IN THE UNITED STATES DISTRICT COURT
DISTRICT OF NEW MEXICO

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

DEFENDANTS' REPLY IN SUPPORT OF THEIR MOTION TO ALTER OR AMEND THE JUDGMENT

TABLE OF CONTENTS

INTRODUCTION 1

ARGUMENT…….....2

I. NMHC Waived Its Ability to Challenge HHS's Budget-Neutral Approach in the 2014-2017 Rulemakings and HHS Explained Its Approach in the 2018 Rule…… 2

II. The Risk Adjustment Program Is Budget Neutral Because HHS Lacks an Appropriation to Operate It Any Other Way 5

III. Even if HHS's Decision Not to Use Its Program Management Fund on the Risk Adjustment Program Was Discretionary, It Was Not Reviewable. 9

IV. The Court's Remedy Was Clear Legal Error and Manifestly Unjust. 10

CONCLUSION.....12

TABLE OF AUTHORITIES

Cases **Page(s)**

Ariz. ex rel. Darwin v. EPA,
852 F.3d 1148 (9th Cir. 2017) 3

FCC v. Fox Television Stations, Inc.,
556 U.S. 502 (2009) 3

Helicopter Ass'n Int'l, Inc. v. FAA,
722 F.3d 430 (D.C. Cir. 2013) 5

Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United States,
48 F.3d 1166 (Fed. Cir. 1995) 7

Lincoln v. Vigil,
508 U.S. 182 (1993) 9, 10

Maine Cmty. Health Options v. United States,
133 Fed. Cl. 1 (2017) 8

Nat'l Ass'n of Home Builders v. Defs. of Wildlife,
551 U.S. 644 (2007) 7

Nelson v. City of Albuquerque,
283 F. Supp. 3d 1048 (D.N.M. 2017) 1

NLRB v. Wyman-Gordon Co.,
394 U.S. 759 (1969) 5

NRDC v. EPA,
755 F.3d 1010 (D.C. Cir. 2014) 4

Olivares v. TSA,
819 F.3d 454 (D.C. Cir. 2016) 6

Small Refiner Lead Phase-Down Task Force v. EPA,
705 F.2d 506 (D.C. Cir. 1983) 3

Univ. of Colo. Health at Mem'l Hosp. v. Burwell,
164 F. Supp. 3d 56 (D.D.C. 2016) 6

Universal Health Servs., Inc. v. Thompson,
363 F.3d 1013 (9th Cir. 2004) 4, 5

Zoranovic v. Sessions,
713 F. App'x 794 (10th Cir. 2018) 4

Statutes

5 U.S.C. § 551 10

31 U.S.C. § 1301 8

31 U.S.C. § 1341 7

42 U.S.C. § 18063 ..... 8, 9

Rules

Fed. R. Civ. P. 12(h)(3) 10

Fed. R. Civ. P. 59(e) 12

Regulations

PPACA; Standards Related to Reinsurance, Risk Corridors and Risk Adjustment,
Proposed Rule, 76 Fed. Reg. 41,930 (July 15, 2011) 9

HHS Notice of Benefit and Payment Parameters for 2018,
81 Fed. Reg. 94,085 (Dec. 22, 2016) 11

HHS Notice of Benefit and Payment Parameters for 2019,
83 Fed. Reg. 16,954 (Apr. 17, 2018) 7, 11

Other Authorities

The Honorable Jeff Sessions, the Honorable Fred Upton,
B–325630, 2014 WL 4825237 (Comp. Gen. Sept. 30, 2014) 9

INTRODUCTION

In their Rule 59(e) motion, Defendants (collectively, "HHS") outlined four types of clear error in the Court's Judgment and accompanying Memorandum Opinion and Order ("Opinion"). *First*, NMHC could not have challenged HHS's budget-neutral approach to risk adjustment in the 2014-2017 Rules because no commenter challenged that approach during those rulemakings, and as for the 2018 Rule, the Court overlooked HHS's explanation that it lacked an appropriation to operate the program in any other way, an explanation the Court suggested would be sufficient. *Second*, under binding principles of appropriations law, HHS could not have operated the program any differently. *Third*, even if the agency could conceivably have diverted its lump-sum "program management" appropriation to shore up the program, the Court lacked jurisdiction to review any determination in that regard because the allocation of lump sum funding is committed to agency discretion by law and unreviewable under the Administrative Procedure Act ("APA"). *Fourth*, even assuming the APA required additional explanation of HHS's budget neutral approach, the proper remedy in such circumstances, and the equitable remedy here, is remand without vacatur.

NMHC's primary response to these principles is to argue that they cannot be raised on a motion under Rule 59(e). But the very purpose of Rule 59(e) is to correct misinterpretations of the parties' positions, clear errors of law, and manifest injustice, all of which are present here. *Nelson v. City of Albuquerque*, 283 F. Supp. 3d 1048, 1099 (D.N.M. 2017) ("There is no sound reason for a district judge to be unable to change a ruling he or she has made if he or she has become concerned that he or she is wrong."). The contention that HHS should have raised these arguments earlier is baseless, because NMHC has only ever challenged HHS's use of the statewide average premium, rather than the agency's independent budgetary determination that the program

is self-funding. Defs.' Mot. to Alter or Am. J. at 7–9, ECF No. 57 ("Mot."). Indeed, NMHC *concedes* that it has "not challenge[d] [HHS's] decision not to allocate funds" to the program, Pl.'s Mem. of Law in Opp'n to Defs.' Mot. at 16, ECF No. 63 ("Opp'n"), yet it nevertheless insists that HHS was required to explain *that decision* in the administrative record and defend it in this case. NMHC fails to cite a single case in which an APA plaintiff expressly disavowed challenging a particular decision, yet successfully rested on a failure to explain that decision as a basis for invalidating a different one. NMHC's assertion that HHS cannot address fundamental legal principles regarding a decision that was never clearly challenged should be rejected.

ARGUMENT

I. NMHC Waived Its Ability to Challenge HHS's Budget-Neutral Approach in the 2014-2017 Rulemakings and HHS Explained Its Approach in the 2018 Rule.

In its Motion, HHS explained that NMHC cannot challenge HHS's budget neutral approach to the risk adjustment program in the 2014-2017 Rules because neither it nor any other commenter objected to that approach with respect to those Rules. Mot. at 9–11. And when commenters did first critique the budget neutral framework during the 2018 rulemaking, HHS promptly responded by explaining that budget-neutrality was dictated by the "absence of additional funding" for the program. Mot. at 18 (quoting 2018 Rule, 81 Fed. Reg. 94,058, 94,101 (Dec. 22, 2016), AR009638). The Court's Opinion overlooked this explanation, even while recognizing that a lack of "funding to make up the shortfall between the risk adjustment charges and credits" would be an "excellent . . . reason[] for making the risk adjustment [program] budget neutral." Mem. Op. and Order at 68 ("Op."), ECF No. 55.

In response, NMHC contends that there was no waiver as to the 2014-2017 Rules because it and other commenters challenged the agency's use of the statewide average premium during the

2017 and 2018 rulemakings. *See* Opp'n at 7. However, comments to the 2017 and 2018 Rules do not constitute objections to the previously-promulgated 2014-2016 Rules. Nor does NMHC explain how comments to the 2017 Rule challenging the use of the *statewide average premium* provided fair notice to the agency that an entirely different parameter of the program—the budget-neutral framework announced as early as 2011—was under challenge as well. *See* Mot. at 9–11.

Nor do NMHC's various proposed exceptions to exhaustion apply here. *See* Opp'n at 8–9. With respect to the "key assumption" doctrine, the agency *did*, repeatedly, state its assumption that the program was budget-neutral (as did the Congressional Budget Office in 2014),[1] and no commenter questioned it. In any event, the "key assumption" line of cases is an exception to the Clean Air Act's exhaustion requirement for review of EPA rulemaking pursuant to that statute that has no application to rulemaking under the APA. *See Ariz. ex rel. Darwin v. EPA*, 852 F.3d 1148, 1159 (9th Cir. 2017) (noting that "[t]he asserted duty to examine 'key assumptions' has no textual origin" and was based on "a line of cases from the D.C. Circuit finding an exception to § 7607(d)(7)(B) [of the Clean Air Act] when a new argument challenges 'key assumptions' underlying an EPA rule"). In contrast to the detailed findings required for rulemaking under the Clean Air Act, *see Small Refiner Lead Phase-Down Task Force v. EPA*, 705 F.2d 506, 518–19 (D.C. Cir. 1983), agency action "of less than ideal clarity" should be upheld under the APA "if the agency's path may reasonably be discerned." *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513–14 (2009). The "key assumption" doctrine is inapposite.

NMHC's assertion that HHS considered challenges to its budget neutral approach "*sua sponte*" is even less persuasive. "*Sua sponte*" consideration by an agency only excuses

[1] *See* Mem. in Supp. of Pl.'s Mot. for Summ. J. at 25 n.9, ECF No. 33.

administrative exhaustion where the "very argument pressed" by a plaintiff was *actually addressed* by the agency during the rulemaking process. *NRDC. v. EPA*, 824 F.2d 1146, 1151 (D.C. Cir. 1987); *cf. Zoranovic v. Sessions*, 713 F. App'x 794, 797–98 (10th Cir. 2018) ("narrow" "*sua sponte*" exception to statutory exhaustion requirement applicable only where agency "*clearly identif[ied] . . .* argument not presented by the petitioner" and "*explicitly decide[d] that matter in a full explanatory opinion or substantive discussion*" (citation omitted)). Here, the "very argument pressed" by NMHC is that the risk adjustment program need not be budget neutral because HHS could use its lump sum "program management" appropriation to shore up the program or, absent that, issuers could sue in the Court of Federal Claims to collect any additional payments. Opp'n at 13–14. That particular challenge was neither raised by commenters nor "expressly addressed" by HHS in the 2014-2017 rulemakings. *NRDC v. EPA*, 755 F.3d 1010, 1023 (D.C. Cir. 2014).

