UNITED STATES DISTRICT COURT
DISTRICT OF MASSACHUSETTS

MINUTEMAN HEALTH, INC.,	)	
	)	
Plaintiff,	)	
	)	
v.	)	No. 16-cv-11570-FDS
	)	
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, CENTERS FOR MEDICARE AND MEDICAID SERVICES, THOMAS E. PRICE, M.D., Secretary of Health and Human Services, in his Official Capacity, and SEEMA VERMA, Administrator for the Centers for Medicare and Medicaid Services, in her Official Capacity,	)	**Leave to file granted on March 13, 2017**
	)	
Defendants.	)	

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

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TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases **Page(s)**

Statutes

State Laws

Administrative & Executive Materials

Other Authorities

INTRODUCTION

The Patient Protection and Affordable Care Act ("ACA") was enacted in 2010 with the goal of expanding coverage in the individual health insurance market. Among the ACA's major measures were a series of provisions that prohibited health insurance plans from denying coverage or setting premiums based on the health status of their enrollees. Notwithstanding these prohibitions, Congress knew that insurance companies, whether advertently or inadvertently, could still design their plans or business practices in such a way that would discourage enrollment by individuals with preexisting conditions, thereby concentrating the costs of treating these individuals in a few plans that might raise premiums higher and higher to cover costs. One of the provisions enacted to address this problem was section 1343 of the ACA (now codified as 42 U.S.C. § 18063), which created a program known as "risk adjustment." Under the program, assessments are collected from plans enrolling healthier-than-average enrollees and used to make payments to plans enrolling sicker-than-average enrollees, thereby distributing actuarial risk among plans. Congress entrusted the Department of Health and Human Services (the "Department"), in consultation with states, with the complex task of devising a way to measure and compare actuarial risk among plans and then to distribute the costs of that risk among eligible plans in each risk pool in each state.

Plaintiff Minuteman Health, Inc. ("Minuteman") is a start-up health insurance entity that has operated in the State of Massachusetts since 2014 and in the State of New Hampshire since 2015. Minuteman's members have been healthier than average, and so Minuteman has been required to pay risk adjustment charges into the risk adjustment program. Those funds have been distributed to other plans in Massachusetts and New Hampshire covering sicker-than-average enrollees, thereby ensuring that even though Minuteman's membership is healthier than average

(and therefore cheaper to insure), Minuteman shoulders its fair share of the costs of insuring sick people in Massachusetts and New Hampshire. Unhappy with these risk adjustment assessments, Minuteman filed this lawsuit under the Administrative Procedure Act ("APA"), 5 U.S.C. § 706, claiming primarily that the Department's use of a weighted average of state-wide premiums as a basis for assigning cost to actuarial risk exceeds the Department's statutory authority and is arbitrary and capricious because it "penalizes" price-cutting issuers and discourages competition. Minuteman also argues that the Department's pre-2018 methodology is arbitrary and capricious because it excludes pharmaceutical data, fails adequately to account for the risk of healthy people and "partial year enrollees," and disproportionately impacts low cost plans known as "Bronze" plans. But all of these claims—to the extent Minuteman has standing to raise them—must be rejected because Congress delegated broad authority to the Department to develop a risk adjustment methodology and the Department's exhaustively considered approach to that assignment easily satisfies both the APA and section 1343.

As a threshold matter, Minuteman lacks standing to assert its Massachusetts-based claims because the State of Massachusetts developed and operated its own risk adjustment program for the 2014-2016 benefit years. Minuteman's only explanation for bringing these claims against the Department, rather than the State of Massachusetts, is its suggestion that the Department limited the State's ability to deviate from the federal methodology. But in fact, Massachusetts had significant discretion to design its own methodology, and it exercised that discretion in several important respects, including by adjusting its formula for partial year enrollment. Minuteman thus fails to demonstrate that the federal methodology has caused it harm for its business in Massachusetts. Minuteman also cannot show that a favorable decision in this case would cause the State of Massachusetts to reduce its charges for the 2014-2016 years; indeed, Massachusetts

has stated that it will not retroactively modify risk adjustment transfers because doing so would hurt other insurance plans that relied on the methodology and disrupt the State's insurance market. Accordingly, Minuteman has no standing to assert its Massachusetts-based claims here.

Minuteman's attack also fails on the merits. The risk adjustment methodology is the product of years of extensive analysis informed by five rounds of notice and comment, the publication of several white papers, expert analysis, and input from hundreds of interested parties, including state insurance commissioners, health insurance issuers, researchers, trade groups, and consumer advocates. In that process, the Department considered and reasonably addressed each and every critique asserted in this case. For example, the Department elected not to use a plan's own premium as the basis of the risk adjustment transfer calculation because it was concerned that such an approach would not adequately compensate "sicker" plans for the costs of adverse selection, would not eliminate incentives for insurers to design their plans to exclude sick people, and would require an after-the-fact adjustment undermining the stability of the formula. The Department also reasonably elected not to utilize prescription drug data in the initial risk model because it was concerned that such an approach would favor pharmaceutical therapies over behavioral therapies, encourage gaming, and pose complex methodological challenges. Nevertheless, it continued to evaluate the issue and ultimately decided to add limited prescription drug data beginning with the 2018 benefit year. The Department likewise considered and reasonably addressed Minuteman's other concerns by adjusting the methodology to account for preventive services and partial year enrollment, and it has exhaustively considered the effect of the program on Bronze and other "metal level" plans (and continues to do so). There can be no doubt that the Department has gone far and above the requirements of the APA in considering the relevant factors, weighing the difficult and exceptionally complex scientific and policy objectives

underlying the risk adjustment program, and identifying a rational explanation for each decision made. Moreover, the Department has continued to update and improve the model, even as it balances those efforts against the desire for stability and predictability. Neither the APA nor section 1343 require more.

Finally, even if Minuteman could identify any legal defect in the Department's approach (it cannot), its request that the Court vacate the methodology for all prior years—thus requiring a refund of all money that issuers have paid into the program since its inception—must be rejected. The Court's authority under the APA does not extend to claims seeking compensatory payments from the government, and Minuteman's claims fall squarely into that category. Moreover, because Minuteman's payments have been distributed to other health plans, refunding that money likely would require the Department to collect funds back from the plans that received them or reduce payments to plans in the future. The burden of such relief—if it could even be accomplished—would thus be shouldered by other plans that covered sicker-than-average enrollees, thus undoing the risk spreading function that Congress intended and creating further uncertainty in the insurance markets. Even if such relief could be framed as "relief other than money damages," it would not be equitable, and it must be denied.

BACKGROUND

I. The Affordable Care Act

A. Overview

Enacted in 2010, the ACA adopted a series of measures designed to expand coverage in the individual health-insurance market. *King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). The Act's key provisions are threefold: (1) it prohibits health insurance companies from denying coverage or setting premiums based upon health status or medical history; (2) it generally requires

individuals to maintain health insurance coverage or make a payment to the Internal Revenue Service; and (3) it provides subsidies to make insurance more affordable to eligible consumers. *Id.* at 2486 (citations omitted).[1]

To implement these reforms, the Act created Health Benefit Exchanges ("Exchanges"), virtual marketplaces in each state where individuals and small groups can purchase health coverage and obtain federal subsidies. 42 U.S.C. §§ 18031-18041. Health plans sold on an Exchange (excluding catastrophic plans) are categorized into four different tiers or "metal levels" based on actuarial value, which refers to the percentage of benefits covered by the plan. The metal levels are Bronze, Silver, Gold, and Platinum, which provide actuarial values of sixty, seventy, eighty, and ninety percent of covered benefits, respectively. 42 U.S.C. § 18022(d). Low actuarial value plans such as Bronze plans tend to attract healthier enrollees who anticipate fewer healthcare needs (and therefore lower costs) whereas higher actuarial value plans such as Gold and Platinum plans tend to attract sicker enrollees who anticipate greater healthcare needs (and therefore greater costs). *See* Ex. A, RTI Memorandum, State Health Insurance Exchange Risk Adjustment and Plan Metals Level ("RTI Metal Level Mem.") (Dec. 15, 2011) at 3, A.R.000811; Ex. B, 2011 Risk Adjustment Implementation Issues ("2011 White Paper") at 31, A.R.004397.[2]

[1] The Department is responsible for administering many programs under the ACA, either directly or in conjunction with states or other federal agencies. 42 U.S.C. §§ 18041(a)(1), (b), (c)(1). The Department delegated certain of these responsibilities to the Centers for Medicare & Medicaid Services ("CMS") and the Center for Consumer Information and Insurance Oversight ("CCIIO"). The Department, CMS, CCIIO, Secretary Price, and Administrator Verma are collectively referred to in this motion as "the Department" or "HHS."

[2] On February 16, 2017, the Department filed the Administrative Record, citations to which are referred to with the prefix "A.R." Minuteman subsequently filed supplemental materials partially consisting of materials inadvertently omitted from the original Administrative Record. Those materials are referred to with the prefix "MH."

The Act also created a number of temporary and permanent programs designed to facilitate and support the Act's primary provisions by, *inter alia*, promoting high quality care, reducing cost, increasing competition, and stabilizing premiums. To name just a few: the Act enacted Medical Loss Ratio rules that require insurance plans to spend a certain percentage of their premiums on claims cost and quality improvement activities or rebate the difference to their enrollees, 42 U.S.C. § 300gg-18; established rate review provisions that seek to limit unreasonable increases in health insurance premiums, *id.* § 300gg-94; and appropriated billions of dollars to help finance non-profit insurance start-ups or "CO-OPs" to compete with other plans sold on the Exchanges, *id.* § 18042.

B. The "3Rs" Programs

The ACA's Exchanges created business opportunities for insurers electing to participate. Like most business opportunities, risk was involved—here, in the form of pricing uncertainty arising from the unknown health status of an expanded risk pool and the fact that insurers could no longer charge higher premiums or deny coverage based on an enrollee's health. In an effort to mitigate the pricing risk and incentives for adverse selection arising from this system, the ACA established three premium-stabilization programs modeled on preexisting programs established under the Medicare program. Informally known as the "3Rs," these ACA programs began with the 2014 calendar year and consist of reinsurance, risk adjustment, and risk corridors. *See generally* 42 U.S.C. §§ 18061-18063. The 3R programs distribute risks among insurers and mitigate risk attendant to the new opportunities created by the ACA.

