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

MINUTEMAN HEALTH INC., a Non-Profit Corporation, Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, THOMAS E. PRICE, M.D. Secretary of the United States Department of Health and Human Services, in his official capacity, and SEEMA VERMA, Acting Administrator for the Centers for Medicare and Medicaid Services, in her official capacity, Defendants.	)	Civ. No. 16-cv-11570 (Judge Saylor) **LEAVE OF COURT GRANTED TO FILE ON MARCH 13, 2017**

PLAINTIFF'S REPLY AND OPPOSITION TO
DEFENDANTS' CROSS-MOTION FOR SUMMARY JUDGMENT

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I. Introduction

The exchange marketplaces created by the Affordable Care Act ("ACA") are in crisis as insurance carriers flee, leaving many counties with only one issuer offering coverage.[1] Where issuers remain, they are requesting massive premium increases in 2018, many well in excess of 30%.[2] As Minuteman showed in its opening Memorandum, HHS's[3] unlawful, arbitrary, and capricious risk adjustment program, which penalizes price-cutting and innovation and underestimates the costs of insuring all but the most chronically ill individuals, has played a large role in crippling the exchanges. Due to the sit-on-our-hands approach of HHS, as acknowledged in its Memorandum, the problems continue to mount. The Massachusetts Department of Insurance recently blamed a slew of double-digit premium increases upon HHS's risk adjustment program.[4] This merely joins the deafening chorus of state insurance regulators

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[1] See Ex. A, *Many U.S. Counties Will Only Have One Option for ACA Coverage in 2018*, Associated Press (June 22, 2017), http://www.omaha.com/money/many-u-s-counties-will-have-only-one-option-for/article_12b136a6-4178-50a8-89e2-99da536a1177.html ("[M]ore than 40 percent of U.S. counties to have only one insurer selling coverage on the exchange").

[2] *See e.g.,* Ex. B, *Maryland Insurers Request 38.5 Percent Rate Increase for Individual Health Plans*, Baltimore Business Journal (May 5, 2017), http://www.bizjournals.com/baltimore/news/2017/05/04/maryland-insurers-request-38-5-percent-rate.html (In Maryland, "[t]he proposed rate increases average at 38.5 percent"); Ex. C, JC Reindl and Todd Spangler, *Obamacare Rates in Michigan Could Skyrocket as Much as 31% in 2018*, Detroit Free Press (June 14, 2017), http://www.freep.com/story/money/2017/06/14/obamacare-rates-michigan/392687001/ ("Some health insurers in Michigan will be seeking record-level rate hikes next year for plans they sell to individuals – potentially as much as 31%."); Ex. D, Zachary Tracer, *New York Health Insurers Ask for 16.6% Boost to Obamacare Rates,* Bloomberg (June 7, 2017), https://www.bloomberg.com/news/articles/2017-06-07/new-york-health-insurers-ask-for-16-6-boost-to-obamacare-rates ("Insurers [in New York] are seeking to boost their premiums 16.6 percent on average…[T]he requested increases rang[e] from 4.4 percent to 47.3 percent, depending on the insurer…In Maryland, Virginia and Connecticut, premiums will rise more than 20 percent on average…"); Ex. E, Associated Press, *Nevada Health Insurance Rates Face Proposed Increases*, U.S. News (July 1, 2017), https://www.usnews.com/news/best-states/nevada/articles/2017-07-01/nevada-health-insurance-rates-face-proposed-increases (Nevada silver plans face an average increase of 38% under proposed rates for 2018); Ex. F, Patricia Daddona, *Most CT Insurers Propose Double-Digit Rate Hikes*, Hartford Business (May 8, 2017), http://www.hartfordbusiness.com/article/20170508/NEWS01/170509936 ("the state of Connecticut is about to grapple with double-digit rate increase requests from insurers that go as high as 33.8 percent.")

[3] All defendants are collectively referred to as "HHS." Citations to documents MH001687 – MH001850 are contained in the Supplemental Appendix being filed contemporaneously with this Reply.

[4] *See* Ex. G, Jessica Bartlett, *Three Health Insurers Plan Double-Digit Rate Hikes for Third Quarter,* Boston Business Journal (May 18, 2017), http://www.bizjournals.com/boston/news/2017/05/16/three-health-

who have denounced HHS's risk adjustment scheme.[5] Desperate to fix their marketplace, the Massachusetts Association of Health Plans recently voted overwhelmingly to ask the Governor to try to suspend risk adjustment in the Commonwealth, highlighting how it is causing skyrocketing premiums.[6]

Yet HHS asks this Court to ignore the disastrous effects of the agency's actions. Instead, HHS's Memorandum first directs the Court to focus on the agency's hopes in 2012, when it put together the initial Benefit Year 2014 risk adjustment rule. HHS then tries to justify its decision to ignore all later developments, supposedly because "it is important to maintain model stability." *See* Defendants' Cross-Motion for Summary Judgment and Opposition to Plaintiff's Motion for Summary Judgment (Dkt. No. 52), at 12 (hereafter "HHS Br."). But HHS cannot ignore or wish away the real world. To the contrary, the Administrative Procedures Act ("APA") requires the agency to evaluate its programs and adjust course based upon what actually happens. As detailed below and in Minuteman's opening Memorandum, HHS's risk adjustment regulations violate the APA and should be vacated.[7]

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insurers-plan-double-digit-rate-hikes.html?ana=RSS&s=article_search ("Three Massachusetts insurers will see double-digit rate hikes in the third quarter, which the state's Division of Insurance says is largely due to volatility of the Affordable Care Act's risk adjustment program.")

[5] *See* Ex.L, Minuteman Am. Compl. (Dkt. No. 39), at ¶¶ 31-39. HHS has very recently reaffirmed, again, the primary expertise of the states in insurance regulation. *See* Ex. H, HHS, Reducing Regulatory Burdens Imposed by the Patient Protection and Affordable Care Act & Improving Healthcare Choices to Empower Patients, 82 Fed. Reg. 26,885, 26,887 (proposed June 12, 2017) (acknowledging "*the traditional regulatory authority of the States in regulating the business of health insurance*" and their "primary role in regulating the health insurance markets they know best") (emphasis in original).

[6] *See* Ex. I, Jessica Bartlett, *Massachusetts Insurers Ask State to Suspend Key Obamacare Program*, Boston Business Journal (May 2, 2017), http://www.bizjournals.com/boston/news/2017/05/01/massachusetts-insurers-ask-state-to-suspend.html.

[7] Minuteman agrees with HHS that traditional Rule 56 summary judgment procedures are inapplicable, as this Court is not assessing whether there are disputed issues of fact for trial but rather is reviewing the agency's conduct for compliance with the APA. *See* HHS Br. at 14. For purposes of convenience, Minuteman attaches a compendium of exhibits that includes all public comments cited within this brief, as well as any Federal Register documents that are not otherwise assigned an exhibit number. *See* Ex. M ("Compendium of Cited Public Comments and Federal Register Documents").