Likewise, there were no "obvious" problems pertaining to HHS's budget neutrality analysis to which HHS was obligated to respond. Opp'n at 8. Indeed, the only thing "obvious" to the agency was that it lacked the budgetary flexibility to implement the program in any other manner. Nor did "exceptional circumstances" exist that would offer a "compelling reason" justifying NMHC's failure to raise the issue with the agency. *Universal Health Servs., Inc. v. Thompson*, 363 F.3d 1013, 1021 (9th Cir. 2004). Any legal objections to HHS's budget neutral approach could have been made when the agency was developing the program, and NMHC cites no case suggesting that hindsight is an "exceptional circumstance" allowing a backward-looking challenge the agency could have addressed at the time.

In sum, the Court should not allow NMHC's *post-hoc* arguments to override the "agency's interests in applying its expertise, correcting its own errors, making a proper record, enjoying

appropriate independence of decision and maintaining an administrative process free from deliberate flouting." *Universal Health Servs.*, 363 F.3d at 1021.

II. The Risk Adjustment Program Is Budget Neutral Because HHS Lacks an Appropriation to Operate It Any Other Way.

HHS also explained in its opening brief that, because of black-letter constraints on the authority of agency officials to obligate federal funds absent or in advance of an appropriation, as well as constitutional constraints on the ability of administrative agencies to mandate funding by states, the agency was required to devise a risk adjustment program that could be funded with amounts the agency then knew would be available to make risk adjustment payments. Because the only such source of funding was risk adjustment charges, HHS properly determined that the program needed to be self-funded. Mot. at 13–18.

NMHC's primary response is to argue that the Court may not consider these points because they are "*post-hoc*" reasoning of litigation counsel. Opp'n at 11. But, having failed to raise the issue during the 2014–2017 rulemakings and thereby deprived the agency of the opportunity to explain itself during the rulemaking process, NMHC should not now be heard to complain that the agency's reasoning is *post-hoc*. Moreover, although a court generally "can affirm agency action only on grounds provided by the agency, this requirement gives way . . . when there is not the slightest uncertainty as to the outcome" on remand. *Helicopter Ass'n Int'l, Inc. v. FAA*, 722 F.3d 430, 439 (D.C. Cir. 2013) (citation omitted); *see also NLRB v. Wyman-Gordon Co.*, 394 U.S. 759, 766 n.6 (1969) (holding that the *post-hoc* rule of *Chenery* does not prevent affirmance where "the substance of the [agency's decision] is not seriously contestable").

As the legal principles articulated in HHS's opening brief demonstrate, there is not the "slightest uncertainty as to the outcome on remand" because HHS cannot design a program to

commit funds that Congress has not provided, nor can it require states to inject their own money into a program absent specific statutory authority. Mot. at 13–18. Thus, the *post-hoc* rule does not prevent the Court from considering the binding legal principles that constrained the agency to the approach that it took.

In any event, the *post-hoc* rule is inapplicable because HHS itself, not litigation counsel, has explained that its budget-neutral approach to the risk adjustment program is necessitated by a lack of funding.[2] In the 2018 Rule, the agency confirmed that budget neutrality is mandated by the "absence of additional funding" other than charges collected under the program. 2018 Rule, 81 Fed. Reg. at 94,101, AR009638. In connection with the present motion, HHS also submitted the Declaration of Jeffrey Wu, Associate Deputy Director for Policy Coordination of the CMS Center responsible for administering the risk adjustment program—who has been with that Center at all relevant times—who explained that "[d]ue to the absence of additional funding for the risk adjustment program, risk adjustment must balance payments and charges across plans." Wu Decl. ¶ 9; *see also id.* ¶ 7. In addition, since filing the Rule 59(e) motion, HHS completed a final rule for the 2019 benefit year again emphasizing the lack of "additional funding" for the program and elaborating that the agency "could not have relied on the potential availability of general appropriation funds without creating uncertainty for issuers in the amount of risk adjustment payments they could expect" to receive, "reducing funding available for other programs[,]" and/or

[2] The *post-hoc* "rule does not forbid *an agency*, itself, from 'provid[ing] an explanation for an inadequately articulated decision.'" *Univ. of Colo. Health at Mem'l Hosp. v. Burwell*, 164 F. Supp. 3d 56, 65 (D.D.C. 2016) (citation omitted). Nor does the rule prevent the Court from considering the declaration of Mr. Wu. *Id.* ("[T]here is nothing improper in receiving declarations that merely illuminate[ ] reasons obscured but implicit in the administrative record." (citation omitted)); *see also Olivares v. TSA*, 819 F.3d 454, 464 (D.C. Cir. 2016) (courts may consider materials from key decisionmakers that "illuminate the reasons that are implicit in the internal material").

delaying the establishment of "parameters for any risk adjustment payment proration rates [until] well after the plans were in effect for the applicable benefit year." HHS Notice of Benefit and Payment Parameters for 2019 ("2019 Rule"), 83 Fed. Reg. 16,930, 16,955 (Apr. 17, 2018). HHS further explained that it could not "rely on any potential State budget appropriations . . . as such funds would not have been available for . . . the HHS-operated risk adjustment program." *Id.*

NMHC's responses to these straightforward budgetary constraints range from illogical to fundamentally mistaken. First, it suggests that the absence of funding is too "bare-bones" an explanation because it is "not a *policy* justification for designing the program to be inherently budget neutral." Opp'n at 11 (emphasis added). The Court, however, has already concluded that a lack of funding is an "excellent" reason for a budget-neutral approach, Op. at 68, and indeed, "[a]gencies may not spend, or commit themselves to spend, in advance of or in excess of appropriations." GAO, Principles of Federal Appropriations Law ("GAO Redbook") at 1-8 (4th ed. 2016). Thus, a lack of funding is all the justification required.[3] NMHC also maintains that HHS could simply have disregarded limits on its budget authority and, in the event of a shortfall between payments and charges, issuers could have sued in the Court of Federal Claims to collect the balance. NMHC is mistaken. Absent an appropriation or other special authority, HHS had no ability to create an obligation on which issuers could collect in the Court of Federal Claims. 31 U.S.C. § 1341 (a)(1)(B); *see also Highland Falls-Fort Montgomery Cent. Sch. Dist. v. United*

[3] To the extent NMHC insists that HHS was required to provide a "policy" justification—as opposed to a legal justification—for budget neutrality, Opp'n at 11, that contention makes no sense. Congress holds the purse strings, not HHS, and HHS was not required to offer a "policy" rationale for a decision that Congress itself has made. *Cf. Nat'l Ass'n of Home Builders v. Defs. of Wildlife*, 551 U.S. 644, 667–68 (2007) ("an agency cannot be considered the legal 'cause' of an action that it has no . . . discretion not to take").

States, 48 F.3d 1166, 1171 (Fed. Cir. 1995) (an "agency may not spend more money for a program than has been appropriated for that program"). None of NMHC's cited cases suggest that HHS was allowed, much less required, to disregard these binding appropriations principles.[4]

Finally, NMHC contends that HHS could have designed the program to rely upon additional federal funding notwithstanding the absence of an appropriation for that purpose because, in the event of a shortfall between risk adjustment charges and payments, HHS could have used its subsequently-appropriated "program management" fund to shore up the program. Opp'n at 14. As HHS has explained, it could not have relied on those funds because they (a) had not yet been appropriated when HHS was finalizing the rules at issue, (b) are for "responsibilities of CMS," not the responsibilities of the state governments for whom HHS acts under 42 U.S.C. § 18063, and (c) are designated for administrative and operational expenses of CMS, not program payments. Mot. at 16.[5] NMHC fails entirely to address these points. Instead, it hangs its hat on a single Government Accountability Office ("GAO") opinion that addressed a different program and an entirely different legal question. Opp'n at 14. The GAO opinion examined whether *risk corridors* payment requests under a *statutory* formula administered by HHS could be liquidated with program management funds, assuming that such funds were again appropriated in future

[4] Although NMHC cites two opinions by the same judge holding that a lack of funding under the risk corridors program did not defeat issuers' rights to collect statutory payments under that program, Opp'n at 13, three other judges in the Court of Federal Claims disagreed with that conclusion, and the matter is currently on appeal to the Federal Circuit. *See Maine Cmty. Health Options v. United States*, 133 Fed. Cl. 1, 3, 12–13 (2017) (citing cases).

[5] Moreover, those funds have either expired and/or have been spent as to prior fiscal years, and HHS may not use subsequent appropriations on payments for earlier fiscal years. *See* 31 U.S.C. § 1301; GAO Redbook at 1-8 ("Appropriations made for a definite period of time may be used only for expenses properly incurred during that time."). NMHC is therefore incorrect to suggest that HHS's program management funds could be used for prior year payments. Opp'n at 14.

years. *See generally* The Honorable Jeff Sessions, the Honorable Fred Upton, B–325630, 2014 WL 4825237 (Comp. Gen. Sept. 30, 2014). The GAO was not asked to analyze, and it did not analyze, the entirely separate question of whether HHS itself could *create* a payment formula requiring expenditures exceeding amounts available in existing appropriations. In fact, the GAO recognized that "[a]gencies may incur obligations . . . *only as permitted by an appropriation*," *id.* at *2 (emphasis added). The GAO opinion thus provides scant support for NMHC's claims.

NMHC also suggests that Tenth Amendment constraints are inapplicable because NMHC "is not challenging a state-run program, but the federal HHS program that has always applied in New Mexico." Opp'n at 12. However, section 1343 tasked HHS with designing a program that *could be operated by states*, regardless of whether states chose to take on that task. *See* 42 U.S.C. § 18063(a)–(b). Indeed, at the time HHS announced its budget-neutral interpretation in 2011, many states had not yet decided whether they would operate their own program. *See* Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,938 (July 15, 2011). Moreover, a state can change its mind. Thus, in carrying out the statutory command to "establish criteria and methods" that could be used by states to administer their own risk adjustment programs, HHS had no authority to ignore the constraints of the Tenth Amendment.

III. Even if HHS's Decision Not to Use Its Program Management Fund on the Risk Adjustment Program Was Discretionary, It Was Not Reviewable.

Even had HHS possessed the ability to rely upon its not-yet-appropriated lump-sum "program management" funding when it promulgated the rules at issue, NMHC's theories must still be rejected because "[t]he allocation of funds from a lump-sum appropriation is an[] administrative decision traditionally regarded as committed to agency discretion." Mot. at 19 (quoting *Lincoln v. Vigil*, 508 U.S. 182, 192 (1993)). Such decisions are exempt from notice-and-

comment rulemaking procedures and immune from judicial review under the APA. *Id.* at 19–21.

