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/WPL

DEFENDANTS' REPLY IN SUPPORT OF CROSS-MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Plaintiff New Mexico Health Connections' ("NMHC's") combined reply and opposition brief confirms that it seeks what is not allowed under the Administrative Procedure Act ("APA"): to undo five years of highly technical, exhaustively considered, and eminently reasonable policy choices by the Department of Health and Human Services ("HHS" or the "Department") based on hindsight and the self-interest of a handful of healthier-than-average plans that set their premiums too low to cover their share of actuarial risk. The impropriety of that request is highlighted by the fact that the Department *has already addressed*—and continues to carefully monitor and consider—all of the material concerns NMHC raises in this lawsuit (as well as the countervailing concerns that NMHC seeks to disregard). When those facts are accounted for, what is left of this case is a request for the Court to unwind the risk adjustment program since its inception solely so that the matter can be remanded to the agency to: (1) consider—again—alternatives to the state average premium, though NMHC cannot actually identify an alternative that would meet its reading of section 1343, (2) consider—again—the temporary adjustment proposed by Richard Foster, though the Department reasonably rejected that proposal as likely to cause distortions in the model, and (3) continue to "grapple" with the effect of the risk adjustment methodology on Bronze plans, an issue the Department is already monitoring.

NMHC's reply brief contains nothing that would justify such extraordinary and burdensome relief; it merely highlights the flaws in its theories. For example, unable to deny the fact that its preferred alternative to the state average premium—use of an issuer's own premium—would reward gaming and either require additional funding Congress did not provide or encourage plans to avoid sick enrollees, NMHC now abandons its argument that the Department is required

to adopt that approach and argues instead that the agency is "free to consider" other alternatives on remand. But even putting aside the fact that the agency already has considered such alternatives at length, and the heightened deference due that consideration, the only other alternative identified by NMHC (average claims costs) would not do what NMHC says the methodology must do, which is to isolate the costs of risk selection from those attendant to inefficient network design and care management. The reason is simple: perfectly isolating, for each plan, costs that flow from "inefficiency" rather than risk selection is not required by the statute or realistic for a real-life, self-funding model that must be applied to hundreds of plans. And the fact that NMHC cannot identify an alternative that would achieve such precision is proof that Congress did not require it.

NMHC's remaining claims are equally meritless. NMHC focuses on the tendency of the model from 2014-2016 to slightly under-predict the costs of healthy people and over-predict the costs of sick people, but not only is this claim (like all of NMHC's claims) based on hindsight, NMHC still cannot say why the model does so, whether it will continue to do so now that the Department has refined the model to include preventive health costs, or what should be done to fix it without causing distortions along other dimensions of the model. NMHC likewise has not established that the Department's duly-considered approaches to pharmacy data, partial-year enrollment, and Bronze plans either were unreasonable when adopted or are unreasonable now.

Unable to show that any methodological choice made by the Department is arbitrary, capricious, or contrary to statute, NMHC resorts to hyperbole and straw man argument. It suggests that risk adjustment is to blame for the market-wide instability in the health insurance markets, even when there is broad consensus that such instability is caused by a sicker-than-expected risk pool, whose costs far exceeded the charges NMHC claims were too high. It argues that the

Department's decision to update the program in recent years shows that the original model was arbitrary, even though it has elsewhere acknowledged that "[t]he risk adjustment . . . program[] [was] designed with considerable thought and care" and "[e]very risk adjustment program in use today . . . has gone through such reviews and adjustments." Consumers for Health Options, Insurance Coverage in Exchanges in States ("CHOICES") letter to Hon. Sylvia Burwell re 2017 Proposed Rule (Nov. 4, 2015), at 2, AR008635. And it suggests that the Court need not worry about the impact of its requested relief because the Department's concerns about unwinding a program that has transferred billions of dollars between insurance plans is mere "hand-wringing."

NMHC is wrong on all of these points. Retroactively unwinding a self-funding risk-spreading program affecting an entire industry so that the Department can reconsider issues it has already exhaustively considered and reasonably implemented is neither allowed under the APA nor fair to the hundreds of plans that relied on risk adjustment to offset the costs of their sicker-than-average membership. Judgment should be granted for the Department.

ARGUMENT

I. HHS's Use of a State Average Premium as a Cost Factor in the Transfer Formula is Consistent with the Statute and Reasonable.