II. Argument

A. HHS Has No Discretion To Ignore Real World Developments

HHS breezily dismisses the mass of evidence that Minuteman has marshalled about how risk adjustment has wreaked havoc. It asks the Court to do the same by arguing that (i) HHS made an "informed conjecture" in 2012 when crafting the original risk adjustment rule for benefit year 2014 and (ii) HHS then had the right to sit on its hands in all later years (despite initiating a separate rulemaking proceeding for each year), in the name of stability. Under HHS's logic, because the only rulemaking that should be reviewed is the original one for the 2014 benefit year (all others getting a free pass), the only evidence the Court should review is what was before the agency in 2012/2013 during that first rulemaking, before the program started. *See* HHS Br. at 12-13, 19-20, 37-38.

But the APA does not permit HHS to disregard evidence of the damage its rules have done: "when there is a known or significant change or trend in the data underlying an agency decision, the agency must either take that change or trend into account, or explain why it relied solely on data pre-dating that change or trend." *Zen Magnets, LLC v. Consumer Prod. Safety Comm'n*, 841 F.3d 1141, 1149 (10th Cir. 2016); *see also Dow AgroSciences LLC v. Nat'l Marine Fisheries Serv.*, 707 F.3d 462, 473 (4th Cir. 2013) ("[W]hen an agency acknowledges that its data are either outdated or inaccurate, it should, at the very least, analyze the new data or explain why it nevertheless chose to rely on the older data."). Where an agency chooses to ignore new data without adequate explanation, its conduct is arbitrary and capricious. *See e.g., Zen Magnets,* 841 F.3d at 1149 (vacating safety standard for magnets where agency ignored data showing "significant market changes triggered by" earlier regulatory efforts); *Dow AgroSciences,* 707 F.3d at 472-73 (agency opinion on pesticides was arbitrary and capricious where agency ignored "more recent available data"); *Sierra Club v. EPA,* 671 F.3d 955, 968 (9th

Cir. 2011) (agency's approval of an environmental plan was arbitrary and capricious where plan was based on old data from outdated model); *Maine Assoc. of Interdependent Neighborhoods v. Petit,* 659 F. Supp. 1309, 1322-23 (D. Me. 1987) (HHS's rule was arbitrary and capricious where HHS relied on old data that was no longer accurate).

Even if HHS could not have anticipated the monumental flaws in its risk adjustment formula when it devised the 2014 rule,[8] it certainly was well aware of the problems shortly after the program commenced. After the monetary assessments for the first year of risk adjustment were published in 2015, and a new notice and comment period opened for the Benefit Year 2017 Rule, the agency was flooded with comments by Minuteman and others, backed by real world data, describing how the methodology, as implemented, had disastrous effects.[9]

[8] Any such assertion is highly dubious. With the exception of bias against bronze plans, all of the issues in this case were raised in the original rulemaking for 2014. *See* Ex. M-1, Blue Cross Blue Shield Assoc. ("BCBSA") 2014 Amendment Cmt., at 1, 7, Rec. at 004301, '4307 (statewide average premium and HCC estimation bias); Ex. M-2, BCBSA 2014 Cmt., at 49, Rec. at 003095 (pharmacy data); Ex. M-3, CA Dept. of Ins. et al. 2014 Cmt., at 2, attachment at 1, Rec. at 003539-40; Ex. M-4, NY Health Benefit Exch. 2014 Cmt., at 1, Rec. at 002981 (same); Ex. M-5, OR Ins. Div. of the Dept. of Consumer and Business Servs. 2014 Cmt, at 1, MH001687 (same); Ex. M-6, Pharma. Research and Manuf. of America 2014 Cmt., at 1, 4-6, Rec. at 002765, '2768-70 (same); Ex. M-7, WellCare Health Plans, Inc. 2014 Cmt., at 2, Rec. at 002890 (same); Ex. M-8, Assoc. for Comm. Affiliated Plans 2014 Cmt., at i-iii, 2-8, 13-15, MH001579-81, '1583-89, '1594-96 (partial year enrollment); Ex. M-9, Nat'l Assoc. of Comm. Health Ctrs. 2014 Cmt, at 2-5, Rec. at 003187-90 (HCC estimation bias); Ex. M-10, WA Assoc. of Comm. & Migrant Health Ctrs. 2014 Cmt., at 2-4, Rec. at 003415-17 (same); Ex. M-11, Hank Frantz 2014 Cmt., at 2, Rec. at 003251 (statewide average premium). HHS nevertheless contends that the question of estimation bias for enrollees without an HCC was not raised in the 2014 rulemaking. *See* HHS Br. at 30, n. 10. But, the BCBSA clearly raised the issue: "testing of the risk adjustment methodology indicates that it over-compensates issuers for members with HCCs, while under-compensating issuers for members without HCCs." Ex. M-1, BCBSA 2014 Amendment Cmt., attachment at 5, Rec. at 004307.

[9] *See e.g.*, Ex. M-12, Aetna 2017 Cmt., at 3, 9-10, Rec. at 008419, '8425-26; Ex. M-13, America's Health Ins. Plans 2017 Cmt., at 18, MH001707; Ex. M-14, American Acad. of Actuaries 2017 Cmt., at 2-4, Rec. at 008137-39; Ex. M-15, American Hosp. Assoc. 2017 Cmt., at 9, Rec. at 008293; Ex. M-16, Anthem 2017 Cmt., at 3, 8-10, MH001523, '1528-30; Ex. M-17, BCBSA 2017 Cmt., at 2, 11, 13-14, 35-36, MH001749, '1758, '1760-61, '1782-83; Ex. M-18, NMHC 2017 Cmt., at 1-4, App. A, App. B (CHOICES, *Technical Issues with Risk Adjustment and Risk Corridor Programs* (Nov. 4, 2015)), MH001452-72; Ex. M-19, Common Ground Healthcare Cooperative 2017 Cmt., at 1, MH001829; Ex. M-20, CVS Health 2017 Cmt., at 1-2, Rec. at 008348-49; Ex. M-21, Evergreen Health 2017 Cmt., at 1-2, Rec. at 009435-009436; Ex. M-22, Evolent Health 2017 Cmt., at 4, MH001835; Ex. M-23, Express Scripts 2017 Cmt., at 1, MH001838; Ex. M-24, Land of Lincoln Health 2017 Cmt., at 1-5, Rec. at 009003-07; Ex. M- 25, Minuteman Health 2017 Cmt., at 3-7 and attachment (CHOICES, *Technical Issues with Risk Adjustment and Risk Corridor Programs* (Nov. 4, 2015)), MH001439-43, '1437.001-.016; Ex. M-26, Nat'l Assoc. of Ins. Comm. 2017 Cmt., at 2, 5, Rec. at 009363, '9366; Ex. M-27, Pharma. Care Mgmt. Assoc. 2017 Cmt., at 2, 5-7, MH001659, '1662-64; Ex. M-28, Priority Health 2017 Cmt., at 2-3, Rec. at 009344-45; Ex. M-29, Viva Health

While HHS claims that relying on its prior methodology would maintain stability, as commenters pointed out, the model was destroying the market. Having received these comments, the agency could no longer idly sit back and rest on its prior analysis. It was required to meaningfully respond. *Zen Magnets*, 841 F.3d at 1149.