1. Transitional Reinsurance

The transitional reinsurance program was a temporary program for the 2014-2016 benefit years that sought to mitigate the impact of high-cost claims for plans in the individual markets. *See generally* HHS Notice of Benefit and Payment Parameters for 2014 ("2014 Benefit Rule" or

"2014 Rule"), 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013). For each applicable benefit year, the program has provided payments to qualifying plans for a percentage of claims costs incurred by individual policyholders that fall between a monetary threshold or "attachment point" and a "cap." *See* 42 U.S.C. § 18061(b)(1); 45 C.F.R. § 153.230. These payments are funded by mandatory annual contributions from health insurance issuers and group health plans. 45 C.F.R. §§ 153.220–153.235. The Act authorized states to administer their own reinsurance programs but required the Department to operate the program on behalf of any states that did not do so. 42 U.S.C. §§ 18061(b), 18041(a)-(c). Nearly all states deferred to the Department to administer their reinsurance programs. 2014 Rule, 78 Fed. Reg. at 15,453.

2. Temporary Risk Corridors

The risk corridors program was a temporary program for the 2014-2016 benefit years under which amounts collected from profitable insurers are used to fund payments to unprofitable insurers. *See generally* 42 U.S.C. § 18062; *see also Land of Lincoln Mut. Health Ins. Co. v. United States*, 129 Fed. Cl. 81, 89-91 (2016). Unlike reinsurance, which seeks to mitigate financial burdens associated with individual enrollees, the risk corridors program mitigates risk for plans that underestimated their claims costs in aggregate (including any risk adjustment charges, as set forth below). 2014 Rule, 78 Fed. Reg. at 15,411; 45 C.F.R. § 153.530(b)(1).

3. Permanent Risk Adjustment

The third of the 3Rs programs—and the program at issue in this case—is risk adjustment, which targets a third type of risk: that of adverse selection. Even though the ACA prohibits plans from conditioning coverage and setting rates based on health status, Congress was aware that insurance companies could nevertheless design their plans in such a way as to attract individuals that are healthier and therefore cheaper to insure. For example, a plan might use marketing

techniques or technology platforms that appeal to younger (and therefore healthier) policyholders. *See, e.g.*, Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options,* 20 Kan. J.L. & Pub. Pol'y 222, 224 (Spring 2011). Or, a plan might offer lower premiums by excluding from its provider networks specialty hospitals and doctors that treat high cost conditions. *Id.* (explaining mechanisms of "risk avoidance," such as "selective marketing" or "structuring [a] network of doctors and hospitals to exclude providers preferred by higher risk patients"). Such plans would be attractive to healthier members due to their low costs, but unattractive to sicker members who would not have access to the range of care they need. Accordingly, Congress enacted risk adjustment as a permanent program to ensure, on an ongoing basis, that the financial burdens of covering high risk enrollees are spread evenly among insurance plans in a risk pool in a state. The program seeks to reduce incentives for plans to avoid high risk enrollees and to even the playing field for plans that enroll sicker people, giving effect to "the premise that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population." 2014 Rule, 78 Fed. Reg. at 15,417, A.R.000234.

a. Overview of the Risk Adjustment Program

The text of section 1343 provides that each state "shall 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 conversely, that a state "shall 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). Section 1343 directs the Department "in consultation with States" to "establish criteria and methods to be used in carrying out the risk adjustment activities

under this section." *Id.* § 18063(b). Thus, as with reinsurance, the ACA contemplated that states would operate their own risk adjustment programs pursuant to standards and criteria promulgated, in advance, by the Department, but also provided that the Department would operate the program on behalf of any state that elected not to do so. 42 U.S.C. § 18041(c). Massachusetts initially elected to operate its own program for the 2014-2016 benefit years (the only state to do so), 78 Fed. Reg. at 15,439, but as of 2017, it has joined the rest of the states in deferring to the Department to operate its program. *See* HHS Notice of Benefit and Payment Parameters for 2017 ("2017 Benefit Rule" or "2017 Rule"), 81 Fed. Reg. 12,204, 12,230 (Mar. 8, 2016), A.R.007774.

As with both reinsurance and risk corridors, the ACA did not appropriate or authorize any external source of funding for the risk adjustment program. *See* 42 U.S.C. § 18063(b). Accordingly, since 2011, HHS has treated risk adjustment as a self-funded program under which monies collected from low actuarial risk plans are the sole source of funding for payments to high actuarial risk plans. *See, e.g.*, Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, Proposed Rule, 76 Fed. Reg. 41,930, 41,938 (July 15, 2011), A.R.000010 ("risk adjustment is designed as a budget neutral activity"); Ex. B, 2011 White Paper at 4, A.R.000650. So administered, risk adjustment spreads actuarial risk among insurance plans and conforms to the absence of any external funding source identified in the Act.

Although risk adjustment transfers are based on actuarial data for a single "benefit year" (*i.e.*, a calendar year in which a plan provides coverage, 45 C.F.R. §§ 153.20, 155.20), the administrative life cycle for each program year spans more than two calendar years. At the front end, the Department's regulations require advance notice of the methodology to be used for a particular year in an annual "Notice of Benefit and Payment Parameters" (referred to here as a "Benefit Rule" or "Rule") published prior to the benefit year it will take effect so that insurance

companies can account for that information when they set annual rates and benefits. 45 C.F.R. §§ 153.100(b)-(c), 153.320; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,200, 17,223 (Mar. 23, 2012). After the benefit year concludes, plans are required to submit their risk adjustment data to the Department by April 30 of the following year, 45 C.F.R. § 153.730, and risk adjustment transfer amounts are announced two months later, by June 30. *Id.* § 153.310. The Department then collects risk adjustment charges and uses those collections to make payments to issuers, typically within 30-60 days of collection. This extended time frame means that more than two years elapse between publication of a Benefit Rule and the announcement of risk adjustment payments and charges under that Rule.

b. The Risk Adjustment Methodology

i. The Methodology Promulgated in the 2014 Benefit Rule

"Developing a risk adjustment program is methodologically and operationally complex." 77 Fed. Reg. at 17,229, A.R.000068. After nearly two years of extensive consideration that included public meetings, in-depth expert analysis by the Department's contractor RTI, input from state insurance commissioners, the publication of a white paper entitled "Risk Adjustment Implementation Issues," and full notice and comment rulemaking, the Department set forth its complete risk adjustment methodology in painstaking detail in the 2014 Benefit Rule published on March 11, 2013. 78 Fed. Reg. at 15,417-34, A.R.000234-51. To greatly simplify, the methodology developed through that process involves three steps:

Measuring Enrollee Risk: First, the methodology measures the actuarial risk of each enrollee—that is, the predicted relative cost of insuring that enrollee as compared to other enrollees. The methodology does so through a "risk adjustment model" based on demographic data (age and sex) and diagnostic data (such as diabetes, asthma, and so on). 2014 Rule, 78 Fed.

Reg. at 15,419, A.R.000236. Diagnoses considered by the model are known as Hierarchical Condition Categories or "HCCs." *Id.* at 15,420, A.R.000237. The model applies a statistical regression algorithm to a sample commercial data set that has been coded for HCCs, demographic factors, and actual insurance costs. The regression produces a weight or "coefficient" for each demographic and diagnosis factor that predicts the relative healthcare costs associated with that factor. *Id.* at 15,419-20, A.R.000237-37. For example, the coefficient for being a male aged 21-24 in a silver plan is .141, and the coefficient for being diabetic is 2.198. *Id.* at 15,421-23, A.R.000238-40. To determine the predicted relative cost of a particular enrollee, the model adds the applicable coefficients. So a 21-year-old male who has diabetes gets a score of 2.339 (2.198 + .141); the model expects him to cost 234% (more than twice as much) as what an average enrollee costs to insure.

Plan risk score: Second, the model aggregates the risk scores for each enrollee in each plan in order to determine an overall plan risk score—a prediction of how much healthier (or sicker) than average a plan's enrollees are as a whole, and so how much cheaper (or more expensive) they will be to insure relative to a plan of average actuarial risk. Aware that there is significant "churn" in insurance markets—enrollees picking up insurance part-way into the year or dropping insurance in the middle of the year—the Department designed its methodology to calculate risk on a "per member per month" basis so that risk scores reflect the amount of time an enrollee actually spends in a plan. *Id.* at 15,431, A.R.000248.

Payment transfer formula: Finally, the model compares each plan within a state market risk pool in order to assign monetary transfers that counteract the cost burden of insuring a sicker-than-average population (or the cost benefit of insuring a healthier-than-average population). The methodology does this through a complicated "transfer formula" that compares the plan's actual

predicted costs (based on its risk score) to the predicted costs of a plan of average actuarial risk in that state's risk pool, using an adjusted weighted average of all premiums in the risk pool as a measure of cost. *Id.*[3] For some plans, this comparison yields a risk adjustment "charge," because their predicted costs are lower than the state average. For others, this comparison yields a risk adjustment payment, because their predicted costs are greater than the state average.

ii. Evolution of the Methodology Since the 2014 Benefit Rule

Consistent with its regulations, in each year since publication of the 2014 Benefit Rule in 2013, the Department has republished the risk adjustment methodology in an annual Benefit Rule issued before the benefit year to which it will apply. *See* 2015 Benefit Rule, 79 Fed. Reg. 13,744, 13,753 (Mar. 11, 2014), A.R.004542; 2016 Benefit Rule, 80 Fed. Reg. 10,750 10,759 (Feb. 27, 2015), A.R.005691; 2017 Benefit Rule, 81 Fed. Reg. at 12,216, A.R.007760; 2018 Benefit Rule, 81 Fed. Reg. 94,058, 94,070 (Dec. 22, 2016), A.R.009607.