Again, NMHC does not and cannot contest these principles. Its only response is that "NMHC is not challenging a decision not to allocate funds" but only the agency's "us[e] [of] the statewide average premium instead of each issuer's own premium." Opp'n at 16.[6] But if NMHC is not "challenging a decision not to allocate funds," then there is no basis for the Court to vacate the agency's rules on the ground that the agency did not explain that decision. In any event, NMHC's attempt to distinguish between the decision to administer risk adjustment in a budget-neutral fashion and the decision not to use a lump sum appropriation to fund that program is baseless. *See* Opp'n at 6.[7] In *Lincoln*, the plaintiffs did not challenge "a decision not to allocate funds"; they challenged the *programmatic effects* of that decision: the agency's discontinuance of clinical services for handicapped children. *Lincoln*, 508 U.S. at 189. Just as the programmatic effects of that decision were unreviewable, so too are they unreviewable here.

IV. The Court's Remedy Was Clear Legal Error and Manifestly Unjust.

Finally, even if NMHC were not fundamentally mistaken on the merits, it errs once again in asserting that vacatur is the "standard remedy" for the type of violation the Court found here. Opp'n at 16. As HHS demonstrated in its opening brief, where an agency's only error is a failure to adequately explain the rationale underlying a decision or rule, the presumptive approach is

[6] NMHC argues that a principle constraining the Court's jurisdiction "cannot be raised for the first time on a Rule 59 motion." Opp'n at 6. Not so. *See* Fed. R. Civ. P. 12(h)(3).

[7] NMHC also does not explain why the agency's budget-neutral interpretation, which was announced in several proposed and final rules, did not constitute "agency action" within the meaning of the APA. Opp'n at 6. *See* 5 U.S.C. § 551(13) (defining "[a]gency action" as including "the whole *or a part* of an agency rule"). If, however, the agency's position on budget neutrality was not "agency action," then it was not subject to the explanation requirement of section 553(c), which only applies to "rules." *Id.* § 553(c). NMHC cannot have it both ways.

remand *without* vacatur. Mot. at 22–24. NMHC fails to cite a single case suggesting otherwise.

Moreover, as NMHC concedes, the decision to vacate is always within the Court's equitable discretion, *id.* at 21–22, Pl.'s Opp'n at 17, and the Court did not weigh the equities or otherwise demonstrate that it was exercising that discretion here. But NMHC claims that the equities favor vacatur because HHS has purportedly "taken no steps to remedy" the errors identified by the Court. NMHC is simply wrong. As discussed above, not only did HHS explain its decision in the 2018 Rule and the Wu Declaration, both of which are properly considered by the Court, *see supra* n.2, but, in response to the Court's ruling, HHS elaborated further upon its budget-neutral rationale in the 2019 Rule. 83 Fed. Reg. at 16,954.

NMHC also argues that vacatur is equitable, and will not lead to uncertainty in health insurance markets, because some insurance companies were unable to accurately predict the level of their risk adjustment charges in prior years. Opp'n at 20–24. But whether or not certain issuers had trouble predicting risk adjustment payments and charges in the past,[8] NMHC does not address the interests of the many other issuers who have structured their business plans around the methodology as it currently exists and have specifically asked HHS to prioritize consistency and stability in the applicable methodology in order to facilitate rate-setting. *See* 2018 Rule, 81 Fed. Reg. at 94,085 (explaining that "many commenters strongly disagreed with any approach that prevents issuers from having final factors at the time of rate setting" and that additional uncertainty is "likely to result in higher rates"). Moreover, even if the risk adjustment methodology is not

[8] Issuers' ability to predict risk adjustment transfers has improved significantly since the inception of the program. *See* Ex. A, Interim Summary Report on Risk Adjustment for the 2017 Benefit Year, at 3 (Apr. 27, 2018).

perfectly predictable, this does not militate in favor of depriving issuers of important payments they would otherwise receive on behalf of their sicker-than-average enrollees in 2017 and 2018,[9] creating additional uncertainty regarding the status of transfers administered since the inception of the program, and causing multiple downstream effects for the Medical Loss Ratio rules and the risk corridors program. *See* Wu Decl. ¶¶ 13–22. Finally, as HHS has elsewhere explained, NMHC's attempt to pin wider problems in the insurance markets on the risk adjustment program, Opp'n at 20–24, ignores the larger picture of an imbalanced risk pool, high costs of covering sicker enrollees, and broad uncertainty in the health insurance markets. *See* Defs.' MSJ Reply at 23–24, ECF No. 41. NMHC articulates no basis to conclude that this market-wide situation would be improved by the further disruption that would be caused by vacating the 2014-2018 Rules.

NMHC last argues that the Court should not limit its relief to New Mexico because courts "regularly vacate and enjoin enforcement of nationwide regulations." Opp'n at 24. However, as HHS has shown, courts do *not* regularly vacate rules where the only flaw in the agency's decision-making is an inadequate explanation. Mot. at 22–24. Moreover, the fact that courts might issue that remedy under circumstances presenting different equitable considerations is not a reason for this Court to do the same here. The Court should apply its equitable discretion and impose this more limited relief if it concludes vacatur is warranted. *See id.* at 27.

CONCLUSION

HHS respectfully requests that the Court grant its Motion pursuant to Fed. R. Civ. P. 59(e).

[9] *See* Ex. B, Paul D. Jacobs et al., *Risk Adjustment, Reinsurance Improved Financial Outcomes For Individual Market Insurers With The Highest Claims*, 36 HEALTH AFFAIRS 755 (2017) (describing economic significance of risk adjustment transfers for issuers with highest claims costs in 2014 and 2015).

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Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on May 17, 2018, I caused the foregoing document to be served on counsel for plaintiff by filing with the court's electronic case filing system.

/s/ James Powers
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EXHIBIT A

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
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INTERIM SUMMARY REPORT ON RISK ADJUSTMENT FOR THE 2017 BENEFIT YEAR

Published: April 27, 2018

I. Background

Section 1343 of the Patient Protection and Affordable Care Act establishes a permanent risk adjustment program to provide payments to health insurance issuers that attract high-risk enrollees, such as those with chronic conditions, thereby reducing the incentive for issuers to avoid those enrollees and lessening the potential influence of risk selection on the premiums that plans charge.

The risk adjustment methodology developed by the Department of Health and Human Services (HHS) is based on the premise that premiums should reflect differences in plan benefits, quality, and efficiency rather than the health status of the enrolled population. The HHS-developed risk adjustment methodology determines each plan's risk adjustment transfer amount based on the actuarial risk of enrollees, the actuarial value (AV) of coverage, utilization and the cost of doing business in local rating areas, and the effect of different cost-sharing levels on utilization. HHS applied this methodology in all 50 states and the District of Columbia for the 2017 benefit year.

II. Description of Data

As described in the November 3, 2017, "Evaluation of EDGE Data Submissions for 2017 Benefit Year" bulletin,[1] HHS evaluated whether issuers provided access to EDGE server data sufficient for HHS to release an interim risk adjustment summary report for each specific state. HHS evaluated each issuer to determine if the issuer loaded at least 90% of its enrollment data and 90% of its claims data linked to enrollees (i.e., non-orphaned medical and pharmacy claims data) for the first three quarters of the 2016 benefit year (the data "quantity" evaluation). HHS also evaluated each issuer's EDGE server data to investigate outliers on a number of criteria (the data "quality" evaluation). If an issuer had a specific data outlier, the issuer was provided an opportunity to explain the outlier. If the outlier was determined to be a true data quality issue, or if the issuer submitted no explanation, the issuer failed data quality. As described in the bulletin, HHS is issuing interim risk adjustment summary information for a state ***only*** if all credible issuers in that state pass both data quantity and quality thresholds.[2] For 2017 benefit year risk adjustment interim summary results, **all 50 states and the District of Columbia are eligible for the 2017 benefit year interim risk adjustment report.**

The data displayed in this report is preliminary – final risk adjustment data may differ significantly in magnitude and possibly direction of the transfers from the data presented in this report. To qualify for interim risk adjustment reporting, issuers were required to submit at least 90% of their first three quarters of enrollment and claims data; however, many issuers have submitted more than this threshold amount. Because an issuer's risk adjustment transfer amount is dependent on the data other issuers within a risk pool market and state submit, a stable risk score between interim and final risk adjustment may not reflect a stable risk adjustment transfer amount. The final risk adjustment transfer results and final state average calculations based on issuers' final data submissions may diverge from the data patterns reflected in this report.

Therefore, the risk scores provided in this interim risk adjustment report will not necessarily be predictive of final 2017 benefit year risk adjustment transfers. If an issuer wishes to use this interim information to assist in estimating the 2017 benefit year risk adjustment amounts, it should do so with

[1] Available at: https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/EDGE-Submissions-2017.pdf.
[2] Issuers were generally deemed credible if they had at least 0.5% market share.

caution and in combination with other significant data. In particular, smaller issuers may experience a wider degree of variation, given the impact larger issuers have on transfers within a state and market.

III. Comparison of Interim and Final Risk Adjustment Results for the 2016 Benefit Year

As we discussed in the 2016 Benefit Year Summary Risk Adjustment Report, issued on June 30, 2017, we have conducted additional analysis comparing the 2016 benefit year interim and final risk adjustment results to illustrate predictability and variation.[3]

Predictability between interim and final risk scores was noticeably improved in the 2016 benefit year. For the 2015 benefit year, the initial year CMS provided interim risk scores, 20 states plus the District of Columbia received interim risk adjustment results. For the 2016 benefit year, 48 states plus the District of Columbia received interim results, marking a significant improvement in the quality and quantity of issuer data submissions. In addition to the significant increase in the number of issuers and states eligible for interim risk scores for the 2016 benefit year, there was also marked improvement in predictability of transfers by risk score quartile as compared with 2015 in both markets. This increased predictability associated with interim risk scores reflected higher quality data earlier in the data submission process and provided more reliable estimates prior to final data submission for issuers' rate setting and financial forecasts in 2016.