HHS also was required to address comments raised after the 2014 rulemaking because it was presented with requests for reconsideration of its prior risk adjustment rules. Under the APA, the agency is required to "give an interested person the right to petition for the . . . amendment or repeal of a rule." 5 U.S.C. § 553(e). Any interested person therefore has a statutory right to seek reconsideration of a rule. In evaluating such a request, the agency is required to provide a "reasoned" explanation for its decision to grant or deny the request. *Am. Horse Prot. Ass'n v. Lyng*, 812 F.2d 1, 5 (D.C. Cir. 1987). For its analysis to pass muster, an agency must have "considered the relevant factors, [and] explained the 'facts and policy concerns' relied on," demonstrating that the "facts have some basis in the record." *Id.* (quotation and citation omitted).

In 2016, Minuteman clearly indicated that, in addition to submitting comments to the proposed new 2018 rule, it also sought reconsideration of prior rules. Ex. 31, Minuteman 2018 Cmt., at 8, MH000008 ("[HHS] must thoroughly and immediately fix the Risk Adjustment methodology, apply those changes in the 2016 and 2017 benefit years as well as 2018 and apply them retroactively to 2014 and 2015" and "Minuteman's [original] Complaint [in this case seeking relief for 2014-2017 rules] is hereby incorporated in its entirety into these comments"); Ex. 32, Declaration of Thomas Policelli (Oct. 6, 2016), Minuteman 2018 Cmt., Ex. B-1, at ¶¶ 72, 94, 104, MH000054, '60, '62.

2017 Cmt., at 2-4, MH001564-66; Ex. M-30, Health New England 2017 Cmt., at 1-7 and attachments, Rec. at 008483-651.

Importantly, when responding to a request for reconsideration of a prior rule, the agency is required to examine the newly submitted data supporting such a request, including, if appropriate, other comments addressing the issue. *See Lyng*, 812 F.2d at 5. That is, the agency is required to consider materials before it *at the time of the petition for reconsideration*, which here was in October 2016. The requirement to consider new information is especially critical when the petition for reconsideration alerts the agency to new data and developments since a rule's initial inception. *See id.* In *Lyng*, when faced with a petition for reconsideration of a prior rule that included a study demonstrating the problems with that rule, the agency was required to present a "reasonable explanation" for its denial of the reconsideration petition. The agency failed to meet its burden where it relied upon "conclusory" and "stale" justifications for deferring its rulemaking to the future, "particularly in light of" the newly submitted study. *Id.* Here, HHS is trying to engage in exactly the type of behavior rejected in *Lyng*. Despite having received a request for reconsideration supported by voluminous data and analyses, it believes it can ignore the evidence and maintain the status quo merely because it (inadequately) addressed the issues raised in its very first rulemaking – *before* there was any available data on how HHS's methodology would actually work. This is simply not permitted under the APA.

B. HHS's Use Of The Statewide Average Premium Is Contrary To Law And Arbitrary And Capricious

1. The Use Of The Statewide Average Premium Violates The ACA

Congress was clear on what it intended the risk adjustment program to do: "assess a charge on health plans and health insurance issuers . . . 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" and "provide a payment to health plans and health insurance issuers . . . 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) (emphasis added).

The problem is that HHS transfers funds not based on actuarial risk (*i.e.*, the relative health or sickness of the plan's enrollees), but rather by multiplying relative actuarial risk against the statewide weighted average premium. The statewide average premium sweeps in all the cost elements of an insurance plan, many of which are unrelated to the relative health or sickness of its insureds. Among the non-risk factors that drive premiums are 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, and by reducing administrative overhead. *See e.g.,* Ex. 33, CHOICES, *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs* (Nov. 4, 2015), Minuteman 2018 Cmt., Ex. E-2, at 9, MH000175; Ex. 34, Letter from CHOICES to CMS (Apr. 22, 2016), Minuteman 2018 Cmt., Ex. E-5, at 2-3, MH000195-96; Ex. 35, David V. Axene & Gregory G. Fann, *Comments on Proposed Rule (Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2018)* (Oct. 5, 2016), Minuteman 2018 Cmt., Ex. I-1, at 8-14, MH000597-603. HHS has conceded this point. Ex. 36, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper* (Mar. 24, 2016), Minuteman 2018 Cmt., Ex. F-1, at 93, MH000345 ("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").

Perhaps most telling, Minuteman's CEO has submitted sworn testimony in the administrative record that Minuteman sets its premiums based on average actuarial risk in the

marketplace. Ex. 32, Policelli Decl., at ¶ 56, MH000050. Its lower premiums are therefore not driven by an assumption of healthier enrollees, but rather by its innovative strategies to lower prices paid to hospitals and doctors. *Id.* Despite assuming average risk in its premiums, Minuteman has still been hammered with risk adjustment charges equal to 40%-70% of its premium revenue.

Minuteman cited in its opening Memorandum the actuarial expert white papers in the administrative record that demonstrate that, to the extent a low-cost competitor like Minuteman undercuts the statewide average premium by bringing down its non-risk related costs, its risk adjustment charges will be artificially inflated by the formula. *See* Memorandum of Law in Support of Minuteman Health Inc.'s Motion for Summary Judgment (Dkt. No. 50), at 19-21 (hereafter "MH Br."). HHS does not even try to rebut this evidence. Instead, HHS seizes upon the fact that the statute does not use the word "only" before "actuarial risk." HHS thus asserts that it had a blank check to transfer funds based on other factors so long as "actuarial risk [is] the dispositive factor in determining whether to assess a risk adjustment charge or make a risk adjustment payment." HHS Br. at 20-21. That is, according to HHS, once it divides insurers into creditors and debtors in the risk adjustment program, it can set the *amount* of those payments and credits however it pleases.

This is absurd. There is nothing in the statute's text that indicates charges and payments will be based on any factor other than "actuarial risk." *See generally* 42 U.S.C. § 18063(a)(1)-(2). Nor does HHS cite to anything in support of its sweeping claim other than the *absence* of the word "only." Courts do not presume that Congress intends to give totally unbounded discretion to administrative agencies. *California v. FCC*, 905 F.2d 1217, 1230 (9th

Cir. 1990) ("an agency's discretion is not boundless."). There is no reason to depart from the plain language of the statutory text, here the best and sole guide to Congressional intent.[10] *Id.*

No doubt recognizing that it is overreaching, HHS offers the fallback argument that Minuteman's position must be wrong because it is impossible to devise a payment formula that perfectly converts relative actuarial risk into the expected incremental costs derived solely from such actuarial risk. But this is not a case about *de minimis* leakage of non-actuarial risk factors. Roughly one in every three dollars of risk adjustment payments that Minuteman has made is due to pricing below market average premiums, even though its price-setting, as noted above, assumes market-average levels of actuarial risk; in other words, the formula is off by 30% or more.[11] *See* MH Br. at 21.