The Department has used this annual rulemaking as an opportunity to update the risk adjustment model with more recent data and make other modifications reflecting programmatic experience, but it has not reconsidered the entire methodology anew each year. The Department has been clear in its belief that "it is important to maintain model stability in implementing the risk adjustment methodology in the initial years of risk adjustment" and therefore that it was not proposing "to significantly change the model" in these early years of the program. 2015 Rule, 79 Fed. Reg. at 13,753, A.R.004542; *see also* 2016 Proposed Rule, 79 Fed. Reg. 70,674, 70,684 (Nov. 26, 2014), A.R.005604 ("We propose to continue to use the same risk adjustment methodology

[3] Because plans are permitted to vary their rates based on actuarial value, age categories, and geographical cost factors, the transfer formula applies certain adjustments so that risk adjustment transfers do not compensate for these differences. 78 Fed. Reg. at 15,430-34, A.R.000247-51.

finalized in the 2014 Payment Notice, with changes to reflect more current data[.]"); 2017 Rule, 81 Fed. Reg. at 12,217, A.R.007761 (same). At the same time, the Department has monitored the performance of the model, balancing possible improvements against model stability. *See* 2014 Rule, 78 Fed. Reg. at 15,418, A.R.000235 ("[W]e seek to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data becomes available."); Ex. C, CMS March 24, 2016 Discussion Paper ("2016 White Paper") at 35, A.R. 009759 (describing desire to "improv[e] the accuracy and performance of the HHS risk adjustment model in a data-driven fashion, while balancing the need for model predictability and stability").

By the time the results for the program's first year (2014) were announced on June 30, 2015, the Department had already promulgated its annual Benefit Rules for 2015 and 2016. However, in the first annual rulemaking following that event (for 2017) the Department immediately began to consider ways to update the methodology for future years in light of the program's experience in its first year. In the 2017 Rule, the Department updated the model with preventive care costs to better reflect the cost of treating individuals without an HCC diagnosis and sought exploratory comment on adding adjustments for prescription drug use, high-cost enrollees, and partial year enrollment. 81 Fed. Reg. at 12,218-20, A.R.007762-64. Shortly thereafter, in March 2016, the Department published a lengthy Discussion Paper on the risk adjustment program and convened a public meeting to consider modifications to the methodology. *See generally* Ex. C, 2016 White Paper, A.R.009721. In the 2018 Rule, the Department applied this analysis to add an adjustment for partial-year enrollees beginning in 2017 and limited pharmaceutical data beginning in 2018. 81 Fed. Reg. at 94,072-76, A.R.009609-13.

II. Minuteman Health

Plaintiff Minuteman is a new entrant to the insurance markets financed by subsidized loans

from the Department under the ACA's CO-OP program. Pl.'s Mot. for Summ. J. ("Pl.'s Mot."), at 11-13, ECF No. 50. Minuteman entered the Massachusetts Exchange in 2014 and expanded to the New Hampshire Exchange in 2015. Am. Compl. ¶ 93, ECF No. 39. Minuteman's business model seeks to drive down costs by partnering with "a select network of providers" who permit Minuteman to offer "low-cost [insurance] options that are up to 40% lower" than its competitors. *Id.* ¶ 89. In other words, Minuteman is able to price its premiums lower than its competitors by limiting coverage to specific low-cost healthcare providers. *See id.* ¶ 87. Minuteman also sells a larger proportion of lower-cost Bronze plans as compared to its competitors, which enables it to further reduce premiums by covering a lower percentage of medical costs. *Id.* ¶ 115.

Whether due to its narrow provider networks, its start-up nature, its high percentage of Bronze plans, or other reasons, Minuteman has attracted enrollees that are significantly healthier than the average enrollees in the States of Massachusetts and New Hampshire. As a result, Minuteman has been assessed risk adjustment charges for each of its years in operation for which risk adjustment transfers have been calculated: In 2015 (for the 2014 benefit year), Minuteman was required to pay risk adjustment charges of approximately $3.1 million to the State of Massachusetts. Am. Compl. ¶ 122. And in 2016 (for the 2015 benefit year), Minuteman was required to pay risk adjustment charges of $6.1 million to the State of Massachusetts and $10.5 million to the Department for plans sold in the State of New Hampshire. *Id.* ¶¶ 7, 122. Payments and charges for 2016 have not yet been determined, but they will be announced by June 30, 2017.

STANDARD OF REVIEW ON SUMMARY JUDGMENT

"[I]n cases involving review of agency action under the APA, the traditional Rule 56 standard does not apply due to the limited role of a court in reviewing the administrative record." *Bennett v. Murphy*, 166 F. Supp. 3d 128, 139 (D. Mass. 2016). Rather, "summary judgment is

merely the vehicle by which the Court will decide the ultimate issue." *Brilmyer v. Univ. of Chicago*, 431 F. Supp. 2d 154, 161 (D. Mass. 2006). "Under the APA, the agency's role is to . . . arrive at a decision that is supported by the administrative record, and the court's role is to 'focus on whether the agency examined the relevant data and articulated a satisfactory explanation for its action[.]'" *Bennett*, 166 F. Supp. 3d at 139 (citing *Sistema Universitario Ana G. Mendez v. Riley*, 234 F.3d 772, 777 (1st Cir. 2000)). The Court's review under the APA extends to and is limited by the record that was before the agency at the time it made its decision, "not some new record made initially in the reviewing court." *Camp v. Pitts*, 411 U.S. 138, 142 (1973). Moreover, "[b]ecause the APA standard affords great deference to agency decisionmaking and because the Secretary's action is presumed valid, judicial review, even at the summary judgment stage, is narrow." *Lovgren v. Locke*, 701 F.3d 5, 20-21 (1st Cir. 2012) (citation omitted). "The burden is on the party challenging the Secretary's reasoning to show that it fails to pass muster under the reasonableness standard." *S. Shore Hosp., Inc. v. Thompson*, 308 F.3d 91, 101 (1st Cir. 2002).

ARGUMENT

I. Minuteman Lacks Standing to Bring Its Massachusetts-Based Claims

As a threshold matter, Minuteman has no standing to assert claims arising from its participation in the Massachusetts risk adjustment program. To satisfy the Article III requirement of standing, a plaintiff must identify—for each claim—not only a legally cognizable injury, but also "a sufficiently direct causal connection between the challenged action and the identified harm" and that "a favorable resolution of her claim would likely redress the professed injury." *Drouin v. Am. Home Mortg. Servicing, Inc.*, No. 11-CV-596-JL, 2012 WL 1850967, at *2 (D.N.H. May 18, 2012) (citing *Katz v. Pershing, LLC*, 672 F.3d 64, 71-72 (1st Cir. 2012)).

Here, the State of Massachusetts operated its own risk adjustment program and promulgated its own methodology for the 2014-2016 benefit years, and Minuteman fails to establish either that the Department caused any harm in relation to that program or that such harm is redressable through a favorable decision in this case. Minuteman's only effort to meet its burden on these issues is its contention that it "raised its objections [to the methodology used by the State of Massachusetts] . . . with Massachusetts state officials" who allegedly "replied [that the State] had no authority to vary its formula because its hands were tied by HHS, which refused to provide any regulatory flexibility." Pl.'s Mot. at 10 n.6. But that broad assertion finds no support in the cited material, which merely observes that the State's ability to deviate from the Department's methodology was limited, rather than nonexistent. *See* Am. Compl. Ex. 25 at 3.

In fact, the Department's rules allowed states substantial room to deviate from the federal methodology. *See, e.g.*, Ex. B, 2011 White Paper at 4, A.R.000650 ("States can request that an alternate risk adjustment methodology be certified."); 2014 Rule, 78 Fed. Reg. at 15,415, A.R.000232 (states "may elect to submit an alternate methodology to HHS for approval"). The State of Massachusetts leveraged that opportunity to certify a methodology that differs from the Department's methodology in several respects. *See generally* 2014 Rule, 78 Fed. Reg. at 15,439-52, A.R.000256-69. For example, Massachusetts included an adjustment for partial year enrollees in its methodology, even though the Department initially did not. *Id.* at 15,441, A.R.000258 ("Massachusetts . . . developed a set of factors to adjust for partial-year eligibility"). And while it is true that the Department required Massachusetts to use the state average premium to calculate payments and charges, Minuteman has not shown that Massachusetts lacked authority to vary the other aspects of the methodology challenged here (such as the methodology's treatment of pharmaceutical data) or that, given additional flexibility, the State of Massachusetts would have

chosen to alter the methodology in the manner that Minuteman urges. Indeed, the record reveals that Massachusetts independently decided to exclude prescription drug data from the model. *See* Ex. D, RTI Memorandum, Prior Drug Use in Risk Adjustment Modeling ("RTI Rx Mem.") (Dec. 15, 2011) at 7, A.R.000841 ("the use of drug-based risk adjustment was considered and rejected by the Massachusetts Connector program"). For these reasons, Minuteman cannot show (and in any event, has not shown) that each of the challenged aspects of the Department's methodology caused it harm in Massachusetts.

Nor can Minuteman demonstrate that those claims are redressable. The State of Massachusetts is not a party to this case, and Minuteman cannot show that if it were to prevail in this case, the State would choose to alter its methodology retroactively for past years. The State previously rejected Minuteman's backward-looking challenge to the methodology because "[o]nce the methodology is certified, it is relied upon by carriers in predicting risk adjustment's impacts on rate setting and budgeting. A retrospective change in methodology would upset expectations and introduce uncertainty into the market." Am. Compl. Ex. 25 at 5. Massachusetts has thereby indicated that it is not willing to alter its approach retroactively and that risk adjustment transfers calculated for prior years will not be recalculated or refunded as a result of any decision in this case. As a result, Minuteman lacks standing to assert its Massachusetts-based claims here.

II. The Department's Methodology Easily Survives APA Review

In any event, all of Minuteman's claims fail on the merits because the Department's methodology is an eminently reasonable and well-considered approach to an exceptionally complex actuarial challenge that is consistent with the statute and easily satisfies the applicable standard of review.

A. Standard of Review under the APA

Under the APA, courts must uphold agency action unless it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law," 5 U.S.C. § 706(2)(A), or is "in excess of statutory jurisdiction, authority, or limitations," 5 U.S.C. § 706(2)(C). This standard "tightly circumscribes judicial review." *S. Shore Hosp., Inc.*, 308 F.3d at 97. When it is clear based on the language of the enabling statute that "Congress has spoken directly on a particular issue and the traditional tools of statutory interpretation reveal that congressional intent is clear, an inquiring court must give effect to Congress's intent." *Maine Med. Ctr. v. Burwell*, 841 F.3d 10, 17 (1st Cir. 2016) (citing *Chevron U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 & n.9 (1984)).