We compared the national data quantity completion rate at the data submission deadlines for the interim reports for the 2016 and 2017 benefit years, which were determined by comparing each issuer's EDGE server data submission to their final baseline representing the full year of data for 2016 and 2017. For the 2016 benefit year interim risk adjustment estimates excluding Hawaii and Massachusetts,[4] we calculated a data completion of 94.6% as of an interim deadline of February 9, 2017. For 2017 benefit year interim risk adjustment estimates, we calculated a data completion of 90.7% with a much earlier interim deadline of January 13, 2018. We note that depending on issuers' data quantity submissions beyond three quarters of data for all issuers in a given state market risk pool, the estimates from interim to final could change significantly, depending on issuers' relative portion of data submitted by the interim deadline and market share and claims costs once final data has been loaded. As demonstrated in Table 1 below, 2016 benefit year interim risk scores rose an average of 6 percent in the small group market and 7 percent in the individual market form interim to final 2016 risk adjustment.

[3] Available at: https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf.

[4] These states were excluded from the 2016 benefit year summary interim report because Hawaii had two (2) credible issuers who were unable to pass the quantity threshold and Massachusetts operated its own State-operated risk adjustment program for the 2016 benefit year.

Table 1. Percent Change in Select Risk Adjustment Variables, Interim to Final, in States Eligible for BY16 Interim Risk Adjustment Report

	Individual Market		Small Group Market	
Variable	**Mean**	Standard Deviation	**Mean**	Standard Deviation
Plan Liability Risk Score	7.15%	4.91%	6.04%	3.36%
Billable Member Months	0.05%	1.24%	1.12%	2.40%
Monthly Premiums	-1.00%	6.57%	-0.20%	1.16%
Age Rating Factor	-0.01%	0.14%	-0.09%	0.38%
Actuarial Value	0.02%	0.06%	0.00%	0.10%

IV. HHS-operated Risk Adjustment Program State-specific Data

Included in this report are the key elements of the risk adjustment transfer formula for the states that met the credibility requirements.

Table 2. Description of Risk Adjustment Data

DATA ELEMENT	DESCRIPTION
State Average Monthly Premium	The state average premium for state market risk pool is the weighted average monthly premium for the state market risk pool, weighted by plan share of statewide enrollment in the state market risk pool.
State Average Plan Liability Risk Score (PLRS)	The state average PLRS is calculated as the summed products of PLRS and billable member months for all plans within the state market risk pool divided by total billable months for all plans within the state market risk pool.
State Average Allowable Rating Factor (ARF)	The state average ARF is calculated as the summed products of ARF and billable member months for the plans within the state market risk pool divided by total billable member months for all plans in the state market risk pool.
State Average Actuarial Value (AV)	The state average AV is calculated as the summed products of AV and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. AV corresponds with metal and catastrophic tiers as follows: *Catastrophic: 0.57 *Bronze: 0.60 *Silver: 0.70 *Gold: 0.80 *Platinum: 0.90

DATA ELEMENT	DESCRIPTION
State Average Induced Demand Factor (IDF)	The state average IDF is calculated as the summed products of IDF and billable member months for the plans within the state market risk pool divided by the total billable member months within the state market risk pool. IDF corresponds with metal and catastrophic tiers as follows: *Catastrophic: 1.00 *Bronze: 1.00 *Silver: 1.03 *Gold: 1.08 *Platinum: 1.15
Billable Member Months	Billable member months are the member months of an individual or family policy that are included when setting the policy's premium rate.

Table 3. Interim Risk Adjustment State Averages with State Billable Member Months[5]

State	Risk Pool	STATE AVERAGE MONTHLY PREMIUMS	STATE AVERAGE PLAN LIABILITY RISK SCORE	STATE AVERAGE ALLOWABLE RATING FACTOR	STATE AVERAGE ACTUARIAL VALUE	STATE INDUCED DEMAND FACTOR	STATE BILLABLE MEMBER MONTHS
AK	Individual	$1,048.27	1.320	1.628	0.650	1.015	190,351.5
	Small Group	$734.60	1.036	1.430	0.700	1.035	130,143.4
	Catastrophic	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
AL	Individual	$574.08	1.922	1.626	0.695	1.030	2,274,896.1
	Small Group	$439.22	1.404	1.473	0.770	1.068	2,473,696.4
	Catastrophic	$253.35	0.966	1.107	0.570	1.000	13,325.4
AR	Individual	$390.14	1.797	1.464	0.699	1.030	4,050,114.9
	Small Group	$391.05	1.265	1.407	0.787	1.076	353,016.8
	Catastrophic	$156.79	0.250	0.987	0.570	1.000	4,989.7
AZ	Individual	$629.90	1.427	1.652	0.679	1.024	1,758,065.9
	Small Group	$385.23	1.104	1.373	0.730	1.050	1,713,170.6
	Catastrophic	$168.63	0.399	0.854	0.570	1.000	15,121.8
CA	Individual	$440.43	1.236	1.593	0.694	1.034	24,864,256.6
	Small Group	$453.11	1.056	1.371	0.769	1.072	23,760,296.2
	Catastrophic	$180.01	0.290	0.946	0.570	1.000	330,231.2
CO	Individual	$438.56	1.141	1.593	0.656	1.018	2,741,868.8
	Small Group	$426.57	1.010	1.363	0.724	1.046	2,833,634.7
	Catastrophic	$194.57	0.441	0.963	0.570	1.000	86,233.4
CT	Individual	$536.74	1.444	1.708	0.684	1.027	1,718,611.6
	Small Group	$495.84	1.175	1.464	0.722	1.045	2,017,375.8
	Catastrophic	$184.82	0.386	1.011	0.570	1.000	22,918.8
DC	Individual	$366.16	1.175	1.084	0.723	1.051	201,779.0
	Small Group	$475.05	1.126	1.039	0.825	1.102	891,542.9
	Catastrophic	$96.15	0.273	0.735	0.570	1.000	9,299.4
DE	Individual	$572.92	1.481	1.643	0.681	1.027	312,233.9
	Small Group	$568.87	1.141	1.442	0.751	1.059	329,323.4

[5] State catastrophic risk pools where there are no issuers offering risk adjustment covered plans are listed as "N/A."

State	Risk Pool	STATE AVERAGE MONTHLY PREMIUMS	STATE AVERAGE PLAN LIABILITY RISK SCORE	STATE AVERAGE ALLOWABLE RATING FACTOR	STATE AVERAGE ACTUARIAL VALUE	STATE INDUCED DEMAND FACTOR	STATE BILLABLE MEMBER MONTHS
	Catastrophic	$264.03	0.236	0.988	0.570	1.000	1,973.9
FL	Individual	$460.75	1.510	1.652	0.688	1.028	18,407,372.4
	Small Group	$494.35	1.228	1.452	0.761	1.065	3,525,820.9
	Catastrophic	$209.87	0.499	1.067	0.570	1.000	24,706.5
GA	Individual	$442.96	1.448	1.573	0.682	1.025	5,805,129.9
	Small Group	$465.52	1.156	1.404	0.736	1.050	2,091,160.7
	Catastrophic	$170.32	0.412	1.009	0.570	1.000	92,570.8
HI	Individual	$476.70	1.628	1.648	0.722	1.048	383,194.1
	Small Group	$419.74	1.331	1.456	0.886	1.140	458,977.0
	Catastrophic	$184.80	0.162	0.905	0.570	1.000	1,220.1
IA	Individual	$541.34	1.452	1.734	0.664	1.019	666,063.6
	Small Group	$406.49	1.154	1.395	0.736	1.051	1,107,526.9
	Catastrophic	$196.18	0.277	0.954	0.570	1.000	7,965.5
ID	Individual	$431.52	1.360	1.571	0.677	1.025	1,179,945.5
	Small Group	$376.01	1.075	1.351	0.747	1.056	555,225.9
	Catastrophic	$181.73	0.416	0.898	0.570	1.000	14,553.4
IL	Individual	$521.54	1.353	1.655	0.670	1.022	4,574,728.0
	Small Group	$481.00	1.169	1.401	0.782	1.078	4,332,054.2
	Catastrophic	$276.57	0.311	0.955	0.570	1.000	16,175.8
IN	Individual	$432.35	1.497	1.699	0.679	1.025	1,990,914.0
	Small Group	$478.69	1.201	1.432	0.719	1.042	1,163,390.3
	Catastrophic	$212.05	0.443	0.931	0.570	1.000	18,104.8
KS	Individual	$465.62	1.547	1.587	0.683	1.027	1,321,665.3
	Small Group	$398.82	1.173	1.383	0.763	1.065	926,003.1
	Catastrophic	$196.43	0.316	0.917	0.570	1.000	16,046.8
KY	Individual	$406.29	1.560	1.671	0.684	1.027	1,114,081.9
	Small Group	$438.82	1.290	1.416	0.736	1.050	715,253.1
	Catastrophic	$151.44	0.290	0.966	0.570	1.000	8,705.0
LA	Individual	$560.40	1.656	1.627	0.682	1.027	1,598,548.5
	Small Group	$438.40	1.236	1.393	0.764	1.066	1,419,619.5
	Catastrophic	$177.94	0.202	1.001	0.570	1.000	5,719.7
MA	Merged	$438.14	1.278	1.506	0.757	1.061	9,221,126.0
	Catastrophic	$206.80	0.311	1.210	0.570	1.000	15,032.7
MD	Individual	$434.52	1.382	1.592	0.688	1.029	2,573,685.1
	Small Group	$431.70	1.097	1.404	0.751	1.060	2,999,578.0
	Catastrophic	$117.56	0.320	0.972	0.570	1.000	100,031.6
ME	Individual	$519.76	1.297	1.729	0.672	1.022	907,572.7
	Small Group	$400.04	0.984	1.478	0.691	1.032	612,132.1
	Catastrophic	$203.98	0.325	1.063	0.570	1.000	10,731.5
MI	Individual	$410.34	1.414	1.659	0.670	1.022	4,296,557.1
	Small Group	$413.11	1.262	1.391	0.793	1.082	4,280,551.8
	Catastrophic	$165.10	0.357	0.972	0.570	1.000	85,303.3
MN	Individual	$557.43	1.225	1.810	0.650	1.017	1,790,594.0