2. Use Of The Statewide Average Premium Is Arbitrary And Capricious

In the alternative, to the extent the statutory text is not conclusive, HHS's use of the statewide average premium is arbitrary and capricious. In reviewing HHS's conduct under the arbitrary and capricious standard, 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,

[10] The one case cited by HHS, *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36 (D.D.C. 2012), is off point. There, a rural critical access hospital argued HHS lacked authority to reduce its Medicare reimbursement rates because a particular statute only authorized the reduction in rates to a different grouping of hospitals. The court rejected the argument that the statute's silence as to rural critical access hospital rates should be given dispositive weight. *Id.* at 45. But Minuteman's argument is not from statutory silence. Rather Minuteman relies on the sole indicia of Congressional intent here – the plain text of the ACA – which speaks only of "actuarial risk". Minuteman seeks to give import to Congress's words; it is HHS that grasps for straws from the ACA's silence on the exact configuration of the payment formula.

[11] HHS argues that its use of the statewide average premium must be upheld because use of an issuer's own premium would be no better. *See* HHS Br. at 22-25. This misstates the role of judicial review. This Court assesses whether HHS's regulations comport with the APA; if not, the agency on remand must consider alternatives. *Steinhorst Assocs. v. Preston*, 572 F. Supp. 2d 112, 125 (D.D.C. 2008). This Court does not weigh one option against the other as a super-agency rewriting the regulations itself. *Citizens for Balanced Env't & Transp. v. Volpe*, 650 F.2d 455, 462 (2d Cir. 1981). Use of an issuer's own premium is one alternative, which Minuteman favors and which HHS itself seriously considered; other commenters have suggested using medical claims costs instead of any measure of premium at all. *See* Ex. M-37, Land of Lincoln 2017 Cmt., at 5, Rec. at 009007; Ex. M-38, Alliance Comm. Health Plan 2018 Cmt., at 3, MH001845; Ex. M-39, Anthem 2018 Cmt., at 18, MH001490 . There may be other alternatives, and the agency is free to consider any of them on remand.

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) (citation omitted). The Supreme Court has cautioned that "[e]xpert discretion is the lifeblood of the administrative process, but unless we make the requirements for administrative action strict and demanding, expertise, the strength of modern government, can become a monster which rules with no practical limits on its discretion … Congress did not purport to transfer its legislative power to the unbounded discretion of the regulatory body."[12] *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 167 (1962) (quotations and citations omitted).

Here, as discussed above, the one factor that Congress directed HHS to consider in devising a risk adjustment program was relative "actuarial risk." Yet HHS's use of the statewide average premium sweeps in the many factors unrelated to actuarial risk that impact premiums, such as how effectively a plan negotiates prices with hospitals and physicians, how well it manages its members' medical care, and how ably it controls administrative expenses.

The use of the statewide average premium also undermines the ACA's policy of promoting vigorous competition and innovation to reduce premiums. *See* HHS Br. at 26

[12] HHS suggests that, because risk adjustment is technically complex, this Court should rubber stamp its decisions. *See e.g.,* HHS Br. at 3-4, 17-19, 34. But that is not the law. The requirement that an agency decision "must not be arbitrary and capricious … exists even in technical areas." *Puerto Rico Sun Oil Co. v. EPA,* 8 F.3d 73, 77 (1st Cir. 1993). A court "may not automatically defer to an agency's conclusions, even when those conclusions are scientific." *Locke,* 776 F.3d at 994 (internal citation omitted). "Rather, review must be sufficiently probing" to determine the validity of the agency's decision. *See id.; see also NRDC Inc. v. Pritzker,* 828 F.3d 1125, 1139 (9th Cir. 2016) (agency's scientific decision was arbitrary and capricious); *Natural Resources Defense Council, Inc.,* 824 F.2d at 1282 (invalidating scientific decision where agency "presented no reasoned explanation"); *N. Plains Res. Council, Inc. v. Surface Transp. Bd.,* 668 F.3d 1067, 1075, 1079 (9th Cir. 2011) (agency's scientific decision was arbitrary and capricious); *Puerto Rico Sun Oil Co.*, 8 F.3d at 78 (agency's scientific decision was arbitrary and capricious); *United States Sugar Corp. v. EPA,* 830 F.3d 579, 629 (D.C. Cir. 2016) (agency's scientific action was arbitrary and capricious). "A different approach would not simply render judicial review generally meaningless, but would be contrary to the demand that courts ensure that agency decisions are founded on a reasoned evaluation of the relevant factors." *Locke,* 776 F.3d at 994-95 (quotation and citation omitted).

(conceding "the ACA as a whole seeks to promote competition, efficiency, and innovation…"). Outside this case, HHS's statements have rung the alarm about how the lack of competition can destroy the reforms of the ACA by preventing access to affordably priced insurance products:

> A stabilized individual and small group insurance market will depend on greater choice to draw consumers to the market and vibrant competition to ensure consumers have access to competitively priced, affordable, and quality coverage. Higher rates . . . resulting from minimal choice and competition, can cause healthier individuals to drop out of the market, further damaging the risk pool and risking additional issuer attrition from the market.

Ex. J, HHS, Patient Protection and Affordable Care Act; Market Stabilization, 82 Fed. Reg. 18,346, 18,346 (Apr. 18, 2017).[13] As detailed on pages 17-22 of Minuteman's opening Memorandum, however, using the statewide average premium artificially penalizes carriers that have lowered premiums beneath that average by innovating to secure lower prices from hospitals and doctors, better management of enrollees' health care, and low administrative overhead.

In fact, use of the statewide average premium prevents consumers from benefitting from the entry of new low-cost competition. To the extent a new entrant can use innovative strategies and operating efficiencies to drive down premiums below the statewide average, it will see its risk adjustment charges artificially inflated by the difference between its low premiums and the higher statewide average. *See* MH Br. at 19-21. HHS rules that penalize price-cutting will either drive out the new entrant or force it to raise premiums.

These are not theoretical concerns. In the ACA, Congress appropriated billions of dollars for the Consumer Oriented and Operated Plans ("CO-OP") program, in which HHS

[13] HHS has objected to Minuteman's citation to government statements outside of the rulemaking records and to media articles. HHS Br. at 19, n. 4. But this Court can and should properly take judicial notice of these public materials. *See e.g., Banner Health v. Burwell,* 126 F. Supp. 3d 28, 61 (D.D.C. 2015) (taking judicial notice of public statements by CMS); *Pharm. Research & Mfrs. of Am. v. HHS,* 43 F. Supp. 3d 28, 33 (D.D.C. 2004) (taking judicial notice of FDA website); *N.M. ex rel. Richardson v. BLM,* 565 F.3d 683, 307 n. 22 (10th Cir. 2009) (taking judicial notice of websites of two federal agencies); *Am. Bankers Ass'n v. NCUA,* 347 F. Supp. 2d 1061, 1068 (D. Utah 2004) (taking judicial notice of a news article).

extended loans to insurance start-ups to inject low-priced competition into stagnant insurance markets around the country. *Id.* at 11-12 (describing program). However, roughly three-quarters of CO-OP's have failed. An investigation by the House Energy and Commerce Committee squarely blamed excessive risk adjustment assessments for destroying many CO-OPs.[14] Ex. M-40, 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 Cmt., Ex. C-1, at 19-22, MH000085-88.