If the statute does not address the issue, "the question reduces to whether the agency's view is based on a permissible construction of the statute." *Id.* Courts exercise broad deference to the programmatic choices promulgated by an administrative agency because "[w]here Congress has chosen to cede substantial discretion to an agency, a reviewing court should scrutinize the administrative record with due regard for that discretion[.]" *S. Shore Hosp.*, 308 F.3d at 106 (citation omitted). Agency action is not arbitrary and capricious unless "the agency has 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." *Adirondack Med. Ctr. v. Sebelius*, 891 F. Supp. 2d 36, 44 (D.D.C. 2012). An agency's decision must be upheld so long as the agency considered the relevant data and articulated an explanation establishing a "rational connection between the facts found and the choice made." *Burlington Truck Lines, Inc. v. United States*, 371 U.S. 156, 168 (1962). And

judicial deference is at its apex where, as here, the regulation at issue "concerns a complex and highly technical regulatory program." *Visiting Nurse Ass'n Gregoria Auffant, Inc. v. Thompson*, 447 F.3d 68, 76 (1st Cir. 2006) (citation omitted). Courts may "reject an agency's choice of a scientific model only when the model bears *no rational relationship* to the characteristics of the data to which it is applied." *San Luis & Delta-Mendota Water Auth. v. Jewell*, 747 F.3d 581, 621 (9th Cir. 2014) (emphasis added and citation omitted).

Finally, while the APA requires agencies to respond to significant comments raised during the rulemaking process, "[t]here is no requirement . . . that an agency respond to significant comments in a manner that satisfies the commenter." *FBME Bank Ltd. v. Mnuchin*, No. 15-CV-01270 (CRC), 2017 WL 1379311, at *3 (D.D.C. Apr. 14, 2017). An agency need not "provide exhaustive, contemporaneous legal arguments to preemptively defend its action." *Nat'l Elec. Mfrs. Ass'n v. U.S. Dep't of Energy*, 654 F.3d 496, 515 (4th Cir. 2011). The agency "must only address significant comments 'in a reasoned manner' that allows a court 'to see what major issues of policy were ventilated . . . and why the agency reacted to them as it did[.]'" *FBME Bank Ltd.*, 2017 WL 1379311, at *3 (citations omitted).

B. The 2014 Rule Is Consistent with the Statute and Is Reasonable

As an initial matter, Minuteman erroneously combines its challenges to the 2014-2018 Rules in a single multi-year attack, relying on materials in later years to challenge decisions in earlier rulemakings. Indeed, many of its critiques did not materialize until mid-2015 at the earliest, after the Department had already promulgated its Rules for 2014, 2015, and 2016.[4] But review

[4] Minuteman also improperly cites to materials that are not part of the rulemaking record for any year, such as a Congressional Research Services FAQ and newspaper articles from 2016 and 2017. Pl.'s Mot at 8, 11-12, 21; *see also* Aff. of Jaclyn Essinger ¶¶ 9, 13, 16-19, ECF no. 50-1.

under the APA is not based on hindsight; it is based on the record before the agency at the time it made its decision. *See, e.g., Brilmyer*, 431 F. Supp. 2d at 159 ("[I]t would offend interests in finality . . . to shift the focus from [the agency decision] to a moving target by presenting extra-administrative record evidence"). Accordingly, the Court should begin its review with the Rule promulgated for the 2014 benefit year—based on the record before the Department at that time—and then proceed to consider whether the modifications proposed in subsequent years alter that assessment for those years.

1. The Department's Use of the State Average Premium Is Consistent with the Statutory Text and Is Reasonable

Minuteman's most emphatic attack on the Department's methodology relates to its use of the state average premium as a base charge for risk adjustment transfers. Minuteman contends that use of the state average premium is both contrary to the text of section 1343 and arbitrary and capricious. Both arguments fail.

a. Section 1343 Does Not Bar Use of the State Average Premium

Minuteman first contends that "use of the statewide average premium is an unlawful departure from Congress's mandate that risk adjustment assessments be based solely upon actuarial risk." Pl.'s Mot. at 17. This assertion imports a requirement into the statute that does not exist, namely that actuarial risk be the sole criterion for determining transfer amounts. Congress's only specific requirement under section 1343 was that the program assess a charge on program-eligible plans "if the actuarial risk of [their] enrollees . . . is less than the average actuarial risk" in the state and make a payment to such plans "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk" in the state. 42 U.S.C. § 18063(a). Thus, while Congress required that actuarial risk be the dispositive factor in determining whether to assess a risk adjustment

charge or make a risk adjustment payment, Congress did not impose any requirements as to the methodology for determining the *amounts* of charges or payments. *See, e.g.*, *Adirondack Med. Ctr.*, 891 F. Supp. 2d at 45 (rejecting *ultra vires* challenge where statutory language did "not contain prohibitory language" or "limiting language, such as 'the Secretary may adjust *only* the federal rate' or 'an adjustment to the federal rate is the *only* way the Secretary may address [the issue]" (emphasis in original)).

Nor is it methodologically possible to devise a transfer formula that reflects only actuarial risk, as Minuteman suggests. Even if the Department could perfectly isolate actuarial risk from other confounding variables (the Department's hundreds of pages of analysis in the Federal Register and White Papers demonstrate the difficulty of doing so), a formula based solely on actuarial risk would yield only a raw risk score. A raw risk score measures the expected *relative* cost of a particular pool of enrollees compared to the state-wide average, but it does not predict actual expenditures. *See* 78 Fed. Reg. at 15,417, A.R.000234. Thus, a plan with a risk score of .90 is expected to cost ten percent less than an average plan, but without knowing the expected cost of an average plan in the state, the formula cannot convert the risk score into a payment or charge that meaningfully distributes the cost (or cost-savings) associated with the plan's risk score.

Therefore, to determine risk adjustment payment and charge amounts, the Department's methodology necessarily had to consider cost factors. Indeed, Minuteman's proposed alternative to the state average premium (use of a plan's own premium) would suffer the exact same purported flaw as the Department's approach: it would not "be based solely upon actuarial risk." Pl.'s Mot. at 17. Rather, it would be based on pricing choices made by individual insurance plans reflecting the very same factors that Minuteman suggests are improper, such as issuer costs, administrative overhead, efficiency factors, and the like. *Id.* But under Minuteman's approach, risk adjustment

transfers would vary based on pricing choices made by individual plans, whereas the Department's approach adopts a weighted average of all such pricing in a state, thereby ensuring that the formula is uniform and stable and minimally distorted by any extreme or inaccurate pricing decisions by individual insurance plans. 2014 Rule, 78 Fed. Reg. at 15,432, A.R.000249. Because Congress said nothing about how risk adjustment transfers must be calculated, Minuteman's statutory argument should be rejected.

b. The State Average Premium Is a Rational Way of Measuring the Costs of Adverse Selection

Minuteman next contends that even if use of the state average premium is not precluded by section 1343, it is arbitrary and capricious. This argument is equally meritless.

First, as the Department noted during its development of the methodology, plan premiums contain an element of risk selection: "healthier" plans can charge less than "sicker" plans because their members do not consume as much health care. *Id.* ("claims and administrative costs include elements of risk selection"); Ex. B, 2011 White Paper at 40, A.R.000686 ("deviation of premiums . . . is due to the variation in enrollee risk across plans"); Ex. A, RTI Metal Level Mem., at 2, A.R.000810 ("a carrier enrolling enrollees with higher-than-average risk will [absent risk adjustment] . . . have higher-than-average premiums"). Thus, a risk adjustment transfer based on a healthier plan's lower premium might not fully capture the cost of treating sicker enrollees or adequately compensate sicker plans for their sicker membership. *See* 78 Fed. Reg. at 15,432, A.R.000249 ("use of a plan's own premium may cause unintended distortions"). The state average premium, by contrast, averages the cost of treating all individuals in a risk pool—healthy and sick—based on the reasonable assumption that "plans 'price to cost.'" 2014 Proposed Rule, 77 Fed. Reg. 73,118, 73,140 (Dec. 7, 2012), A.R.000135. The state average thereby captures the

"average premium requirement for providing insurance to the applicable market population" as a whole. *Id.* The state average also reduces the effect of inaccurate or outlying pricing decisions by individual plans that could result in the methodology under- or over-compensating for actuarial risk. 2014 Rule, 78 Fed. Reg. at 15,432, A.R.000249; *see also* Ex. A, RTI Metal Level Mem. at 11, A.R.000819 (state average premiums "essentially remove from the calculation the complex decisions . . . that determine plan premiums").

Second and relatedly, because a risk adjustment charge based on a healthy plan's lower premium might not adequately capture the higher cost of treating sicker members, such a charge also would not fulfill another objective of the program: to reduce incentives for plans to avoid high risk enrollees. 2014 Rule, 78 Fed. Reg. at 15,411, A.R.000228. If a risk adjustment charge were based on a plan's own premium, a plan would be better off catering to healthy enrollees because, even with risk adjustment, that plan's costs will be less than if the plan enrolled its share of sicker enrollees (with their higher costs). *See* Ex. B, 2011 White Paper at 36, 50, A.R.000682, 000696. Again, the state average premium eliminates this problem by more accurately measuring and distributing the costs of insuring all individuals in a risk pool—healthy and sick—and thereby eliminating any competitive advantage flowing from adverse selection.