State	Risk Pool	STATE AVERAGE MONTHLY PREMIUMS	STATE AVERAGE PLAN LIABILITY RISK SCORE	STATE AVERAGE ALLOWABLE RATING FACTOR	STATE AVERAGE ACTUARIAL VALUE	STATE INDUCED DEMAND FACTOR	STATE BILLABLE MEMBER MONTHS
	Small Group	$424.44	1.053	1.467	0.740	1.055	3,624,730.1
	Catastrophic	$189.52	0.293	1.019	0.570	1.000	63,185.4
MO	Individual	$479.80	1.577	1.637	0.671	1.022	2,798,925.8
	Small Group	$459.51	1.247	1.399	0.741	1.053	1,305,241.4
	Catastrophic	$207.41	0.369	0.892	0.570	1.000	29,836.2
MS	Individual	$466.02	1.767	1.641	0.705	1.034	968,238.3
	Small Group	$406.37	1.176	1.390	0.754	1.059	283,519.1
	Catastrophic	$213.07	0.624	1.039	0.570	1.000	2,621.9
MT	Individual	$580.64	1.169	1.704	0.653	1.017	667,304.7
	Small Group	$408.70	0.926	1.389	0.715	1.043	587,888.0
	Catastrophic	$227.52	0.296	0.941	0.570	1.000	7,963.6
NC	Individual	$676.28	1.377	1.614	0.685	1.026	5,699,731.5
	Small Group	$496.55	1.127	1.443	0.740	1.053	1,644,869.0
	Catastrophic	$186.76	0.394	0.952	0.570	1.000	143,998.4
ND	Individual	$428.62	1.239	1.525	0.708	1.040	464,774.8
	Small Group	$403.74	1.059	1.286	0.825	1.102	401,725.3
	Catastrophic	$129.37	0.365	0.963	0.570	1.000	28,852.4
NE	Individual	$619.23	1.367	1.583	0.660	1.018	893,129.3
	Small Group	$434.50	1.075	1.376	0.718	1.043	630,988.2
	Catastrophic	$194.79	0.527	0.928	0.570	1.000	40,939.7
NH	Individual	$411.77	1.485	1.589	0.687	1.028	1,152,720.7
	Small Group	$466.53	1.147	1.477	0.734	1.049	621,736.0
	Catastrophic	$135.36	0.235	1.001	0.570	1.000	13,264.7
NJ	Individual	$492.18	1.398	1.638	0.690	1.028	4,064,420.9
	Small Group	$556.58	1.283	1.458	0.749	1.058	4,089,853.2
	Catastrophic	$216.74	0.312	0.997	0.570	1.000	35,315.4
NM	Individual	$385.50	1.313	1.751	0.693	1.031	777,881.1
	Small Group	$440.52	1.170	1.445	0.778	1.073	587,569.1
	Catastrophic	$153.33	0.427	0.963	0.570	1.000	3,815.2
NV	Individual	$382.06	1.358	1.572	0.677	1.025	1,356,104.4
	Small Group	$382.72	1.085	1.341	0.754	1.061	1,159,043.3
	Catastrophic	$160.35	0.323	0.964	0.570	1.000	17,635.2
NY	Individual	$525.48	1.564	0.989	0.731	1.055	3,672,439.6
	Small Group	$640.82	1.559	0.974	0.779	1.076	11,358,808.6
	Catastrophic	$179.97	0.252	0.999	0.570	1.000	168,337.7
OH	Individual	$421.63	1.559	1.712	0.673	1.023	2,965,389.3
	Small Group	$509.74	1.412	1.459	0.734	1.050	1,315,151.0
	Catastrophic	$187.28	0.355	0.977	0.570	1.000	28,975.2
OK	Individual	$620.40	1.713	1.613	0.665	1.020	1,547,419.8
	Small Group	$435.12	1.226	1.415	0.754	1.060	1,613,891.5
	Catastrophic	$222.71	0.395	0.886	0.570	1.000	3,920.2
OR	Individual	$446.09	1.257	1.644	0.677	1.025	2,466,636.3
	Small Group	$409.58	1.055	1.409	0.769	1.069	1,702,815.5

State	Risk Pool	STATE AVERAGE MONTHLY PREMIUMS	STATE AVERAGE PLAN LIABILITY RISK SCORE	STATE AVERAGE ALLOWABLE RATING FACTOR	STATE AVERAGE ACTUARIAL VALUE	STATE INDUCED DEMAND FACTOR	STATE BILLABLE MEMBER MONTHS
	Catastrophic	$181.97	0.278	0.971	0.570	1.000	7,497.9
PA	Individual	$518.50	1.493	1.719	0.703	1.034	5,879,896.8
	Small Group	$499.58	1.284	1.447	0.789	1.080	4,472,054.6
	Catastrophic	$206.55	0.337	1.001	0.570	1.000	32,130.4
RI	Individual	$383.44	1.481	1.682	0.701	1.035	515,671.8
	Small Group	$488.53	1.402	1.482	0.801	1.086	671,614.8
	Catastrophic	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*	*N/A*
SC	Individual	$521.05	1.716	1.663	0.697	1.030	2,402,053.3
	Small Group	$489.92	1.173	1.411	0.742	1.052	816,049.6
	Catastrophic	$224.00	0.336	0.979	0.570	1.000	21,543.5
SD	Individual	$528.78	1.467	1.536	0.674	1.023	420,635.4
	Small Group	$453.61	1.093	1.386	0.718	1.043	390,163.6
	Catastrophic	$219.38	0.323	0.934	0.570	1.000	10,470.8
TN	Individual	$579.17	1.840	1.710	0.673	1.022	2,702,875.0
	Small Group	$405.21	1.198	1.436	0.731	1.050	1,934,091.0
	Catastrophic	$232.50	0.612	1.075	0.570	1.000	25,224.7
TX	Individual	$421.07	1.492	1.588	0.679	1.025	12,448,849.8
	Small Group	$492.61	1.190	1.382	0.732	1.050	7,631,522.0
	Catastrophic	$220.28	0.427	0.944	0.570	1.000	38,753.3
UT	Individual	$335.66	1.227	1.564	0.673	1.023	2,179,792.4
	Small Group	$350.62	1.078	1.409	0.767	1.065	1,386,549.7
	Catastrophic	$186.99	0.514	1.161	0.570	1.000	14,780.4
VA	Individual	$412.89	1.460	1.566	0.683	1.026	4,789,295.5
	Small Group	$446.27	1.155	1.364	0.789	1.081	4,191,643.1
	Catastrophic	$183.55	0.446	1.032	0.570	1.000	80,443.7
VT	Merged	$528.66	1.367	0.981	0.740	1.057	888,959.6
	Catastrophic	$242.91	0.217	0.998	0.570	1.000	3,006.6
WA	Individual	$403.72	1.325	1.671	0.678	1.026	3,356,781.1
	Small Group	$441.77	1.140	1.433	0.768	1.068	2,406,063.9
	Catastrophic	$173.72	0.286	0.991	0.570	1.000	15,173.2
WI	Individual	$528.48	1.451	1.794	0.676	1.024	2,718,698.2
	Small Group	$485.18	1.112	1.406	0.744	1.057	1,226,671.1
	Catastrophic	$192.51	0.308	0.997	0.570	1.000	26,981.2
WV	Individual	$693.60	1.702	1.831	0.687	1.028	400,152.9
	Small Group	$560.12	1.210	1.473	0.747	1.057	198,078.3
	Catastrophic	$297.36	0.516	1.021	0.570	1.000	1,188.2
WY	Individual	$619.53	1.414	1.602	0.674	1.023	312,352.7
	Small Group	$515.15	0.968	1.343	0.720	1.043	101,118.1
	Catastrophic	$286.73	0.276	0.914	0.570	1.000	1,892.4

Table 3 above is also included in Excel format as a separate link, titled Appendix A. The Interim Risk Adjustment State Averages with State Billable Member Months are also provided in Excel format as a separate link, titled Appendix B.

V. HHS-operated Risk Adjustment Geographic Cost Factor (GCF) – Appendix B

The purpose of the geographic cost factor (GCF) adjustment is to remove differences in premium caused by allowable geographic rating variations. GCFs are calculated for each rating area established by the state under 45 C.F.R. § 147.102(b).

The GCFs are calculated based on the observed average silver plan premium for the metal-level risk pool (calculated separately for individual and small group if the state does not have a merged market) or catastrophic plan premium for the catastrophic risk pool, in a geographic area relative to the statewide average silver or catastrophic plan premium. Calculation of the GCF involves three steps. First, the average premium is computed for each silver or catastrophic plan, as applicable, in each rating area (using the same formula that is used to compute plan premiums in the statewide average premium calculation). The second step is to generate a set of plan average premiums that standardizes the premiums for age rating. Plan premiums are standardized for age by dividing the average plan premium by the plan rating factor (calculated at the rating area level), the enrollment-weighted rating factor applied to all billable members. Lastly, a GCF is computed for each rating area. The GCF is simply the ratio of the enrollment-weighted average age-standardized premium revenue for a rating area to the overall statewide enrollment-weighted average age-standardized premium revenue for all silver plans. The enrollment-weighted statewide average of plan GCF values will equal 1.0, so the GCF can be interpreted as the percentage by which any geographic area's costs deviate from the state average.[6]

[6] A GCF of zero indicates no silver plans in the rating area. In final risk adjustment calculations, a GCF of zero will have an imputed value of one.

EXHIBIT B

WEB FIRST

By Paul D. Jacobs, Michael L. Cohen, and Patricia Keenan

Risk Adjustment, Reinsurance Improved Financial Outcomes For Individual Market Insurers With The Highest Claims

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ABSTRACT **The Affordable Care Act (ACA) reformed the individual health insurance market. Because insurers can no longer vary their offers of coverage based on applicants' health status, the ACA established a risk adjustment program to equalize health-related cost differences across plans. The ACA also established a temporary reinsurance program to subsidize high-cost claims. To assess the impact of these programs, we compared revenues to claims costs for insurers in the individual market during the first two years of ACA implementation (2014 and 2015), before and after the inclusion of risk adjustment and reinsurance payments. Before these payments were included, for the 30 percent of insurers with the highest claims costs, claims (not including administrative expenses) exceeded premium revenues by $90–$397 per enrollee per month. The effect was reversed after these payments were included, with revenues exceeding claims costs by $0–$49 per month. The risk adjustment and reinsurance programs were relatively well targeted in the first two years. While there is ongoing discussion regarding the future of the ACA, our findings can shed light on how risk-sharing programs can address risk selection among insurers—a pervasive issue in all health insurance markets.**

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To expand access to insurance coverage, the Affordable Care Act (ACA) reformed the health insurance market for individual coverage. The law subsidizes the purchase of plans, prohibits insurers from denying an applicant coverage because of his or her health status, limits how premiums can vary by applicants' characteristics, and requires that insurers cover a minimum set of health benefits. The intended effect of these and other policies is an individual market (which includes the Marketplaces) where people who are sick can obtain the same coverage, for the same premiums, as people who are healthy.[1]

In an environment where insurers can no longer vary coverage or premiums based on health status, the ACA's risk adjustment program is designed to equalize health-related cost differences across plans. In the absence of risk adjustment, there would be stronger incentives for insurers to avoid covering sick individuals and to attract and retain healthy ones.