A. The Statute Does Not Preclude Use of a State Average Premium, Much Less "Clearly" and "Directly" So.

On reply, NMHC continues to ignore both the legal standard and the statutory text governing its claim that use of an adjusted state average premium as a component of the risk adjustment transfer formula is statutorily precluded. To prevail on this claim, NMHC must show that Congress "*unambiguously*" and "*directly* addressed the *precise* question" of how the Department must measure cost in the transfer formula. *Chevron, U.S.A., Inc. v. Nat. Res. Def.*

Council, Inc., 467 U.S. 837, 843 (1984) (emphasis added). But Congress's only direct and unambiguous statutory command regarding transfer calculations is that they "[u]s[e] the criteria and methods developed" by the Secretary. 42 U.S.C. § 18063(a); *see also id.* § 18063(b). Section 1343 nowhere "directly" and "unambiguously" addresses whether the Department can use a state average premium to project the costs of actuarial risk. In fact, NMHC concedes that section 1343 is "silen[t] on the exact configuration of the payment formula." Pl.'s Reply & Opp'n to Defs.' Cross-Mot. for Summ. J. ("Pl.'s Reply") at 9 n.10, ECF No. 40. The statutory analysis ends there.

Instead of ending there, NMHC suggests that in the face of congressional silence, the Court should supply its own interpretation based on the "the sole indicia of Congressional intent" in the statute. *Id.* This is the opposite of what the Court must do. When a statute is silent, "the court does *not* simply impose its own construction"; rather, it defers to the agency unless the agency's construction is unreasonable. *Chevron*, 467 U.S. at 843 (emphasis added); *see, e.g.*, *Banner Health v. Burwell*, 126 F. Supp. 3d 28, 73 (D.D.C. 2015) (deferring to agency because "[t]he statute does not directly tell the agency how to set the fixed loss threshold").[1]

Unable to refute these points, NMHC first contends that risk adjustment transfers under the Department's current methodology are "not based on actuarial risk." Pl.'s Reply at 7. That is plainly wrong: a plan's risk score is the very first variable in the transfer calculation. *See* HHS Notice of Benefit and Payment Parameters for 2014 ("2014 Rule"), 78 Fed. Reg. 15,410, 15,430

[1] This standard is often referred to as the Chevron "two-step." *See, e.g., S. Utah Wilderness All. v. Dabney*, 222 F.3d 819, 824 (10th Cir. 2000). In step 1, the court asks whether the statute speaks "to the precise question at issue." *Id.* If the statute is silent or ambiguous, the court proceeds to step 2, where it "defer[s] to the agency's interpretation, if it is a permissible one." *Id.* Step 2 is coextensive with arbitrary and capricious review, addressed in the next section. *Judulang v. Holder*, 565 U.S. 42, 52 n.7 (2011).

(Mar. 11, 2013) ("The payment transfer formula includes the following premium adjustment terms: *Plan average risk score*[.]" (emphasis added)). Indeed, in the same sentence in which NMHC attacks risk adjustment as "not based on actuarial risk," it admits that risk adjustment transfers are calculated by "multiplying *relative actuarial risk* against the statewide weighted average premium." Pl.'s Reply at 7 (emphasis added). The Department's methodology is, unquestionably, based on actuarial risk.

Second, NMHC asserts that, "according to HHS, once it divides insurers into creditors and debtors in the risk adjustment program, it can set the amount of those payments and credits however it pleases." *Id.* But the question here is not whether the Department can calculate risk adjustment transfers in "any manner it pleases" (and the Department has never argued that it can) but whether the text of section 1343 "unambiguously" and "directly" precludes use of a weighted average premium to approximate the costs (and cost-savings) of risk selection. It does not.

Third, NMHC complains that the Department "does not even try to rebut [its] evidence" that the state average premium "artificially inflate[s]" risk adjustment charges for certain plans. Pl.'s Reply at 8. However, NMHC's so-called evidence on this point—which consists of the opinions of NMHC, its trade group, and their consultants, years after the state average premium was adopted, that an issuer-specific premium is preferable, *id.* at 7—is irrelevant to whether the text of section 1343 "unambiguously" and "directly" precludes the state average premium.

Finally, NMHC argues that the Court should read section 1343 to prohibit use of the state average premium because NMHC was required to pay a large percentage of its premiums in risk adjustment charges. *Id.* at 9. But that merely shows that NMHC had an unusually healthy group of enrollees—and thus is required to pay risk adjustment, consistent with congressional intent—

but set its premiums too low to cover its share of the costs of the sicker individuals that enrolled in other New Mexico plans. HHS Notice of Benefit and Payment Parameters Proposed for 2018 ("2018 Proposed Rule"), 81 Fed. Reg. 61,456, 61,488 (Sept. 6, 2016), AR009546. It does not show that use of the state average premium violates the statute. NMHC's quarrel here is not with the state average premium but with Congress' decision under section 1343 to redistribute the costs of sicker enrollees and its own rating practices. NMHC's statutory argument should be rejected.