The various justifications tossed up by HHS for its competition-thwarting formula are legally wrong, lack evidentiary basis, or are simply implausible:

Premiums are not a proxy for actuarial risk: HHS's first justification is that premiums are a proxy for actuarial risk because insurance plans price to cost. HHS Br. at 22-23. However, HHS nowhere addresses the evidence that Minuteman cited showing that premiums are not proxies for actuarial risk, because there are many other costs that impact premium-setting. *See* MH Br. at 17-21. Nor does HHS explain its own admissions, outside this litigation, that premiums sweep in many non-risk related costs. *Id.* at 30-31.

Instead, HHS cites three sets of materials. First, HHS cites to a memorandum by its contractor, RTI, which notes in passing that actuarial risk has an impact on premiums. Ex. A to HHS Br., at 2, Rec. at 000810. While true, this does not address Minuteman's argument that there are many other costs also driving premium-setting, such as the ability to negotiate hospital prices. The very previous paragraph in RTI's Memorandum makes Minuteman's point:

[14] HHS suggests the risk corridors program would have mitigated any excessive risk adjustment assessments. HHS Br. at 7. It would be charitable to call this point disingenuous, as HHS woefully underpaid its risk corridors obligations, leading to massive litigation in the Court of Federal Claims. *See e.g., Moda Health Plan, Inc. v. United States*, 130 Fed. Cl. 436 (Fed. Cl. 2017). Minuteman, like two dozen others (including a class action), has filed a lawsuit for the risk corridors funds it is due.

> The purpose of these transfer payments is to reduce as much as possible differences in plan premiums that result from favorable or unfavorable selection (differences in health status). Risk adjustment is ***not*** intended to reduce or account for premium differences between plans due to differences in services covered, ***differences in internal plan expenditures or cost, plan profit, or other plan features associated with differences in plan cost*** . . .

Id. (emphasis added).

Second, HHS cites to page 40 of its 2011 White Paper, *see* HHS Br. at 22, but that merely describes an actuarial table and model that the agency ran.

Third, HHS cites its own statements in the Federal Register made in the course of the 2014 rulemaking process. *Id.* at 22-23. HHS cites its statements that "claims and administrative costs include elements of risk selection" and that "plans 'price to cost.'" *Id.* at 22. Once again this ignores the many other, non-risk selection costs that feed into a premium. Finally, HHS points to its statement that "use of a plan's own premium may cause unintended distortions." *Id.* But the underlying cited Federal Register page, Rec. at 000249, provides no explanation of what these "distortions" are. Nor did HHS provide any evidence that these "distortions" exist. This Court owes no deference to the agency's naked say-so.[15] *McDonnell Douglas Corp. v. U.S. Dep't of the Air Force,* 375 F.3d 1182, 1187 (D.C. Cir. 2004)

There is no Congressional intent to use risk adjustment to prevent plans from dodging sicker enrollees: HHS's second justification is that use of the statewide average premium "reduce[s] incentives for plans to avoid high risk enrollees." HHS Br. at 23. Although HHS argues this was Congress's goal in enacting risk adjustment, it cites no statutory text or legislative history in support. *Id.* at 7-8. The ACA already has separate statutory provisions

[15] While HHS's lawyers in this case introduce this cite with their own spin, this Court only reviews what the agency said in the Federal Register during the rulemaking process. The agency's *post hoc* litigating position receives no deference. *Amerijet Int'l, Inc. v. Pistole*, 753 F.3d 1343, 1351 (D.C. Cir. 2014).

forbidding carriers from denying coverage or raising premiums to sicker enrollees. 42 U.S.C. § 300gg-3. There is nothing in the text of the ACA suggesting Congress intended risk adjustment to somehow be the enforcement mechanism for these provisions. While risk adjustment is clearly intended to neutralize the impact of actuarial risk in marketplace competition, there is no reason to believe – as HHS insists – that risk adjustment was further intended as a mechanism to guarantee access to coverage for sicker enrollees, such that the program should over-compensate plans with sicker enrollees.

Nonetheless, HHS asserts that risk adjustment must be used to protect sicker enrollees because otherwise carriers will use underhanded means to dodge them. HHS Br. at 7-8. HHS cites no evidence of this actually happening, but rather hypothesizes that "a plan might offer lower premiums by excluding from its provider networks specialty hospitals and doctors that treat high cost conditions." *Id.* at 8. But Congress addressed this issue by giving HHS the authority to set provider network adequacy standards for plans on the exchange. 42 U.S.C. § 18001; Network Adequacy Standards, 45 C.F.R. § 156.230. This is not an issue for the risk adjustment program.[16]

HHS further claims that carriers will manipulate their marketing practices. *See* HHS Br. at 7-8. But state insurance regulators already comprehensively regulate insurance marketing. *See e.g.,* 211 CODE MASS. REGS. 40.00. Congress expressly provided the ACA would not preempt, but would work in tandem with, such state regulatory schemes. 42 U.S.C. § 18041(d).

[16] Throughout its Memorandum, HHS takes veiled swipes at Minuteman's limited provider network strategy to reduce costs, implying this is somehow a nefarious scheme to avoid sicker enrollees. HHS itself, however, specifically approved Minuteman's limited network business plan when it approved Minuteman's loan application under the CO-OP program, ultimately providing Minuteman with over $100 million in taxpayer funds to advance this business strategy. *See* MH Br. at 11-12; Ex. M-32, Policelli Decl., at ¶ 28, MH000044; Ex. L, Minuteman Am. Compl., at ¶ 90. If HHS thought Minuteman's approach violated Congressional intent, it certainly acted in a bizarre fashion.