Risk adjustment is intended to make the costs of enrolling a healthy versus a sick person equivalent for health plans, and to lead to plan premiums that reflect the average health status of the entire population enrolled in a risk pool, instead of a particular plan's enrollees. Health plan premiums would then vary solely based upon such dimensions as level of coverage and network type, as well as cost or efficiency differences across issuers. Additionally, by reducing insurers' incentives to avoid covering high-cost peo-

ple, the risk adjustment program is designed to encourage insurers to focus on improving quality and reducing premiums through increased cost efficiency. Risk adjustment has long been used in other health insurance markets, including the Medicare prescription drug program, with the aim of leveling the playing field for competing insurers.

Under ACA risk adjustment, plans with healthier enrollees owe funds, while plans with sicker enrollees receive funds. To accomplish this, the risk adjustment program first calculates a risk score, which reflects the degree to which a plan's claims costs are expected to be above or below average because of the health status of its enrollees. The program then uses a formula to translate those health status differences into dollar transfer amounts that are "balanced"—meaning that payments to insurers with sicker-than-average enrollees are equal to (and entirely funded by) amounts owed from insurers with healthier-than-average enrollees.[2–4] Because transfers are balanced, the program does not, in the aggregate, compensate or penalize insurers if plans are systematically mispriced relative to costs.

Risk adjustment is a permanent program that began in 2014. The ACA also created two temporary programs, the reinsurance and risk corridors programs, to help stabilize premiums in the initial three years of the law's implementation. Reinsurance reduces insurers' risk in the individual market by reimbursing a portion of a plan's health spending for high-cost enrollees (those with annual claims totaling $45,000–$250,000 in 2014 and 2015), regardless of whether the plan has healthier or sicker enrollees, on average. In the risk corridors program, the government partially reimburses insurers with large losses and recoups money from insurers with high profits. The effects of the risk corridors program were beyond the scope of this article.

Since the initial results from the ACA risk adjustment program were released in June 2015, questions have been raised about how different types of insurers fared and the extent to which the program achieved its objective of accounting for health risk differences across plans. The American Academy of Actuaries found that in 2014 the risk adjustment program narrowed differences in insurers' financial performance.[5] Other organizations have questioned whether the risk adjustment formula is correctly compensating insurers.[6] Our analysis differs from previous work in using a better measure of health risk (insurers' paid claims costs associated with enrollees in ACA-compliant plans relative to the market average) and in analyzing only the precise set of insurers that were covered by the risk adjustment program operated by the Department of Health and Human Services (that is, all individual market insurers offering ACA-compliant plans).

This article examines results from the 2014 and 2015 risk adjustment and reinsurance programs for ACA-compliant individual market plans. We used data submitted by insurers to the Centers for Medicare and Medicaid Services (CMS) through the External Data Gathering Environment server reports. We examined how risk adjustment and reinsurance transfers varied across insurers, and we assessed how these program payments compared across insurers given their level of per enrollee claims costs. We found that for the 30 percent of insurers with the highest claims in 2014 and 2015, before risk adjustment, claims exceeded premium revenues by $90–$397 per enrollee per month. After revenues from risk adjustment and reinsurance were incorporated, this effect was reversed, with revenues exceeding claims by $0–$49 per enrollee per month. The transitional reinsurance program will reimburse insurers for high-cost enrollees covered before 2017. There is ongoing discussion regarding the future of the ACA, but our findings remain pertinent for understanding how risk-sharing programs can address risk selection among insurers, which is a pervasive issue in all health insurance markets.

Study Data And Methods

While both the individual and small-group markets are included in the risk adjustment program, we limited our analysis to the individual market. Because the potential for risk selection is greater when risks are not pooled across employer groups, the role of risk adjustment is particularly important in the individual market. Because of the very small number of people enrolled in catastrophic plans, we also excluded these, which are treated separately in the risk adjustment program.

We analyzed the data CMS received from insurers to calculate risk adjustment and reinsurance payments.[7] The data came from all states except Massachusetts, which operated its own risk adjustment program in 2014 and 2015. CMS received data at the plan level within each state. To assess insurers' financial performance, we conducted analyses at the insurer level within each state by calculating weighted averages using the number of enrollee-months across all plans offered by each insurer. Summary statistics presented in the text were weighted by the number of enrollee-months at the insurer level.

Our final data set included 468 insurer observations in 2014 and 533 in 2015. To assess the

Under ACA risk adjustment, plans with healthier enrollees owe funds, while plans with sicker enrollees receive funds.

overall impact in the initial two years, we combined both years in the analyses. As shown in online Appendix Exhibit 1,[8] results were quite similar when computed separately for each year.

We expressed risk adjustment transfers in dollars per enrollee per month. Positive values for transfers indicated that the insurer was a net recipient of funds across its plans; negative values indicated that the insurer owed payments to the risk adjustment program. By design, all risk adjustment transfers within a state market risk pool summed to zero. We also showed average revenues received through the reinsurance program—which, because reinsurance payments are funded primarily from outside the individual market, are always positive.

DIFFERENCES BETWEEN REVENUES AND CLAIMS COSTS We calculated revenues before risk adjustment and reinsurance, using reported premiums per enrollee per month. We also calculated the difference between revenues and claims costs, or the "revenue-claims difference." A negative revenue-claims difference indicated that before any reinsurance and risk adjustment transfers, the value of an insurer's paid health care claims exceeded its revenues.

To gauge how well the reinsurance and risk adjustment programs reimbursed insurers, we defined two additional measures: revenue-claims differences after reinsurance and revenue-claims differences after reinsurance and risk adjustment. The former incorporated any reinsurance amounts the insurer received as revenues. The latter additionally incorporated any risk adjustment receipts as positive revenues and any payments owed as negative revenues. We compared how each of these concepts varied by the health risk of an insurer's enrollees, as defined by per enrollee claims costs relative to the state average. We analyzed revenue-claims differences because these represent costs incurred by insurers that were not reimbursed through premium revenues.

Insurers with positive revenue-claims differences after risk adjustment and reinsurance transfers were incorporated were not necessarily profitable in the ACA individual market. This is because in addition to claims costs, insurers incur administrative and other expenses, and because of data limitations, these expenditures were not included in our analysis. An insurer's revenue-claims difference is related to its medical loss ratio, which is the ratio of paid claims costs (and other qualifying expenses) to premium revenues after risk adjustment and reinsurance payments are incorporated. Risk adjustment was intended to transfer funds to plans whose enrollees had greater overall health risk from plans whose enrollees had lesser health risk, and not to reimburse any set percentage of losses. Thus, unlike the medical loss ratio, we expressed revenue-claims differences in dollars rather than as a percentage of premiums.

HEALTH RISK As a proxy for the health risk of enrollees, we calculated the claims that the insurer paid, on average, per month of enrollment. Because claims may vary for reasons other than health risk, in Appendix Exhibit 2[8] we show the sensitivity of our results to using instead the percentage of an insurer's enrollees with at least one health condition. Results were quite similar for both measures.

CHARACTERISTICS OF INSURERS We assessed how revenue-claims differences varied by the size of the insurer and the percentage of its enrollees covered by relatively more generous plan benefit designs, as indicated by the plan's actuarial value or "metal" tier.[9] We also showed these differences by whether the parent insurance company offered Medicare Advantage plans, operated a Medicaid managed care organization (MCO), or sold plans exclusively outside of the Marketplaces.[10] We categorized insurers as offering Medicare Advantage plans or an MCO if they were either a solely owned Medicare Advantage or an MCO company or if they were a parent company that owned either a Medicare Advantage or an MCO subsidiary.

Revenue-claims differences before and after the risk adjustment and reinsurance payments were incorporated may vary by an insurer's type of parent company for a number of reasons, including how provider networks are structured or the cost of their enrollees. For example, compared to other insurers, MCOs likely had narrower networks, lower payment rates to providers, or networks with different types of physicians. And insurers exclusively selling outside of the Marketplaces, where premium tax credits were unavailable, may have had enrollees with

higher incomes than insurers with disproportionate enrollment in the Marketplaces.

Finally, we calculated revenue-claims differences by two types of state characteristics: whether the insurer's state had adopted the ACA's expansion of Medicaid eligibility and whether the state allowed individuals to remain in "transitional" plans. Transitional plans are those that had been in effect between March 2010 and October 1, 2013; were not subject to all ACA standards; and were not required to make or receive risk adjustment transfers.[11]

LIMITATIONS Our analysis had several limitations. First, the data in the External Data Gathering Environment server reports are aggregated to the plan level, which prevented us from analyzing individual determinants of health risk or assessing how the risk adjustment model could be improved. Second, in 2014 and 2015, the early years of ACA reform of the individual market, some insurers were still learning how to gather, aggregate, and submit data to CMS. If incomplete data were submitted, risk scores or reinsurance revenues might have been lower than they would have been if complete data were available. Third, we were not able to measure the breadth of provider networks or plan efficiency, both of which could affect claims costs.

Finally, our measure of revenues reflected insurer pricing in the first few years of the Marketplaces, and many insurers appeared to underprice their plans, leading to financial losses. Insurers may have underestimated the health risk of Marketplace enrollees, set premiums without knowing how their enrollees' health risk would compare to that in the overall Marketplace, deliberately underpriced plans to gain market share, or—in states that allowed enrollees to renew pre-ACA individual market policies—experienced more risk segmentation (that is, healthier people might have been more likely to stay enrolled in transitional plans, compared to sicker people). While our analysis did not directly address these issues, it is possible that premium setting changed in subsequent years, as insurers became better accustomed to the overall health risk in the Marketplaces and the risk adjustment program.