Third, because the risk adjustment program is self-funded and budget-neutral, payments and charges must balance.[5] But if the Department were to use a plan's own premium as the basis

[5] Minuteman asserts that because Congress did not specifically foreclose use of CMS's "general appropriations" for risk adjustment payments as it did with the related risk corridors program, "presumably, HHS has remained free to fund the risk adjustment program from its general appropriations." Pl.'s Mot. at 25. But the statute itself contemplates that *states* will collect charges and make payments under the risk adjustment program; HHS takes responsibility only if a state declines to administer the program. 42 U.S.C. § 18063(a); 18041(c). Minuteman does not contend that a state must use its general appropriations to make risk adjustment payments, and nothing in the statute directs the Department to do so.

of the transfer calculation, charges and payments would not balance. 2014 Proposed Rule, 77 Fed. Reg. at 73,139, A.R.000134 ("The approaches that used plans' own premiums resulted in unbalanced payment transfers[.]"). Rather, healthy plans would be required to pay lower charges (reflecting the lower premiums paid by their healthier membership) whereas sicker plans would be entitled to receive higher payments (reflecting the higher premiums needed to cover their sicker membership). Bridging the gap between payments and charges therefore would require one of three after-the-fact adjustments: (1) reduce payments to sicker plans, (2) increase charges to healthier plans, or (3) split the difference between sicker and healthier plans. Minuteman does not appear to advocate for the latter two options, *see* Pl.'s Mot. at 26, but in any event, each option has drawbacks. Reducing payments to sicker plans would likely result in sicker plans raising their premiums to offset the anticipated expense of their sicker membership. Ex. B, 2011 White Paper at 36, A.R.000682. Increasing charges for healthier plans would eliminate the incentives of sicker plans to control costs. *Id.* at 14, A.R.000660. And finally, splitting the difference between healthier and sicker plans (by increasing charges and decreasing payments) would be similar to using the state average premium, *id.* at 38, A.R.000684, but it would require an after-the-fact adjustment that would not be known until the program year concluded. *See* 2014 Proposed Rule, 77 Fed. Reg. at 73,139, A.R.000134 ("A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer estimates.")). The state average premium, by contrast, "provides a straightforward and predictable benchmark for estimating transfers" that net to zero and "compensate plans for liability differences associated with risk selection, while preserving premium differences related to the other cost factors[.]" *Id.* The record thus amply demonstrates that the Department considered the relevant policy choices

and rationally elected to use a state average rather than a plan-specific premium. *See E. Niagara Pub. Power All. & Pub. Power Coal. v. FERC*, 558 F.3d 564, 567 (D.C. Cir. 2009) (endorsing agency's use of an average to capture high and low rates because agency "faced a difficult valuation question and answered it in a permissible way given the predictive and inherently speculative nature of the judgment it was required to make").

c. Minuteman's Other Arguments Against the State Average Premium Should Be Rejected

Minuteman asserts a handful of other arguments, none of which has merit.

First, Minuteman suggests that the state average premium encourages gaming by large issuers who are incentivized to raise their rates so as to maximize their risk adjustment transfers. Pl.'s Mot. at 17, 20-21. Quite the opposite—it is Minuteman's proposal that would reward certain types of rate-setting and encourage gaming. This is because the Department's transfer formula does not directly reflect a plan's actual premiums at all; rather, it calculates the difference between the plan's expected costs with risk selection and the plan's expected costs without risk selection, using the state average premium on *both* sides of the equation as an estimation of average cost. *See* 78 Fed. Reg. at 15,430-31, A.R.000247-48. That approach neither penalizes cost-cutting nor rewards inefficiency; it strikes a middle ground by assuming an average level of efficiency. Indeed, if Minuteman was able to reduce its costs below the state average premium while also enrolling sicker members, it would receive more in risk adjustment payments than it needs to cover costs, thereby benefitting from the state average premium. Conversely, expensive plans that price above the mean will receive less in risk adjustment payments than they need to cover costs and will lose customers to their less expensive competitors, thereby retaining incentives to increase

efficiency.[6] Under Minuteman's proposal, by contrast, plans with the same risk score would owe or receive different amounts based on individual pricing decisions, an approach that would encourage sicker plans to charge higher premiums to increase their payments and healthier plans to charge lower premiums to reduce their charges. The Department's approach reasonably minimizes such gaming by decoupling risk adjustment transfers from individual pricing decisions.

Second, the state average premium does not "penalize" cost-cutting plans like Minuteman. Pl.'s Mot. at 16, 18-22. The Department's regulations require advance notice of the risk adjustment methodology precisely so that issuers can price any expected payments or charges into their rates. *See, e.g.*, Ex. B, 2011 White Paper at 13, A.R.000659 ("Issuers generally set plan premiums based on the anticipated revenue needs for their enrolled population, *including any anticipated risk adjustment payments or charges*" (emphasis added)).[7] 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. In that manner, Minuteman can retain its purportedly competitive price-cutting business model while still charging a sufficient premium to cover any expected risk adjustment transfers (alternatively, Minuteman can simply work harder to attract sick enrollees). In any event, while the ACA as a whole seeks to promote competition, efficiency, and innovation

[6] To the extent Minuteman suggests that issuers can raise their rates solely to inflate risk adjustment payments (*i.e.*, in a manner untethered to actual costs), that outcome is foreclosed by the Medical Loss Ratio rules, rate-review provisions, state insurance law, and the laws of economics, all of which help ensure that issuers price to cost. 42 U.S.C. § 300gg–18(b)(1)(A); 42 U.S.C. § 300gg–94(a); 45 CFR § 154.200(a); Mass. Gen. Laws Ch. 175, § 117C (prescribing a minimum loss ratio for health insurance policies); N.H. Rev. Stat. § 415:24 (limiting rate increases).

[7] As the Department has noted, "low cost plans do not necessarily indicate efficient plans. Should a plan be low cost with low claims costs, it is likely an indication of mispricing, as the issuer should be pricing for average risk." Ex. C, 2016 White Paper at 92, A.R.009816.

(and has plenty of provisions directly targeted to these goals), the Department is not required to reward those attributes within the risk adjustment program in particular, especially where those models are confounded with the risk selection that the program seeks to eliminate. *See Brown v. Sec'y of Health & Human Servs.*, 46 F.3d 102, 107 (1st Cir. 1995) (holding that the Department was not obliged to consider statute's "broader purposes" because "Congress left it to the Secretary to decide what policies should be given priority").[8]

Third, Minuteman's assertion that the Department did not provide "explanation or backup data" for its decision is both utterly false and legally meritless. Pl.'s Mot. at 27, 28, 33. The Department exhaustively considered the state average premium relative to other options in nearly thirty pages of analysis consisting of tables, hypothetical simulated scenarios, and two appendices. *See* Ex. B, 2011 White Paper at 14-17, 29-56 & App. Tables at 1-32, A.R.000660-663, 000675-702, 000707-738; 77 Fed. Reg. at 73,139-42. These materials amply demonstrate the Department's rationale for adopting the state average premium. *See, e.g.*, *Louisiana Forestry Ass'n v. Dep't of Labor*, 745 F.3d 653, 678-79 (3d Cir. 2014) (upholding agency's explanation where it discussed alternatives and "explained why it rejected these alternatives"). Moreover, an agency is not required to provide "backup data" for every decision made. The agency need only provide a "rational connection between the facts found and the choice made," such that the "path may reasonably be discerned." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) (citations omitted). This analysis may be "general" and "based on informed conjecture." *Chamber of Commerce of U.S. v. SEC*, 412 F.3d 133, 142 (D.C. Cir. 2005). This is particularly so where

[8] Indeed, Minuteman's suggestion that the methodology should reward innovation and foster competition is at odds with its argument that the methodology can consider *only* actuarial risk.

the agency is making decisions of a "predictive nature." *FCC v. Nat'l Citizens Comm. for Broad.*, 436 U.S. 775, 813 (1978). The Department has more than met these standards here.[9]

In sum, the Department's decision to use the state average premium as a fair estimate of insurance costs in the state as a whole was eminently reasonable and must be upheld.

2. The Department's Use of HCCs Is Reasonable

Minuteman also contends that the risk adjustment model "severely under-predicts the costs of enrollees who do not qualify for an HCC" because an individual without an HCC may still utilize preventive services, get sick or have catastrophic injury. Pl.'s Mot. at 34-37. This critique both misinterprets the purpose of the risk adjustment program and misstates its functioning.

With regard to purpose, risk adjustment is not aimed at random insurance risk, such as accidents. Indeed, when the Department developed the model, it specifically sought to ensure that the methodology did not transfer the risk of random events. *See* Ex. B, 2011 White Paper at 6, A.R.000652 (noting that "some types of health care expenses are random (for example, those due to an accident)" and that risk adjustment should "not remove the insurance risk from spending due to unforeseen events"). Instead, risk adjustment is intended to compensate plans for "the costs of medical conditions *that are predictable to the enrollee* and *could influence enrollment decisions*." *Id.* (emphasis added); *see also* 77 Fed. Reg. at 73,129, A.R.000124 (explaining that HCCs should identify "chronic or systematic conditions," not "random" events); Ex. E, RTI Memorandum, Prospectivized-Concurrent Model (May 1, 2012), at 1, A.R.000762 (model "should primarily predict the 'systematic' portion of health care costs, not the current year random component of

[9] Finally, there is no support for Minuteman's assertion that the risk adjustment program—and use of the state average premium in particular—is to blame for increasing premiums or insurance insolvencies during the last several years, as opposed to a sicker-than-expected risk pool.

costs."). Thus, it is perfectly appropriate that the model does not specifically compensate plans for the costs of treating unexpected injury or illness.

With regard to functioning, although Minuteman is correct that the cost of treating random events is part of providing insurance to healthy enrollees, Minuteman is incorrect to suggest that the model does not consider these costs. Rather, for an individual without an HCC diagnosis, the model measures expected cost based on a sample of enrollee cost data matching the individual's age and sex factors. 2014 Proposed Rule, 77 Fed. Reg. at 73,129-31, A.R.000124-26. Because that sample necessarily includes individuals that got sick, had accidents, or required other treatment, the likelihood and relative cost of such events is incorporated into the coefficient derived for an individual with that demographic profile. In other words, the possibility that an individual without an HCC may still incur treatment costs (whether due to illness, accidents, or some other event) is baked into the risk score estimation process, which matches actual expenditures incurred by a sample of real enrollees to their treatment costs.

The Department's methodology also accounted for treatment costs incurred by healthy people by using a "concurrent" rather than a prospective model. As the Department explained, a concurrent model (*i.e.*, an approach that relies on current year data to predict current year costs) "place[s] greater weight than does a prospective model on certain acute conditions that occur in a given year" as opposed to chronic conditions that occur over time, and therefore "may more closely reflect a plan's costs[.]" Ex. B, 2011 White Paper at 6, A.R.000652.