There is no basis for the program's alleged budget neutrality: Third, HHS asserts that it is appropriate to use the statewide average premium "because the risk adjustment program is self-funded and budget-neutral, payments and charges must balance." *See* HHS Br. at 23. But HHS does not explain why this is so. Nor does HHS respond to the multiple arguments made by Minuteman on pages 23-25 of its opening Memorandum regarding the program's lack of budget neutrality. The only argument HHS makes – in a footnote – is that, if states operated a risk adjustment system, then HHS did not think it had authority to obligate state budgets. *Id.* at 23, n. 5. But HHS has operated the New Hampshire risk adjustment program each year and will operate the Massachusetts program starting in 2017.[17]

The statewide average premium is not predictable: Finally, HHS contends that Minuteman can easily plan for any risk adjustment assessments: "Armed with knowledge of how the formula operates, Minuteman can use an average level of efficiency when pricing expected risk adjustment charges and a higher level of efficiency when pricing the costs of its own healthier membership." HHS Br. at 26. To begin with, HHS admits that risk adjustment forces more efficient plans like Minuteman to artificially increase their premiums, at least in part. But more fundamentally, risk adjustment is not predictable at all. For any small carrier like Minuteman, the statewide average premium is not predictable because its premiums (as opposed to competitors with large market shares) are too small to meaningfully impact the statewide weighted average. Notably, Minuteman must file its premiums with state regulators before a relevant benefit year, but only learns of its risk adjustment liability months after that benefit year

[17] Minuteman further pointed out that, even if risk adjustment were required to be budget neutral, that would not require a formula that guarantees perfect mathematical balance of payments in and out each year, as HHS implicitly asserts by claiming that the statewide average premium is needed to assure budget neutrality in the formula. In the related reinsurance and risk corridors programs, HHS makes pro rata adjustments if payments in are insufficient to fund payments out; it could simply do the same with risk adjustment as well. *See* MH Br. at 25-26.

has ended. *See* MH Br. at 27. Moreover, as Minuteman and its competitors file premiums with state regulators at the same time, Minuteman cannot have advance knowledge of its competitors' rates to use in setting its own.

HHS cites no evidence whatsoever that risk adjustment results have been readily predictable by insurance companies. And with good reason: as Minuteman showed in its opening Memorandum, citing industry studies that HHS completely ignores, insurance companies failed miserably at estimating their risk adjustment liabilities or payments.[18] *Id.* at 27-28.

C. HHS Fails To Account For The Actual Health Care Costs Of Healthier Enrollees

HHS's risk adjustment formula underestimates the medical costs of insureds without a chronic disease (HCC) classification by 10%-35%, resulting in the absurd situation that, net of risk adjustment, carriers actually lose money on every enrollee who is not chronically ill. *Id.* at 35. This is despite the fact that, this past April, HHS stated that "[w]e are acutely aware of the importance of attracting healthy consumers to the individual market, and Exchanges in particular, in order to stabilize and improve the risk pool." Ex. J, 82 Fed. Reg. at 18,357. HHS also recently requested comments as to how to "increase the number of younger and healthier consumers purchasing plans." Ex. H, 82 Fed. Reg. at 26,887. Even in this litigation HHS concedes that a "sicker-than-expected risk pool" has resulted in skyrocketing premiums and insurance carrier insolvencies. HHS Br. at 28, n. 9.

[18] Nor is HHS's belated decision to reduce the statewide average premium by 14% starting in 2018 a solution to the problems identified by Minuteman. This is still a weighted average of all premiums, just now with a downward adjustment, and thus continues to penalize operating efficiency and innovations that allow a carrier to have lower costs than the market average. HHS implicitly agrees that the 14% reduction does not address Minuteman's critique because its arguments in defense of the 2018 methodology are identical to its arguments in defense of the pre-2018 methodology. HHS Br. at 39 (defending 2018 methodology because "***as discussed above***, there is nothing arbitrary and capricious about using a mean to approximate overall health costs in a state" (emphasis added); and repeating flawed arguments about budget neutrality and predictability).

While HHS waxes poetic on what it hoped its formula would do when it was drawn up in 2012, *see id.* at 28-30, it nowhere addresses the evidence that the formula just flat out does not work in predicting costs of medical care. Outside of this litigation, HHS has reluctantly admitted to this estimation bias flaw. Ex. M-41, HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 61,455, 61,472 (proposed Sept. 6, 2016), Rec. at 009530. Although careful not to acknowledge the problem, HHS nonetheless claims it appropriately responded to attempts to address it. First, HHS notes that it will add preventive services to the cost estimation model beginning in 2017. *See* HHS Br. at 41. But both commenters and HHS agreed that this is a minor tweak which will not make a material dent in the estimation bias flaw. *See* Ex. M-16, Anthem 2017 Cmt., at 8-9, MH001528-29 and Ex. M-42, HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,203, 12,218 (Mar. 8, 2016), Rec. at 007762, cited in MH Br. at 36. Once again, HHS simply ignores the evidence.

Second, HHS concedes that, in the 2018 rulemaking, Minuteman submitted a proposal to fix the estimation bias authored by the agency's own former Chief Actuary, Richard Foster. *See* MH Br. at 37; HHS Br. at 40-41. As Minuteman pointed out, HHS failed to respond to this proposal. *See generally* MH Br. at 37-38. HHS nonetheless tries to claim it did respond to Mr. Foster's proposal by citing the following language from the Federal Register:

> Finally, we evaluated an approach 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. We noted that while we believe modifications of this type could improve the model's performance along this specific dimension, there is a risk that such modifications could

> unintentionally worsen model performance along other dimensions on which the model currently performs well. . .
>
> Response: We believe that some of the modeling approaches we considered could improve the model's predictive ability for certain subgroups of enrollees. However, we are still evaluating the tradeoffs that would need to be made in model predictive power among subgroups of enrollees. We continue to focus on encouraging plans to attract high-risk enrollees through the risk adjustment model, but agree with commenters that we should further evaluate solutions prior to making any adjustments to the model. We will continue to explore these modeling approaches . . .

Ex. M-43, HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94,057, 94,083 (Dec. 22, 2016), Rec. at 009620, cited in HHS Br. at 41.

There is no reference to Mr. Foster's proposal here whatsoever, much less any explanation for the supposed conclusion that Mr. Foster's unreferenced model "could unintentionally worsen model performance along other dimensions on which the model currently performs well."[19] But where an agency receives "significant" or "critical commentary," it must "respond in a reasoned manner" to that comment. *See e.g., FMBE Bank Ltd. v. Lew,* 209 F. Supp. 3d 299, 333 (D.D.C. 2016); *Sierra Club et al. v. EPA et al.,* No. 15-1246, at 10 (D.C. Cir. July 18, 2017) (the mere fact that the agency was repurposing a pre-existing standard did not excuse it from the duty to respond to substantive comments on its new rule).

D. HHS Violates Congressional Intent To Have A Robust Market In Bronze Plans

HHS's own data from its Spring 2016 white paper show that bronze plans are ***always*** net payors into risk adjustment. *See* MH Br. at 44. As a result, the risk adjustment formula renders it extremely difficult for bronze plans to be profitable, *see id.*, even though

[19] In a fit of desperation, HHS also claims that Mr. Foster's proposal could only apply to 2015 and 2016. *See* HHS Br. at 40-41. This point is not in the administrative record. It is a *post hoc* rationalization from HHS's litigation counsel, and thus entitled to no deference. *Amerijet Int'l, Inc.*, 753 F.3d at 1351. Moreover, Minuteman proposed, in its comment, applying Foster's proposal to all years from 2014 through 2018. Ex. 31, Minuteman 2018 Cmt., at 8, MH000008. There is nothing about Foster's methodology that was limited to 2015 and 2016.

