at 17-18, MH000606-07; NMHC 2018 Comment, at 7-8, MH000841-42.

Plans submitted a detailed comment explaining the way in which partial year enrollees' risk scores would be understated. ACAP Comment re: NBPP for 2014, MH001568-96. 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.

HHS next received a number of comments addressing the problem and offering solutions in response to its 2017 NBPP. *See e.g.,* Viva Health Comment re: NBPP for 2017, at 2-3, MH001564-65. 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. *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).

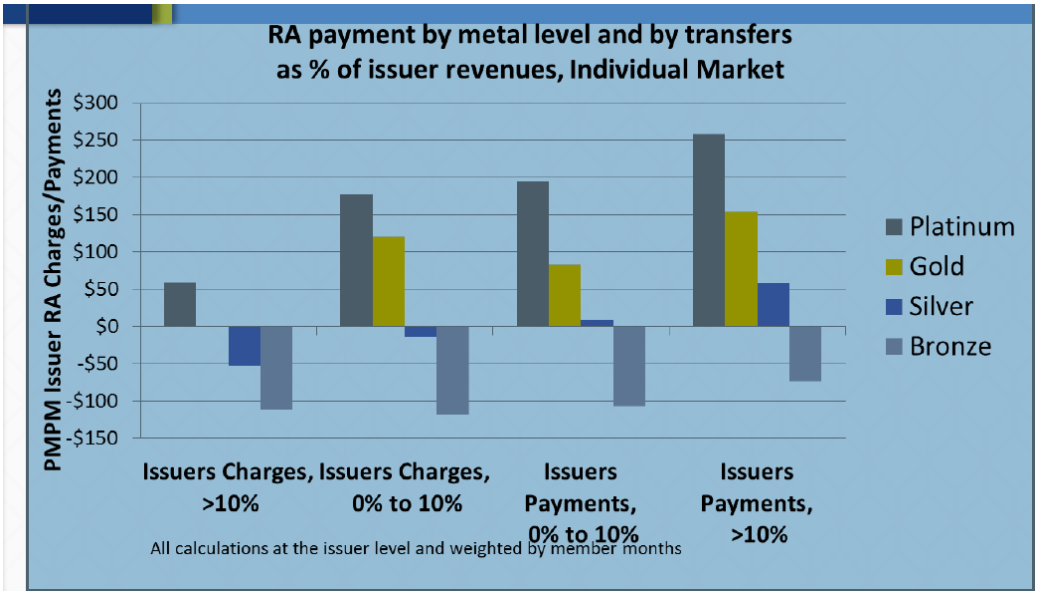
E. HHS Has *De Facto* Banned Bronze Plans in Violation of the ACA

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* Policelli Decl., at ¶ 73, MH000055. 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; MH000055. 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, MH000196; Axene Report, at 19, MH000608. 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* (March 31, 2016), at 31, Rec. at 009881.

In an industry with notoriously slim operating margins – Massachusetts, by law, limits Minuteman to a 1.9% operating margin, *see* MASS. ANN. LAWS ch. 176J, § 6(d) – this pattern has led Minuteman and others to experience sharp losses on bronze plans. *See* Policelli Decl., at ¶ 77, MH000056; Hickey Decl., at ¶ 77, MH000880. Unsurprisingly, issuers around the United States are dropping bronze plans. *See* Policelli Decl., at ¶ 78, MH000056-57. This, of course, will further drive away healthier enrollees needed to stabilize the ACA exchange risk pool. *See* Axene Report, at 19, MH000608; Policelli Decl., at ¶ 81, MH000057.

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. Minuteman and others raised this concern during the risk adjustment rulemaking proceedings. *See e.g.* Minuteman 2018 Comment, at 12, MH000012; NMHC 2018 Comment, at 14, MH000848; CHOICES 2018 Comment, at 5-6, MH001435-36. 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, Minuteman 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. This Court should further order HHS to permit the State of Massachusetts to correct the same flaws in the Massachusetts state risk adjustment methodology in effect from 2014-2016, which HHS has forced upon the state agency.

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Respectfully submitted:

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CERTIFICATE OF SERVICE

I hereby certify that this document filed on April 6, 2017 through the ECF system will be sent electronically to the registered participants as identified on the Notice of Electronic Filing (NEF) and paper copies will be sent to those indicated as non-registered participants on the date of electronic filing.

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