Lastly, before finalizing the model in the 2014 Rule, the Department ran statistical tests to determine how well the model predicts the cost relationships it seeks to measure and determined that each test result fell "within published ranges for concurrent models." 2014 Rule, 78 Fed. Reg.

at 15,420, A.R.000237.[10] Thus, it is simply incorrect to say that the risk adjustment model adopted in 2014 failed to account for the health care needs of persons without HCCs. Minuteman has not shown that this model, or any aspect of it, is arbitrary and capricious.

3. The Department's Approach to Capturing HCCs Is Reasonable

Next, Minuteman complains that the 2014 methodology was arbitrary and capricious because it "fails to accurately identify enrollees who should qualify for an HCC." Pl.'s Mot. at 38. In particular, Minuteman contends that the Department should have adjusted the methodology for partial year enrollment and incorporated prescription drug data into the model. *Id.* Again, these arguments must be rejected because the Department considered and reasonably addressed them when promulgating the risk adjustment methodology.

a. Partial Year Enrollees

Minuteman first contends—citing a single comment submitted by the Association for Community Affiliated Plans ("ACAP")—that the methodology was flawed because it failed to consider the effect of partial year enrollment. Pl.'s Mot. at 38, 40-41.[11] But the Department did consider and address partial year enrollment in its 2014 rulemaking, explaining that its "models were calibrated to account for short-term enrollment in several ways." 78 Fed. Reg. at 15,421, A.R.000238. First, "enrollee diagnoses were included from the time of enrollment," *id.*, meaning

[10] Minuteman's claim that "[i]ssuers have raised this flaw [regarding estimation bias] with HHS from the outset of the program" lacks any support in its motion. Pl.'s Mot. at 35. The only comment to the 2014 proposed rule that Minuteman identifies is one submitted by the Blue Cross Blue Shield Association that was addressed to the payment transfer formula, not the risk adjustment model, A.R. 004330, and to which the Department reasonably responded in the final rule. 2014 Rule, 78 Fed. Reg. at 15,432.

[11] Minuteman also cites other public comments submitted as part of the notice and comment rulemakings for the 2017 and 2018 Rules, Pl.'s Mot. at 40-41, but those comments did not inform the 2014 rulemaking and therefore are not properly considered in reviewing the 2014 Rule.

that if an enrollee joined a plan in April but did not receive her diagnosis until July, she was nevertheless treated as having the condition for the entire period of enrollment (*i.e.*, starting in April). This approach appears to be responsive to one of ACAP's proposed solutions, which was to shorten "the window of time required for diagnostic information to be used in risk adjustment for new members[.]" Ex. F, ACAP, Improving Risk Adjustment in Health Insurance Exchanges to Ensure Fair Payment (Nov. 28, 2012) ("2012 ACAP Comment"), at 6, A.R.003175. Second, the Department's calculation of risk score coefficients accounted for the enrollment duration of the statistical sample set so that risk scores predict a per member per month ("PMPM") expected liability that can easily be applied to partial year enrollees. 78 Fed. Reg. at 15,421, A.R.000238. Third, the Department's decision to adopt a concurrent model was partially influenced by its "anticipat[ion] that enrollees may move between plans" and that a "concurrent model would be better able to handle changes in enrollment than a prospective model because individuals newly enrolling in health plans may not have prior data available that can be used in risk adjustment." 2014 Proposed Rule, 77 Fed. Reg. at 73,128, A.R.000123. In fact, ACAP acknowledged that "[a] concurrent approach will somewhat improve the ability to produce more accurate risk scores for . . . those lack[ing] established diagnostic records." Ex. F, 2012 ACAP Comment at 2, A.R.003171. Thus, the Department did both consider and address concerns regarding partial year enrollment.

Minuteman's critique is not really that the Department failed to consider partial year enrollment (the discussion above conclusively demonstrates that it did), but rather that the Department did not specifically address one possible consequence of partial year enrollment—that in some circumstances, partial-year enrollees might *never* visit a doctor to receive an HCC-

qualifying diagnosis during their period of enrollment. *See* Pl.'s Mot. at 38.[12] But an enrollee who never visits a doctor to receive an HCC-qualifying diagnosis also is not likely to be consuming substantial treatment costs (and of course, the issue is not limited to partial year enrollees—full year enrollees also may not visit a doctor).[13] Moreover, it would appear that insurance plans themselves are best equipped to address this issue through efficient data management and other business practices. *See* Ex. F, 2012 ACAP Comment at 7, AR003176 ("For plans, getting paid with diagnostic adjustment makes gathering diagnoses—thoroughly and efficiently—a key to success."). In any event, Minuteman does not identify a solution to this alleged problem other than consideration of prescription drug data, which is discussed below.

b. Prescription Drug Data

Related to its partial-year enrollment challenge, Minuteman takes issue with the Department's decision to exclude prescription drug data as a predictive component of expenditures. Pl.'s Mot. at 39. But the Department's decision on this issue is presumptively valid

[12] Minuteman also contends that the missing-diagnosis issue is "exacerbated by the methodology's assumption that that health care costs are distributed evenly throughout the year," such as in the case of labor and delivery, where treatment costs are concentrated in a short amount of time. Pl.'s Mot. at 38. But it is unclear how this is the case: a woman incurring treatment costs for labor and delivery at a medical facility necessarily would be seen by a physician to receive a diagnosis. To the extent Minuteman means that one of the measures adopted to address partial year enrollment (allocating treatment costs by time of enrollment) created distortions along other performance measures, it fails to demonstrate either that the cost distribution issue was raised during the 2014 rulemaking, *see id.* (relying on comment to the 2018 proposed Rule) or that it has an easy solution.

[13] Even in hindsight, the Department concluded that missing diagnoses for partial year enrollees only impacts risk adjustment transfers "when a plan's enrollees differ *substantially* from the market as a whole" with respect to enrollment duration. Ex. C, 2016 White Paper at 36, A.R.009760 (emphasis added). This is likely because all plans, including those in the commercial data set, experience some degree of enrollment churn, and "as compared to full year enrollees of the same relative risk, partial year enrollees are less likely to have spending that exceeds the deductible or annual limitation on cost sharing." 2017 Proposed Rule, 80 Fed. Reg. 75,488, 75,500 (Dec. 2, 2015), A.R.007658.

because Congress specifically authorized it to use "criteria and methods similar to [those] utilized under" Medicare Parts C and D, 42 U.S.C. § 18063(b), and the "risk adjustment models for Medicare Parts C and D do not use prescription drug utilization data to identify enrollee diagnoses." Ex. B, 2011 White Paper at 5, 10, A.R.000651, 000656.

In any event, the use of prescription drug data was exhaustively considered and reasonably rejected by the Department during the rulemaking process. The Department observed that while pharmacy data offered certain predictive benefits, its use could create "powerful incentives to steer treatment toward pharmaceutical therapy in order to identify risk of the enrolled population," whereas "[f]or many patients, managing [treatment] behaviorally may be clinically preferable." Ex. B, 2011 White Paper at 9, A.R.000655. "This distortion would create real costs: not only the costs for the drugs themselves but also the health outcomes that would be diminished by any deviation from clinical best practices." Ex. D, RTI Rx Mem. at 4, A.R.000838. Such costs would include not only the risk of doctors steering patients toward drugs rather than behavioral therapies, but also a bias towards certain types of drugs associated with high cost conditions. *Id.* at 6-7, A.R.000840-41. Other problems included the fact 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. *Id.* at 5, A.R.000839.

Incorporating drug data into the model also posed several methodological complexities. The model would "need to be carefully specified" by including only those drugs and therapeutic classes for which "there is nearly universal clinical agreement about their use," a requirement that "poses a big challenge to the model design." *Id.* In addition, "integrating diagnoses with prescription drugs is difficult" because "[d]rugs do not map one-to-one with particular diagnoses."

Id. Moreover, because "clinical indications for a given pharmaceutical may change over time," the model would require "more frequent modifications . . . than if pharmaceutical data were not used." Ex. B, 2011 White Paper at 10, A.R.000656. Finally, the relevant literature indicated that "[a]dding drug flags to a specification that already includes [a full] specification of diagnoses . . . adds very little to the model's explanatory power." Ex. D, RTI Rx Mem. at 6, A.R.000840.

Based on this extensive analysis, the Department reasonably decided not to include prescription drug data in the model because "inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing." 2014 Proposed Rule, 77 Fed. Reg. at 73,128, A.R.000123. The Department noted, however, that it would continue to evaluate "possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives." *Id.* The Department's decision to exclude prescription drugs due to concerns about adverse incentives is utterly rationale and it is entitled to particular deference. *See Maine Med. Ctr.*, 841 F.3d at 17 ("deference is most pronounced when the issue involves 'a complex and highly technical regulatory program'" requiring "significant expertise and . . . the exercise of judgment grounded in policy concerns" (citation omitted)); *S. Shore Hosp., Inc.*, 308 F.3d at 106 (a "respectful approach" to agency decisionmaking "is especially appropriate when the challenged action . . . calls for a delicate balancing of a mélange of factors within the scope of the Secretary's expertise").

c. HHS Adequately Addressed Comments

Finally, Minuteman contends that HHS failed adequately to address comments regarding the use of drug data. Pl.'s Mot. at 40. This contention is belied by the above discussion, which shows that the Department considered and addressed prescription drug data and partial year enrollment at length.

Moreover, here and elsewhere, Minuteman vastly overstates an agency's burden to respond to comments. "The requirement to respond to comments is 'not particularly demanding.'" *Lee Mem'l Health Sys. v. Burwell*, 206 F. Supp. 3d 307, 332 (D.D.C. 2016) (citation omitted). An agency's "failure to respond to comments is significant only insofar as it demonstrates that the agency's decision was not based on a consideration of the relevant factors." *City of Waukesha v. EPA*, 320 F.3d 228, 258 (D.C. Cir. 2003) (citation omitted). Accordingly, agencies "need not supply comprehensive explanations and record citations for each and every conclusion." *New Mexico v. U.S. Dep't of Hous. & Urban Dev.*, No. 84-2347, 1987 WL 109007, at *3 (10th Cir. Jan. 7, 1987); *see also Brown*, 46 F.3d at 110 (holding that Department adequately responded to comments by stating "[w]e stand by our original position. The [decision] was based on the data from a Spring 1979 survey of food stamp recipients. We regard [it] as reasonable and supportable").