Congress intended for there to be bronze plans available in the ACA exchange marketplaces. *See* 42 U.S.C. § 18022(d)(1)(A). As HHS has acted contrary to the clear Congressional intent that there be a robust market in bronze plans, its actions are arbitrary and capricious. *See Ctr. for Biological Diversity v. Nat'l Highway Traffic Safety Admin.*, 538 F.3d 1172, 1194 (9th Cir. 2008) ("We 'must reject administrative constructions which are contrary to clear congressional intent.'" (citation omitted)). Moreover, HHS did not even bother to respond to Minuteman's comments on this point in the 2018 rulemaking, which independently is a basis to find that the agency's conduct was arbitrary and capricious. *See Zen Magnets*, 841 F.3d at 1149; *Sierra Club v. Van Antwerp*, 661 F.3d 1147, 1157 (D.C. Cir. 2012); *Sierra Club,* No. 15-1246, at 10.

HHS does not dispute any of this evidence; nor does it point to any on the record response to Minuteman's comment. Instead, the agency argues that since there are still some bronze plans left, "at least some issuers must find them profitable." HHS Br. at 41. But outside this case, HHS has admitted that "the 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." Ex. J, 82 Fed. Reg. at 18,369. HHS admits the "sicker-than-expected risk pool" is heavily to blame, *see* HHS Br. at 28, n. 9, and that "Bronze plans tend to attract healthier enrollees," *id.* at 5 – the very enrollees HHS admits are needed for a balanced, stable marketplace. It is unclear why HHS believes this Court cannot act until the entire flimsy edifice completely crashes down.

HHS's second argument is that there is no need for judicial relief because the agency is thinking about the problem. *See* HHS Br. at 41-42. But HHS ignored entirely the

comments in the 2018 rulemaking regarding discrimination against bronze plans; it is manifestly ***not*** developing a solution. Judicial intervention is needed.[20]

E. HHS Wrongfully Excluded Prescription Drug Data Before The 2018 Rule

Prior to 2018, the risk adjustment methodology failed to accurately capture HCC status because of HHS's refusal to utilize prescription drug data. *Id.* at 39. This is despite the fact that HHS has acknowledged such data would improve the accuracy of its estimation of relative actuarial risk. Ex. 36, CMS, *March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting: Discussion Paper*, at 40-41, MH000292-93. Why, then, does the pre-2018 model not include prescription drug data? HHS offers a series of excuses that do not withstand even minimal scrutiny.

First, HHS complains that incorporating drug data was too "difficult". HHS Br. at 33-34. But burden and complexity are not sufficient justifications to ignore a proposed solution to a problematic methodology. *See Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 660 (9th Cir. 2011) (HHS cannot substitute Congressional intent for "an alternative that it considers more convenient and less burdensome"). HHS itself ultimately agreed, in Fall 2016, when the apparent difficulties seem to have disappeared and HHS announced the incorporation of drug data into the model starting in 2018. Ex. M-43, 81 Fed. Reg. at 94,071, Rec. at 009608.

Second, HHS (without citing any evidentiary support) claims the inclusion of prescription drug data might inappropriately incentivize physicians to steer patients towards drugs, instead of other therapies. To be clear, HHS has dreamt up a scenario in which a *physician* would alter her treatment decisions and prescribe unnecessary medications, potentially committing medical malpractice and serious ethical violations, to benefit an *insurer* because the

[20] HHS also suggests that the addition of the cost of preventive care services to the formula will make bronze plans viable. *See id.* at 42, n. 17. It will not. *See* MH Br. at 36.

prescription might correlate to an HCC that might lead to a higher risk score. This is pure fantasy and cannot be taken seriously given the absence of any supporting real world evidence. *See Tripoli Rocketry Ass'n v. Bureau of Alcohol, Tobacco, Firearms, & Explosives*, 437 F.3d 75, 83 (D.C. Cir. 2006) ("[W]here its action is founded on unsupported assertions or unstated inferences we will not 'abdicate the judicial duty [to] carefully [] review the record to ascertain that the agency has made a reasoned decision based on reasonable extrapolations from some reliable evidence'").

HHS's next justification is that "drug usage can be a biased indicator of health status because populations with better adherence to drug therapies [such as higher income and better educated populations] will appear sicker and therefore, insurers would have weaker incentives to enroll patients with lower income or lower education." HHS Br. 33 (internal quotations and citation omitted). This argument does not fare any better than the argument that physicians will commit malpractice to enrich insurance companies. It is undisputed that adding prescription drug data will more accurately capture risk for those who receive prescription drug treatment. Failing to accurately reflect the health status of those who do adhere to their drug regimens is no fix for failing to capture reliable data on those who do not. Rather, efforts should be made to increase compliance with prescription drug treatment regimens so that the potential bias HHS identifies is mitigated. Moreover, the current diagnosis code model *already* creates a bias against lower income enrollees. Risk scores are biased downward in lower-income, rural areas because the intensity of care is lower.[21] Ex. M-30, Health New England 2017 Cmt., at 2-5, Rec. at 008484-86.

[21] HHS also argues that excluding prescription drug data is "presumptively valid" because Congress directed the agency to use Medicare's risk adjustment programs as a model, which do not use this data to identify diagnoses. *Id.* at 32-33. But HHS itself has recognized that it cannot simply copy the Medicare programs because the populations are too different; thus, HHS used datasets for commercially insured individuals, and not Medicare

F. HHS's Formula Fails To Account For Partial Year Enrollees

The problem with partial year enrollment is purely one of timing – if the enrollee does not receive a diagnosis from a doctor *during his/her enrollment in the plan*, the issuer will have no knowledge of it and the enrollee's risk score will be understated. Ex. 32, Policelli Decl., at ¶ 99, MH000060. HHS dismisses this concern because "an enrollee who never visits a doctor to receive an HCC-qualifying diagnosis also is not likely to be consuming substantial treatment costs..." HHS Br. at 32. But a short-term enrollee (who may only be insured by Minuteman for one or two months) with a chronic condition may only visit the doctor during the portion of the year during which he was not yet covered by the plan in question. Ex. 32, Policelli Decl., at ¶ 97, MH000061. Once again, the proof is in the data. In the agency's words:

> [E]nrollees that didn't have a full year's enrollment, so those that were in the one month to 11 month group enrollment, enrollment duration groups, these enrollees, their predicted expenditures with the 2014 adult silver model under predicted expenditures, so compared to their actual, what their actual expenditures were, their predicted expenditures were lower. The lower enrollment groups particularly, particularly for the one to seven months of enrollment were under predicted by the 2014 model. On the other hand, enrollees that had a full year of enrollment, a 12-month enrollment, were slightly over predicted by the 2014 silver model.

Ex. M-45, HHS-Operated Risk Adjustment Methodology Meeting Transcript (Mar. 31, 2016), at Supp000019. HHS faults Minuteman for not identifying a solution to the problem, but HHS itself identified a solution starting in 2017 by adding enrollment duration factors. Ex. M-41, HHS NBPP for 2018, 81 Fed. Reg. at 61,468, Rec. at 009526. It needs to apply the fix to all benefit years from 2014 forward.