Study Results

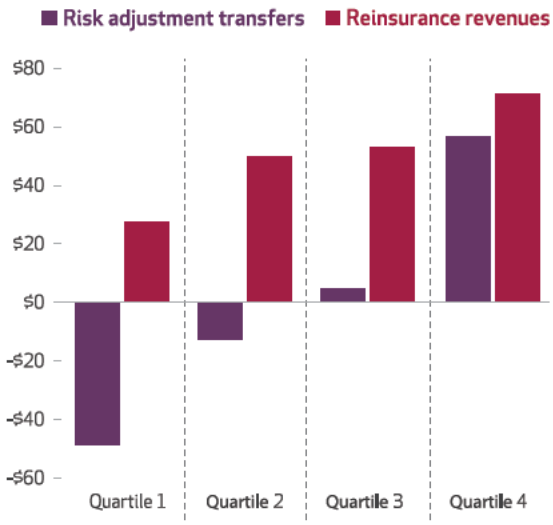
RISK ADJUSTMENT AND REINSURANCE PAYMENTS BY CLAIMS COSTS Receipts from risk adjustment and reinsurance varied greatly, depending on the insurer's paid claims costs per enrollee and the percentage of its enrollees with one or more health conditions (Appendix Exhibit 2).[8] For the risk adjustment program, on average, insurers in the lower two quartiles of paid claims per enrollee per month owed funds (and thus had negative risk adjustment transfers), while insurers in the higher two quartiles received funds (and thus had positive risk adjustment transfers) (Exhibit 1). Insurers in the lowest quartile owed the risk adjustment program $48 per enrollee per month, while insurers in the highest quartile received $56 per enrollee per month through risk adjustment. Transfers were much smaller in magnitude for insurers in the middle two quartiles. Consequently, most of the revenues transferred through the risk adjustment program went from insurers with relatively low paid claims to insurers with relatively high paid claims.

As noted above, reinsurance payments are always positive. On average, reinsurance revenues were higher when insurers had higher paid claims. Insurers in the highest quartile received more than two times what insurers in the lowest quartile received.

DIFFERENCES BETWEEN REVENUES AND CLAIMS COSTS BEFORE AND AFTER RISK ADJUSTMENT AND REINSURANCE For insurers in the lowest decile of claims costs in 2014 and 2015 (less than 47 percent of the average for their state), revenues exceeded claims by $171 per enrollee per month, on average (Exhibit 2). For insurers in

EXHIBIT 1

Per enrollee per month risk adjustment transfers and reinsurance revenues for insurers offering plans compliant with the Affordable Care Act, by quartile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** A positive value for risk adjustment transfers indicates that insurers were due to receive risk adjustment funds. A negative value indicates that insurers owed risk adjustment payments. Quartiles of paid claims costs were calculated relative to the state average.

the highest decile of claims costs (more than 193 percent of the average), the reverse was true: Claims exceeded revenues by $397 per enrollee per month, on average. Accounting for reinsurance funds increased revenues across the deciles of insurers. As expected, insurers in the highest decile saw the largest change, with the revenue-claims difference narrowing from −$397 to −$222 per enrollee per month. For insurers in the lowest decile, reinsurance had a much smaller effect, as expected (changing only from to $171 to $181).

Incorporating the effects of risk adjustment transfers tended to move the revenue-claims difference closer to $0 for insurers across all deciles (Exhibit 2). For insurers in the lowest decile, the difference decreased from $181 to $67 per enrollee per month. For insurers in the highest decile, the difference increased considerably, from −$222 to $6 per enrollee per month. More broadly, before risk adjustment and reinsurance, we found that for the 30 percent of insurers with the highest claims in 2014 and 2015, claims exceeded premium revenues by $90–$397 per enrollee per month. After revenues from risk adjustment and reinsurance were incorporated, this effect was reversed, with revenues exceeding claims by $0–$49 per enrollee per month. While the increase in revenues after incorporating reinsurance and risk adjustment was most pronounced for the insurers in the highest decile, sizable increases were evident for the 60 percent of insurers who had negative revenue-claims differences before considering the effects of these programs.

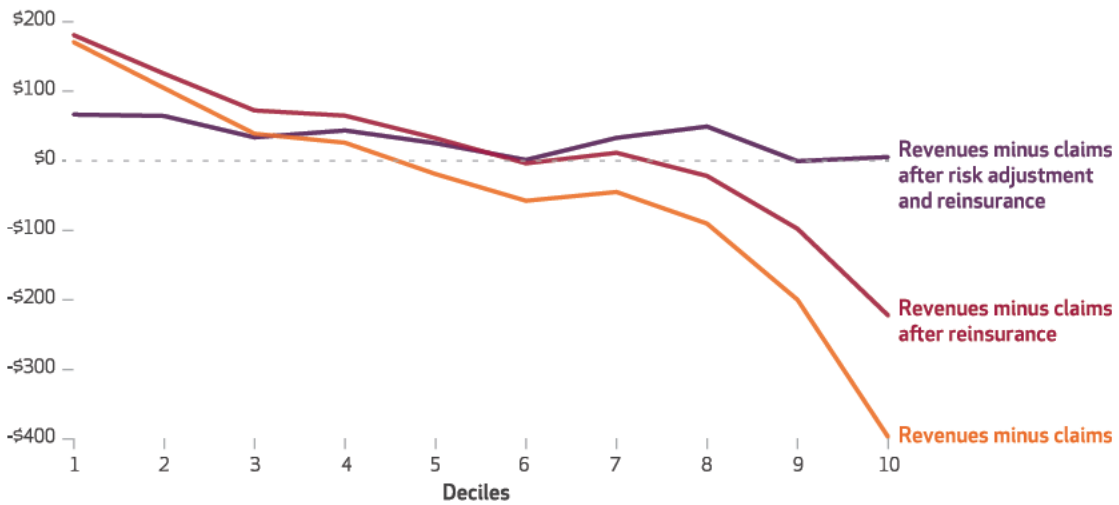
After both reinsurance and risk adjustment payments were incorporated, among insurers in the highest decile of claims costs, revenue-claims differences in the twenty-fifth to seventy-fifth percentiles increased substantially, approaching zero or becoming positive for some insurers (Exhibit 3). And of the insurers that began with positive revenue-claims differences, those in the twenty-fifth to seventy-fifth percentiles had differences that generally stayed positive after the effects of risk adjustment and reinsurance were included.

We also examined how revenue-claims differences varied by the characteristics of insurers, both before and after the effects of risk adjustment and reinsurance were considered. Before reinsurance and risk adjustment, there were substantial differences across types of issuers in revenues minus claims, but after transfers from reinsurance and risk adjustment were considered, performance was much more similar across issuers (Exhibit 4).

Specifically, we found that small insurers—

EXHIBIT 2

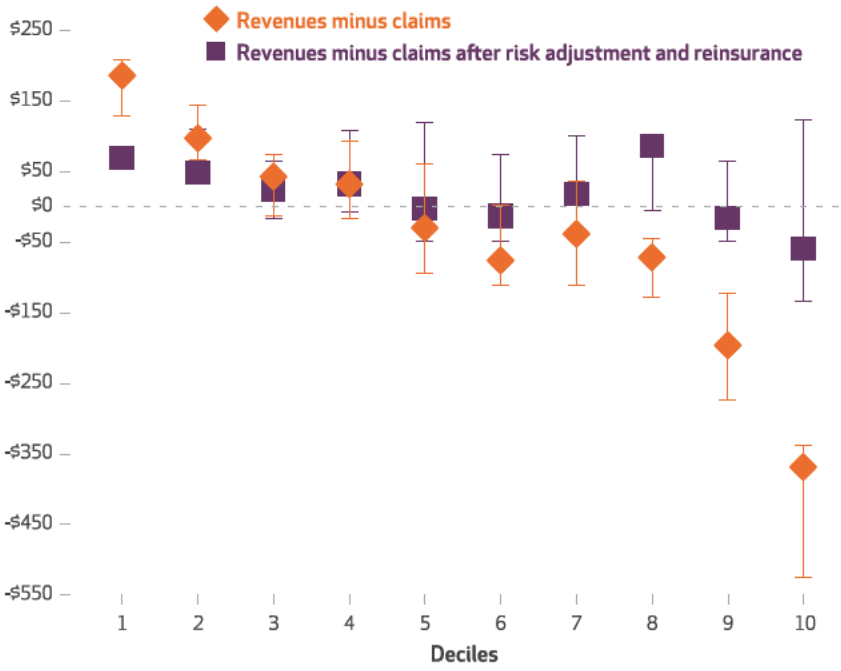
Per enrollee per month differences between revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by decile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** "Revenues minus claims" refers to average premium revenues minus average claims. "Revenues minus claims after reinsurance" includes any reinsurance amounts the insurer received as revenues. "Revenues minus claims after risk adjustment and reinsurance" also includes any risk adjustment receipts or payments as positive or negative revenues, respectively. Deciles of claims relative to average claims in the insurer's state were unweighted to ensure that each decile contained an equal number of insurers (100 insurers were in each decile). The deciles are (from 1 to 10) <47 percent, 47 <67 percent, 67 <82 percent, 82 <91 percent, 91 <101 percent, 101 <109 percent, 109 <125 percent, 125 <148 percent, 148 <193 percent, and ≥193 percent.

EXHIBIT 3

Distribution of per enrollee per month differences between revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by decile of paid claims, 2014–15



SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** "Revenues minus claims" and "revenues minus claims after risk adjustment and reinsurance" are explained in the Exhibit 2 Notes. The bars represent the twenty fifth to the seventy fifth percentiles. Deciles of claims relative to average claims in the insurer's state were unweighted to ensure that each decile contained an equal number of insurers (100 insurers were in each decile). The deciles are explained in the Exhibit 2 Notes.

those with fewer than 5,000 full-year-equivalent enrollees—benefited the most from risk adjustment. While these insurers had a revenue-claims difference of –$81 per enrollee per month, on average, before risk adjustment and reinsurance payments were incorporated, that difference was $46 after these payments were incorporated. Before the effects of the two programs were considered, the revenue-claims differences varied from –$81 to –$17 per enrollee per month depending on the number of full-year-equivalent enrollees, but the differences varied only from $24 to $46 after risk adjustment and reinsurance revenues were included.