In addition, "[t]he APA requirement of agency responsiveness to comments is subject to the common-sense rule that a response be necessary." *Interstate Nat. Gas Ass'n of Am. v. FERC*, 494 F.3d 1092, 1096 (D.C. Cir. 2007) (citation omitted). Thus, where an agency has already considered an issue in prior rulemaking materials, it need not restate its analysis in the final rule. *See Nat'l Res. Def. Council, Inc. v. EPA*, 859 F.2d 156, 188-89 (D.C. Cir. 1988) (where agency "in effect, responded in advance" to comments, "there was no error in failing to respond to . . . objections that were thereafter raised during the comment period."). Here, the Department's exhaustive analysis set forth in the 2011 White Paper, the RTI analysis, and the proposed and final rules easily satisfies its minimal burden to demonstrate that it considered and addressed the prescription drug data and partial enrollment issues. That is all the APA requires.

4. The Program Is Reasonable Vis a Vis Bronze Plans

In challenging the 2014 Rule, Minuteman finally argues that the risk adjustment program disproportionately burdens Bronze plans and that the Department should be required to "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." Pl.'s Mot. at 45.

First, the Department did exhaustively grapple with "the relationship between state health exchange 'metal level' plan actuarial values and the risk adjustment program." Ex. A, RTI Metal Level Mem. at 1, A.R.000809. The Department ultimately addressed this relationship by adopting different risk score models for each metal level plan and catastrophic plans. *See* 2014 Rule, 78 Fed. Reg. at 15,419, A.R.000236 ("We proposed separate risk adjustment models for each metal level because plans at different metal levels would have different liability for enrollees with the same expenditure patterns."). The Department also included an adjustment for actuarial value in the transfer formula so that the program does not compensate plans for differences in actuarial value that are already reflected in the premiums charged by such plans. *Id.* at 15,431, A.R.000248 ("in the absence of [an] AV adjustment, a low AV plan with lower-risk enrollees would be overcharged because the State average premium would not be scaled down to reflect the fact that the plan's AV is lower than the average AV of plans operating in the market"); 2014 Proposed Rule, 77 Fed. Reg. 73,142, A.R.000137 ("If the payment transfer formula were to ignore actuarial value, it would effectively force low-AV plans to subsidize high-AV plans."). However, the Department reasonably elected not to adopt separate risk pools for the different metal level plans because "this approach would fail to correct for systematic risk selection across 'metal levels[.'] That is, low risk enrollees would tend to migrate to plans with a lower actuarial value . . . . which would then gain a premium advantage attributable to risk selection. This result would

not address the mandate of the ACA, which requires that transfer payments be made between plans based on the[] actuarial risk of their enrollees." Ex. A, RTI Metal Level Mem. at 6-7, AR000814-15. Thus, to the extent Minuteman suggests that the Department has not already exhaustively "grappled" with the relationship between metal levels and risk adjustment, it is wrong.

To the extent Minuteman argues that the Department's methodology is arbitrary and capricious because it does not relieve Bronze plans of the financial consequences of risk adjustment, Pl.'s Mot. at 42-45, that argument fails for at least two reasons: First, as Minuteman concedes, Bronze plans tend to have healthier-than-average enrollees and to the extent they do, section 1343 requires them to pay risk adjustment charges. Pl.'s Mot. at 43; Ex. A, RTI Metal Level Mem. at 9, A.R.000817 ("The average platinum plan enrollee is very likely to be higher risk than the average enrollee in a bronze plan"). Second, administrative review is not based on hindsight and it does not appear that Minuteman raised this outcome-oriented critique until the 2018 rulemaking. Pl.'s Mot. at 45 (citing 2018 rulemaking materials). Accordingly, the Court should not consider it in evaluating the reasonableness of the 2014 Rule (or the 2015-2017 Rules).

C. The 2015-2017 Rules Are Consistent with the Statute and Are Reasonable

Minuteman lodges the same challenges to the 2015, 2016, and 2017 Benefit Rules. These arguments fail to the same extent as above because the Department was explicit in those rulemakings that it was not proposing to "significantly change the model." 2015 Rule, 79 Fed. Reg. at 13,753, A.R.004542; *see also id.* ("We proposed to use the [2014] methodology in 2015"); 2016 Rule, 80 Fed. Reg. at 10,760, A.R.005692 ("We proposed to continue to use the same risk adjustment methodology finalized in the 2014 [Rule]"); *id.* at 10,772, A.R.005704 ("As stated above, we wish to use the same risk adjustment models finalized in the 2014 [Rule]"); *id.* at 10,771, A.R.005703 ("We do not propose to alter our payment transfer methodology."); 2017 Proposed

Rule, 80 Fed. Reg. at 75,499, A.R.007657 ("We propose to continue to use the same risk adjustment methodology finalized in the 2014 Payment Notice."); 2017 Rule, 81 Fed. Reg. at 12,230, A.R.007774 ("We did not propose changes to the transfer formula."). The Department also has stated its rationale for not proposing to significantly change the model: "it is important to maintain model stability in implementing the risk adjustment methodology in the initial years of risk adjustment[.]" 2015 Rule, 79 Fed. Reg. at 13,753, A.R.004542.

Minuteman contends that the Department's "refusal to respond" to comments beyond the scope of the proposed rules "is the very epitome of arbitrary and capricious behavior," Pl.'s Mot. at 29, but this too is incorrect. The Department was not obligated to reconsider methodological choices it already had exhaustively considered or to respond anew to comments questioning those choices. *See, e.g.*, *Nat'l Mining Ass'n v. Mine Safety & Health Admin.*, 116 F.3d 520, 549 (D.C. Cir. 1997) (agency was not required to respond to comments "beyond the scope of the rulemaking"); *Sherley v. Sebelius*, 776 F. Supp. 2d 1, 22 (D.D.C. 2011), *aff'd*, 689 F.3d 776 (D.C. Cir. 2012) ("NIH's notice of proposed rulemaking did not invite (and therefore the NIH wasn't obligated to respond to) comments on" issue outside the scope of proposed rulemaking). Thus, Minuteman fails to show that the 2015-2017 Rules violate either section 1343 or the APA.

D. The 2018 Rule Is Consistent with the Statute and Is Reasonable

Minuteman again lodges the same challenges to the 2018 Rule. As Minuteman concedes, however, in that Rule, the Department has now updated its methodology to (1) adopt a downward adjustment to the state average premium; 2018 Rule, 81 Fed. Reg. at 94,100, A.R.009637; (2) include preventive health costs, thereby better measuring the cost of healthy enrollees, 2017 Rule, 81 Fed. Reg. at 12,206, A.R.007750; (3) include additional partial year enrollment factors, 2018 Rule, 81 Fed. Reg. at 94,071-74, A.R.009608-11; and (4) make limited use of prescription drug

data, *id.* at 94,074-80, A.R.009611-17. Thus, the Department has addressed many, if not most, of Minuteman's complaints. Minuteman's remaining grievances are addressed below.

1. The Adjustment to the State Average Premium Is Reasonable

Minuteman first takes issue with the fourteen percent adjustment to the state average premium because "like any average, it underestimates the high performers who work hard to be more efficient" and because Minuteman believes the adjustment should be applied retroactively to 2014. Pl.'s Mot. at 32.[14] But as discussed above, there is nothing arbitrary and capricious about using a mean to approximate overall health costs in a state, nor does section 1343 require risk adjustment transfers to reward "the high performers who work hard to be more efficient." *Id.* Moreover, in the rulemaking process for the 2018 Benefit Rule, the Department again explained that "[u]sing the Statewide average premium minimizes issuers' ability to manipulate their transfers by adjusting their own plan premiums," Ex. C, 2016 White Paper at 83, A.R.009807, and that given the budget neutrality of the program, using a plan's own premium as the basis of the risk adjustment transfer is "likely to lead to substantial volatility in the transfer results and even higher transfer charges for low-risk low-premium plans." 81 Fed. Reg. at 94,100, A.R.009637. The Department also reasonably declined Minuteman's requests to make the adjustment retroactive to 2014, Pl.'s Mot. at 32-33, because "issuers incorporate the applicable benefit year's

[14] Minuteman also argues that the 14 percent reduction is not entitled to deference because it was not specifically stated in the notice of proposed rulemaking. But "an agency may promulgate a final rule that differs from the rule it has proposed without first soliciting further comments if the final rule is a 'logical outgrowth' of the proposal." *Louisiana Federal Land Bank Ass'n, FLCA v. Farm Credit Admin.*, 336 F.3d 1075, 1081 (D.C. Cir. 2003) (citation omitted). The Department sought comments in the 2018 Proposed Rule on the precise issue of whether it should "remov[e] a portion of administrative expenses from the statewide average premium." 81 Fed. Reg. at 61,488, A.R.009546. In response to the comments it received, the Department settled on a specific reduction of 14%. 2018 Rule, 81 Fed. Reg. at 94,099-100. This reduction was a "logical outgrowth" of the Department's proposal, and Minuteman does not contend otherwise.

risk adjustment methodology in their rate setting" and a retroactive change to the rules would not "provide advance notice to permit issuers to incorporate the [changes] in their rate setting." 81 Fed. Reg. at 94,073, A.R.009610. The Department's treatment of these issues was reasonable.[15]

2. The Department Reasonably Addressed the Estimation Bias Critique

Next, Minuteman contends that the Department was arbitrary for declining to respond to or adopt a proposed adjustment to the formula suggested by former CMS Chief Actuary Rick Foster. Pl.'s Mot. at 37. This argument fails as well.