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enrollees, to develop its formula. *See e.g.,* Ex. M-44, HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,117, 73,127 (proposed Dec. 7, 2012), Rec. at 000122 (HHS risk adjustment model was calibrated using commercial data); *see also id.* at 73,128-29, Rec. at 000123-24 ("The [Medicare] CMS HCCs were developed using data from the aged and/or disabled Medicare population… As such, HCCs and [diagnosis groups] may not be the same between the Medicare and HHS risk adjustment models.").

G. HHS's Jurisdictional Defenses Have No Merit

1. Minuteman Seeks Only Declaratory And Injunctive Relief

No doubt recognizing that it cannot defend this case on the merits, HHS contends that Minuteman seeks only money damages for past risk adjustment calculations and thus this action belongs in the Court of Federal Claims. This argument is meritless. The Prayer for Relief in Minuteman's Amended Complaint requests only declaratory and injunctive relief. The Amended Complaint asserts only one count under the APA, which only permits declaratory and injunctive relief. *See* 5 U.S.C. §§ 702, 706. As the 2017 and 2018 risk adjustment rules will not be applied until July 2018 and July 2019, that part of the action can only be seeking prospective relief.[22]

Nevertheless, HHS claims this is really a secret damages case. First, HHS claims it has solved all of Minuteman's challenges in the 2017 and 2018 rulemakings, so this case is supposedly only about the 2014-2016 rules that have already been applied. But this is just not true: HHS still uses the statewide average premium in the 2017-2018 formula, and still has not addressed the estimation bias and bronze plan discrimination flaws. At most, HHS addressed the partial year enrollee issue beginning in 2017 and prescription drug data beginning in 2018.

Second, the relief sought for 2014-2016 is also equitable. Minuteman is not asking to "recalculate and refund charges for prior years." *See* HHS. Br. at 43. Rather, as laid out in its Prayer for Relief, Minuteman is asking this Court to invalidate regulations for past

[22] Because of the destructive effects of the risk adjustment program, Minuteman will be restructuring its operations and the current plaintiff entity, while solvent, will no longer sell insurance in 2018. Ex. K, Press Release, *Minuteman Health, Inc. Management Seeks to Organize a New Insurance Company to Begin Writing Business as of January 1, 2018; Minuteman Health, Inc. Will Stop Writing Business as of January 1* (June 23, 2017), https://minutemanhealth.org/about-us/Minuteman%20Health%20Newsroom/2017/20170623. Minuteman will be subject to risk adjustment for its participation in the individual and small group markets in 2017. Moreover, certain of Minuteman's small group policies may remain in effect into 2018, thus subjecting Minuteman to risk adjustment for 2018, as well.

years so that HHS can then fix the regulatory scheme. If this Court grants the requested relief, HHS will then be directed to conduct a new rulemaking process for those years. *AEP Tex. N. Co. v. Surface Transp. Bd.*, 609 F.3d 432, 444 (D.C. Cir. 2010) (vacating rule and remanding to agency "to reassess its decisionmaking for the 2005 cost of equity estimate."); *Comm. for Fairness v. Kemp*, 791 F. Supp. 888, 898 (D.D.C. 1992) (vacating regulations and remanding for further rulemaking). If it is determined under that new scheme that HHS owes money back to Minuteman (which can only be known after HHS engages in a new rulemaking process after remand), HHS can issue that refund or Minuteman can sue in the Court of Federal Claims.[23]

There is nothing unusual about Minuteman's challenge here, and the case law is clear that claims in District Court to invalidate regulations under the APA for past years are permissible even if the ultimate effect is that the agency may take action down the road that will result in the payment of money. *See e.g., 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*, 791 F. Supp. 888 (ordering recalculation of funds under a regulation for prior years); *AEP Tex. N. Co.*, 609 F.3d 432 (evaluating whether the agency needed to retroactively recalculate the applicable rates for 1998-2005, but only ordering recalculation for 2005 for being arbitrary and capricious).[24]

[23] For this reason, HHS's hand-wringing over the supposed inequity of undoing past risk adjustment transfers is premature, to say the least. That is an issue that the agency can address in its new rulemaking on remand. And, of course, if this Court concurs with Minuteman that the program is not budget neutral, HHS does not need to undo any past transfers because it can fund additional liabilities (should there be any) through its general appropriations. MH Br. at 25. However, Minuteman notes that HHS already provides in its regulations for rejigging past transfers when necessary. For example, if HHS makes a calculation error under the risk adjustment program, an issuer can file an administrative appeal. *See* 45 C.F.R. §156.1220. The filing of such an appeal does not stay the transfers of funds. *See* 45 C.F.R. § 156.1210. Thus, if an issuer prevails on an appeal that its risk adjustment liability or payment was miscalculated, HHS can only grant relief by "unscrambling the egg" and making some retroactive adjustments.

[24] The cases cited by HHS do not hold otherwise. In those cases, the courts ruled that they did not have jurisdiction over the plaintiff's claims because the plaintiff sought a discrete award of money and therefore there was no equitable relief to be granted. *Batsche v. Burwell*, 210 F. Supp. 3d 1130, 1134-35 (D. Minn. 2016) ("Once the

2. Minuteman Has Standing To Challenge the Massachusetts Formula

HHS also challenges Minuteman's standing to contest the Massachusetts state risk adjustment program in effect from 2014-2016. This argument does not apply to Minuteman's claims based upon its participation in the federally run New Hampshire risk adjustment program and the federally run Massachusetts program in 2017 and 2018.

Nor is there any merit to this partial defense. HHS claims there is no causal connection between its actions and the former Massachusetts state program, but admits it "required Massachusetts to use the state average premium to calculate payments and charges…" HHS Br. at 16. HHS also argues this Court cannot redress the wrong because there is no certainty Massachusetts would alter its former methodology. However, if Minuteman prevails, it could petition the state for redress under Mass. Gen. Laws Ch. 30A, §4.

III. Conclusion

For the reasons set forth herein and in Minuteman's opening Memorandum, Minuteman's motion for summary judgment should be granted, HHS's cross-motion should be denied, and the Court should vacate HHS's risk adjustment regulations for all challenged years, "the typical remedy" under the APA. *St. Lawrence Seaway Pilots Ass'n v. U.S. Coast Guard*, 85 F. Supp. 3d 197, 208 (D.D.C. 2015). Alternatively, this Court may remand without a vacatur. *Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993).

Fund collects $762,663.90 from the Department, there will be no injury left to remedy"); *Gerhart v. Dep't of Health & Human Servs.*, No. 4:16-CV-00151, 2017 WL 1019816 (S.D. Iowa Mar. 16, 2017) (holding that the court did not have jurisdiction because the claim only targeted "a specific year of risk adjustment payments", in contrast to a case where there was "a challenge to the entire scheme of risk adjustment . . . payments."). There is no request in the Amended Complaint for a specific sum of money, nor could there be as Minuteman is seeking to have the formula remade, not applied in some way that would trigger a check.

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CERTIFICATE OF SERVICE

I hereby certify that this document filed on July 20, 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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