Before the reinsurance and risk adjustment payments were considered, insurers with less than 10 percent of their enrollees in gold and platinum plans had a positive revenue-claims difference ($11 per enrollee per month), which contrasted with the negative differences for insurers with higher shares of enrollees in gold and platinum plans. However, after the revenues from risk adjustment and reinsurance were incorporated, revenue-claims differences were positive for all of these groups and roughly similar, ranging from $23 to $33 per enrollee per month.

Before risk adjustment and reinsurance program revenues were incorporated, revenue-claims differences varied from –$85 to $4 per enrollee per month depending on the insurer's type of parent company. After those revenues were included, average revenue-claims differences were positive for all insurers, regardless of their type of parent company, and ranged only from $26 to $50. Furthermore, the rank ordering of revenue-claims differences did not change for the types of parent companies.

Before risk adjustment and reinsurance payments were incorporated, insurers operating in states that allowed transitional policies had large negative revenue-claims differences, in both states that had expanded eligibility for Medicaid (–$35) and those that had not (–$58). In contrast, in states that did not allow transitional policies, revenue-claims differences were larger, whether the states had expanded eligibility for Medicaid ($39) or not (–$5). Because risk adjustment transfers are balanced, these amounts changed only because of the effects of reinsurance.

Discussion

Risk adjustment and reinsurance are important mechanisms for fostering competition and reducing adverse selection when consumers choose from competing health plans. We studied the first two years of risk adjustment and reinsurance under the ACA and assessed how the differences between insurers' revenues and claims costs changed after risk adjustment and reinsurance payments across a range of insurer characteristics, including claims costs, insurer size, and type of parent company, were accounted for.

Risk adjustment and reinsurance payments varied with insurers' enrollee health mix, as measured by average claims costs and the percentages of enrollees with one or more health conditions (Exhibit 1 and Appendix Exhibit 2).[8] Insurers with below-average claims costs owed risk adjustment funds, while insurers with above-average claims costs received funds—with the highest payments coming from insurers with the lowest claims costs and the smallest percentages of enrollees with one or more health conditions. By contrast, reinsurance payments were positive for insurers across the claims distribution, reflecting the fact that, on average, all groups had some enrollees with high individual claims costs. Payments were greater for insurers with higher overall claims costs and a higher

EXHIBIT 4

Differences between per enrollee per month revenues and claims costs for insurers offering plans compliant with the Affordable Care Act, by insurer characteristics, 2014–15

Characteristic	Percent of enrollees	Difference before risk adjustment and reinsurance	Net gain from reinsurance	Net gain from risk adjustment	Difference after risk adjustment and reinsurance
All insurers	100	$21	$50	$ 0	$30
SIZE (NUMBER OF FULL-YEAR-EQUIVALENT ENROLLEES)					
Small (fewer than 5,000)	3	81	78	50	46
Medium (5,000 to fewer than 10,000)	3	55	62	16	24
Large (10,000 or more)	93	17	49	2	29
PERCENTAGE OF ENROLLEES IN GOLD AND PLATINUM TIERS					
Less than 10%	31	11	42	22	31
10–25%	39	21	52	2	33
More than 25%	29	55	57	21	23
TYPE OF PARENT COMPANY					
Medicaid MCO	59	4	47	1	50
Participates in Medicare Advantage	82	14	50	0	36
Has only off-Marketplace plans	5	85	72	39	26
STATE ALLOWED TRANSITIONAL POLICIES AND EXPANDED MEDICAID					
Allowed policies and expanded	22	35	50	0	15
Allowed policies and did not expand	43	58	56	0	3
Did not allow policies and expanded	31	39	45	0	84
Did not allow policies and did not expand	5	5	38	0	33

SOURCE Authors' analysis of data for 2014–15 from the External Data Gathering Environment server reports of the Centers for Medicare and Medicaid Services. **NOTES** Amounts are rounded to the nearest whole dollar. "Revenues minus claims" and "revenues minus claims after risk adjustment and reinsurance" are explained in the Exhibit 2 Notes. "Full year equivalent enrollees" denotes member months divided by twelve. Medicaid managed care organization (MCO) refers to an insurer that, either directly or through a subsidiary, offered managed care plans that covered Medicaid beneficiaries in the same state. Transitional plans are those that had been in effect between March 2010 and October 1, 2013, when the first Marketplace open enrollment period began, and were allowed to continue operating. They are not required to make or receive risk adjustment transfers and are not subject to all ACA standards.

share of enrollees with one or more health conditions.

To assess how program payments affected the relationship between insurers' revenues and claims costs, we compared the revenue-claims differences of insurers before and after accounting for revenues from the risk adjustment and reinsurance programs. For insurers in higher claims deciles, revenue-claims differences increased considerably after revenues from the two programs were incorporated. Moreover, the extent of those transfers appeared roughly proportional to the magnitude of the revenue-claims differences. The 30 percent of insurers with the highest per enrollee per month claims costs had revenue-claims differences that varied, on average, between –$397 and –$90 before risk adjustment and reinsurance payments were considered. Revenue-claims differences for these insurers varied between $0 and $49 after those revenues were included.

After the inclusion of risk adjustment and reinsurance payments, revenue-claims differences moved closer to zero for insurers that had either relatively low or relatively high claims costs. In particular, the differences narrowed after risk adjustment payments were incorporated (Exhibit 2). For the insurers with the lowest claims, revenues declined after these payments were incorporated, while for the insurers with the highest claims, revenues increased. This shift is consistent with a key intended impact of risk adjustment: to equalize health-related spending across both insurers that had enrollees with high health risks and those that had enrollees with low health risks.

Insurers with the highest claims costs saw the largest gains from the reinsurance program, which was a direct result of that program's goal to reimburse insurers for their high-cost enrollees. Because reinsurance transfers were funded primarily from outside the individual market, this program shifted revenue-claims differences positively across the distribution of insurers, when ranked by per enrollee claims costs. Of course, because insurers set premiums with an expectation of receiving revenues from the program, premiums were likely deliberately set lower than they would have been in the absence of a reinsurance program, reducing revenue-claims differences before incorporating reinsurance revenues. This may be one reason why, before reinsurance or risk adjustment payments were considered, the average revenue-claims differ-

ence across all insurers was negative (Exhibit 4). Additionally, these negative differences may reflect the effects of risk segmentation arising from transitional policies in some states.

We found strong evidence that while insurers with higher paid claims costs were systematically receiving funds from the risk adjustment program, the revenue-claims differences for insurers with lower paid claims costs largely remained positive even after risk adjustment payments were incorporated. In fact, for insurers with the most positive revenue-claims differences before payments from the risk adjustment and reinsurance programs were incorporated, the middle of the distribution of those differences largely remained positive after those payments were incorporated (Exhibit 3). Furthermore, our analysis of the distribution of insurers' financial outcomes in Exhibit 3 demonstrated that our main findings in Exhibit 2 were consistent across the distribution of issuers and not driven by the presence of a few insurers with anomalous outcomes that disproportionately influenced the averages.

We also considered how revenue-claims differences changed after risk adjustment and reinsurance payments were incorporated, depending on insurer characteristics. Across the range of insurer types we studied, we found that insurers whose claims initially exceeded revenues by the largest amounts experienced the largest net gains from risk adjustment and reinsurance. As a result, differences between revenues and claims narrowed across all of the types of insurers we studied after risk adjustment and reinsurance payments were incorporated.

In particular, insurers with different types of parent companies (Medicaid MCOs, those participating in Medicare Advantage, and insurers with only off-Marketplace plans) likely set up provider networks of varying breadths or attracted different types of enrollees. Nevertheless, these groups ended up with revenue-claims differences after risk adjustment and reinsurance payments that were much closer to one another than before the payments. Moreover, the rank ordering of those differences did not change after revenues from the two programs were incorporated. The absence of any change in rank ordering suggests that the risk adjustment program compensated insurers with the largest claims without indiscriminately burdening insurers with a leaner cost structure. Given the importance of the risk adjustment program in incentivizing insurers to be competitive and efficient while removing incentives to use risk selection, further research on this issue is warranted.

At a broad level, the incentives to focus on risk selection have been attenuated by the risk adjustment program.

Conclusion

There is currently a policy debate about the future of the ACA. Our analysis can inform this debate, particularly because any policy approach that relies on private health insurers' competing for enrollees will have to consider ways to address the effects of risk selection in insurance markets. Based on the experience within the structure of the Marketplaces, our results suggest that the risk adjustment and reinsurance programs were relatively well targeted in the first two years. Before risk adjustment and reinsurance transfers, insurers whose enrollees had high levels of health risk had substantially worse financial performance, compared to insurers whose enrollees had lower levels of risk. After the transfers, financial results were much more similar across insurers. Similarly, before the transfers, insurers with fewer enrollees had substantially worse results, compared to those with more enrollees. The transfers largely equalized the results, on average, between these groups of insurers. While insurers will still likely exercise the discretion they have to retain or attract particular types of enrollees, our findings suggest that, at a broad level, the incentives to focus on risk selection have been attenuated by the risk adjustment program.

In the near term, health care costs, state policies, and enrollment patterns across plans will also change in ways that will likely necessitate continued scrutiny to ensure that costs related to health risk are being sufficiently compensated. For example, CMS has finalized changes to the 2017 risk adjustment methodology, updating it to better reflect the costs of emerging treatments.[12] CMS has also finalized changes to the 2018 methodology, such as incorporating additional information about health risk from prescription drug use, partially compensating insurers for very high claims costs, and account-

ing for enrollees' duration of enrollment.[13] In addition, Alaska has enacted legislation to establish a state-funded program to help reimburse insurers for high-cost claims, and CMS has expressed interest in Alaska's approach.[14] Our results may be of interest to policy makers considering ways to structure risk adjustment and reinsurance programs to promote competition in health insurance markets. ■

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NOTES

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8 To access the Appendix, click on the Appendix link in the box to the right of the article online.

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