First, Mr. Foster's proposal was not intended as a permanent modification to the methodology. He acknowledged that "[i]n recognition of [the estimation bias] issue, CMS is changing how the risk adjustment model is calibrated, starting with plan year 2017, 'by predicting plan liability adjusted to account for preventive services[,]'" and that this modification would "help address the issue of estimation bias, starting with plan year 2017" and "[o]ther changes will further improve risk score accuracy starting in years 2018 and 2019." Ex. H, Mem. from Richard S. Foster to CHOICES Ex. Comm. (July 15, 2016), at 1, 12, MH000219, MH000230. Mr. Foster thus framed his proposal as a way "to address [estimation] bias in the RA model . . . *for the 2015 and 2016 plan years*." *Id.* at 1, MH000219 (emphasis added). Thus, the Foster fix was not proposed

[15] Minuteman's suggestion that the modifications adopted for 2017 and 2018 somehow indicate that the prior formula was irrational is meritless. Pl.'s Mot. at 32. "Every risk adjustment program in use today – from Medicare Advantage to various voluntary commercial methodologies – has gone through . . . reviews and adjustments." Ex. G, Consumers for Health Options, Insurance Coverage in Exchanges in States Letter ("CHOICES White Paper"), at 2, A.R.008635. And "just because the agency later concluded . . . that [a different approach] was more sensible in light of the agency's experience does not make the earlier decision . . . unreasonable." *Banner Health v. Burwell*, 126 F. Supp. 3d 28, 74 (D.D.C. 2015).

as a response to the 2018 proposed rule but as a backward looking adjustment for prior years.[16]

Second, the Department reasonably responded to Mr. Foster's proposal by noting that "there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well"; that "[m]ost commenters did not support an adjustment outside the model;" and that given "the tradeoffs that would need to be made in model predictive power among subgroups of enrollees . . . we should further evaluate solutions prior to making any adjustments to the model." 2018 Rule, 81 Fed. Reg. at 94,083, A.R.009620. The Department also concluded that in light of the addition of preventive services to the model in 2017, "the risk scores of healthy enrollees . . . will likely rise relative to the risk scores of the less healthy[.]" Ex. C, 2016 White Paper at 33, A.R.009757. The Department's decision to postpone any additional adjustments while it monitored the impact of adjustments already made and further evaluated proposed solutions was reasonable. *See Lee Mem'l Health Sys.*, 206 F. Supp. 3d at 331 (affirming Department's decision to monitor Medicare methodology and further evaluate modifications before making changes).

3. Minuteman's Bronze Plan Challenge Fails

Minuteman's last contention is that the methodology "makes it extremely difficult for bronze plans to be profitable." Pl.'s Mot. at 44. But in fact, Bronze plans still exist so at least some issuers must find them profitable. In any event, the sole relief that Minuteman seeks on this point is remand with an instruction "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." Pl.'s Mot. at 45. However, the Department stated in its 2018 rulemaking that it

[16] As noted, the Department has been clear that it is not considering retroactive changes to the methodology. 2018 Rule, 81 Fed. Reg. at 94,073.

continues to evaluate approaches to "improve the model's predictive ability for certain subgroups" such as Bronze plans. 2018 Rule, 81 Fed. Reg. at 94,083, A.R.009620.[17] Since the Department is already "grappling" with these issues, judicial relief is unnecessary.

III. There Is No Basis for the Retroactive Relief Minuteman Seeks

A. The Court Lacks Jurisdiction to Award Relief that Is Primarily Monetary

Finally, even if Minuteman had raised a meritorious legal challenge to any of the rules at issue, its request for retroactive—and primarily monetary—relief must fail. The APA's authorization of judicial review is limited to claims seeking "relief other than money damages." 5 U.S.C. § 702; *see also Tortorella v. United States*, 486 F. Supp. 2d 159, 163 (D. Mass. 2007) (explaining that jurisdiction under the APA is limited to claims "seek[ing] *non-monetary relief* from a decision of a federal agency." (emphasis added)). A litigant may not circumvent this limitation "by framing a complaint in the district court as one seeking injunctive, declaratory or mandatory relief where the thrust of the suit is to obtain money from the United States." *Christopher Village, L.P. v. United States*, 360 F.3d 1319, 1328 (Fed. Cir. 2004) (citing cases). Because "[i]t is easy to disguise an action for money damages as one for declaratory [or injunctive] relief," a court "must look beyond the facial allegations of the complaint to determine the true nature of th[e] suit." *Batsche v. Burwell*, 210 F. Supp. 3d 1130, 1133 (D. Minn. 2016).

Here, although Minuteman nominally seeks an injunction requiring the Department to revise its risk adjustment formula "for all benefit years from 2014 forward," Am. Compl. at 61, the thrust of its suit is for a refund of money already paid to the Department. That is because, as

[17] Indeed, in the 2016 White Paper, the Department noted that its inclusion of preventive services should improve outcomes for Bronze and Silver plans. *See* Ex. C, 2016 White Paper at 33, A.R.009757.

Minuteman concedes, the Department already has revised its methodology to address partial year enrollees, prescription drug data, and the state average premium, and the Department continues to evaluate possible solutions related to estimation bias. *See* 2018 Rule, 81 Fed. Reg. at 94,083, A.R.009620. What the Department has not done, however—and what Minuteman therefore hopes to achieve here—is to recalculate and refund charges for prior years. But because those funds have already been distributed to other plans, any "refund" likely would need to come from an alternative funding source, and thus would be "substitute" relief falling squarely within the Supreme Court's definition of money damages. *Bowen v. Massachusetts*, 487 U.S. 879, 895 (1988); *cf. Batsche*, 210 F. Supp. 3d at 1135 (dismissing APA claim for refund of reinsurance fees because alleged injury "could be remedied only through entry of a money judgment"); *Gerhart v. Dep't of Health & Human Servs.*, No. 4:16-CV-00151, 2017 WL 1019816, at *7 (S.D. Iowa Mar. 16, 2017) (dismissing APA claim for lack of jurisdiction because plaintiffs sought to "requir[e] HHS to 're-do' the [risk adjustment] calculation under a proper method. . . . A money judgment would adequately address [this] claim").[18]

Minuteman concedes in a footnote that a refund for prior years amounts to "retroactive payments," but it argues that the receipt of "future credits" rather than "retroactive payments" would eliminate this problem. Pl.'s Mot. at 32 n.12. The APA's money damages limitation is not so easily manipulated: a monetary credit is no different than a cash payment for purposes of section 702 where both seek to correct for retroactive events. *See Brazos Elec. Power Co-op., Inc. v. U.S.*

[18] To the extent Minuteman suggests that a refund of its previously paid charges should come from a funding source other than risk adjustment payments, it has not identified an unexhausted appropriation that may be used for such a purpose. *See, e.g., Cty. of Suffolk v. Sebelius*, 605 F.3d 135, 138 (2d Cir. 2010) ("Where, as here, the congressional appropriations relating to the funds sought by private litigants have been lawfully distributed—and therefore exhausted—by a federal agency, courts lack authority to grant effectual relief" under the APA).

Dep't of Agric., 144 F.3d 784, 787 (Fed. Cir. 1998) ("Cancellation of debt owed to the federal government . . . is just as much a form of monetary damages for purposes of the Tucker Act as the direct payment by the federal government of conventional monetary damages." (citation omitted)). The Court should reject Minuteman's improper attempt to obtain backward looking monetary refunds from the Department in the guise of declaratory relief.

B. Even if Backward Looking Recalculations Are Not "Money Damages" They Are Inequitable and Should Not Be Awarded Here

Even if backward-looking refunds to Minuteman could be characterized as "relief other than money damages," vacatur should still be denied because vacating the risk adjustment methodology for all prior years would harm plans that enrolled sicker than average enrollees. "A reviewing court that perceives flaws" in an agency's regulation "is not required automatically to set aside" that regulation. *Cent. Maine Power Co. v. FERC*, 252 F.3d 34, 48 (1st Cir. 2001) (citation omitted). "Whether to do so rests in the sound discretion of the reviewing court; and it depends *inter alia* on the severity of the errors, the likelihood that they can be mended without altering the order, and on the balance of equities and public interest considerations." *Id.*

Here, the only equitable remedy—to the extent any is warranted—would be remand without vacatur. First, for each of the years at issue, the Department promulgated its methodology in advance. Even if the methodology was not perfect, issuers knew how it operated and could price it into their rate-setting. By contrast, a "retrospective change in methodology would upset expectations and introduce uncertainty into the market." Am. Compl. Ex. 25 at 5. Second, the funds that Minuteman has paid into the program have already been distributed to other plans and are no longer in the Department's coffers. Thus, the program has already been administered and it would be difficult, if not impossible, to unwind it. *See, e.g., Sugar Cane Growers Co-op. of Florida v. Veneman*, 289 F.3d 89, 97 (D.C. Cir. 2002) (denying vacatur where "the egg has been

scrambled and there is no apparent way to restore the status quo ante"); *In re Long-Distance Tel. Serv. Fed. Excise Tax Refund Litig.*, 853 F. Supp. 2d 138, 144 (D.D.C. 2012) (denying vacatur because "casting doubt" on tax refunds already paid would be an "invitation to chaos'").[19] Third, because agencies generally are not permitted to apply new regulations retroactively, *see Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208-09 (1988), the Department would not be able to recover the refunded money, an outcome that would nullify the risk spreading function of the program and thwart congressional intent. Remand without vacatur is the proper remedy in such circumstances. *Heartland Reg'l Med. Ctr. v. Sebelius*, 566 F.3d 193, 197-99 (D.C. Cir. 2009); *see also MCI Telecomms. Corp. v. FCC*, 143 F.3d 606, 609 (D.C. Cir. 1998) (denying vacatur where it would leave private parties "all but uncompensated").

CONCLUSION

For the foregoing reasons, the Department respectfully requests that summary judgment be granted in favor of the Department and Minuteman's motion for summary judgment be denied.

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Respectfully submitted,

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[19] The cases on which Minuteman relies do not suggest otherwise. Indeed, *Nat'l Fuel Gas Supply Corp. v. FERC*, 59 F.3d 1281, 1290 (D.C. Cir. 1995) specifically observed that retroactive application of a judicial decision should not be applied where it would create a "grave disruption or inequity" (as it would here). *Accord United States v. Goodner Bros. Aircraft, Inc.*, 966 F.2d 380, 384 (8th Cir. 1992).

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CERTIFICATE OF SERVICE

I hereby certify that on the 25th day of May, 2017, I caused the foregoing document to be served on counsel for plaintiff by filing with the court's electronic case filing system.

/s/ Serena Orloff
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