B. The Department's Use of a State Average Premium is Reasonable.

NMHC's claim that the state average premium is arbitrary and capricious fares no better. NMHC first reiterates its contention that the state average premium "sweeps in . . . many factors unrelated to actuarial risk," such as how effectively "a plan negotiates prices with [providers]" and "manages its members' medical costs[.]" Pl.'s Reply at 11. NMHC believes that by failing to isolate these cost factors for each plan, the state average premium "undermines the ACA's policy of promoting competition and innovation to reduce premiums." *Id.* As the Department has shown, however, if a plan can cut costs without also driving away sicker enrollees, it should *profit* from the use of the state average premium, a point NMHC fails to address. Defs.' Mem. in Supp. of its Cross-Mot. for Summ. J. ("Defs.' Mem.") at 24, ECF No. 35. The state average premium thus fully preserves incentives to control costs while also meeting the health needs of sicker enrollees.

Nor can NMHC identify an alternative to the adjusted state average premium presently in use that would exclude the cost factors it claims should be isolated from the transfer equation. As the Department has shown, NMHC's preferred approach—use of an issuer's own premium—would not do so, nor would it be predictable. Instead, it would merely encouraging gaming in rate-setting and lead to an inevitable shortfall between payments and charges that would not be

calculable until years after issuers had set their rates and could result in even higher charges to healthy plans. Defs.' Mem. at 20-24. NMHC's proposal to bridge that shortfall by reducing payments to sicker plans would encourage health insurers to dodge sick people, precisely the outcome section 1343 seeks to prevent. *See* HHS Notice of Benefit and Payment Parameters for 2014, Proposed Rule ("2014 Proposed Rule"), 77 Fed. Reg. 73,118, 73,119 (Dec. 7, 2012), AR000114. And NMHC's alternative suggestion that government pick up the tab for any shortfall not only ignores the lack of any appropriation for that purpose,[2] but would do nothing to deter gaming or adverse selection; it would simply shift the costs of those behaviors to the government.[3]

Essentially conceding that its preferred alternative to the state average premium would fare no better than the adjusted state average premium in isolating cost factors that influence risk selection (and would fare far worse along other dimensions), NMHC now retreats from its argument that the Department is required to use an issuer's own premium and suggests instead that

[2] NMHC continues to deny that the program must be self-funded. Pl.'s Reply at 15. But it cannot deny that Congress established the program as a system of monetary transfers that could be operated by states without the necessity for external funding. *See* 42 U.S.C. § 18063. Nor does it contend that the Department was *required* to use its program management appropriations on the program. That should be the end of the inquiry.

[3] NMHC's only response to these arguments is to deny that the risk adjustment program seeks "to prevent plans from dodging sicker enrollees." Pl.'s Reply at 14-15 (emphasis omitted). It is generally understood, however, that risk adjustment programs aim to reduce incentives for plans to avoid sick enrollees, and both the Department and stakeholders have consistently interpreted section 1343 to do so. *See*, *e.g.*, 2014 Proposed Rule, 77 Fed. Reg. at 73,119, A.R.000114, ("the risk adjustment program is intended to . . . reduce the incentives for issuers to avoid higher-risk enrollees"); 2018 Proposed Rule, 81 Fed. Reg. at 61,460, A.R.009518 (same); Nat'l Council of Urban Indian Health comment to 2014 proposed rule (Dec. 31, 2012), AR003150 ("risk adjustment . . . reduce[s] incentives for health plans to avoid higher-risk enrollees."); Ass'n for Cmty. Affiliated Plans ("ACAP"), Improving Risk Adjustment in Health Insurance Exchange to Ensure Fair Payment (Nov. 28, 2012), at 9, AR003178 ("Effective risk adjustment encourages plans to take on . . . people with greater needs rather than avoiding them because they are bad risks.").

"[t]here may be other[]" alternatives that the Department "is free to consider . . . on remand" such as average "claims costs." Pl.'s Reply at 9 n.11. This new angle renders NMHC's theory virtually incoherent. First, average claims costs (being an average) likewise would "sweep in" cost factors that NMHC says cannot be swept in, such as how effectively a plan negotiates its rates and manages its members' medical care. *Id.* at 13. Indeed, elsewhere in its reply brief, NMHC attacks the modified state average premium adopted for the 2018 plan year on the sole basis that it is "*still a[n] . . . average*." *Id.* at 16 n.17 (emphasis added). Second, because claims costs greatly exceeded premiums among exchange plans for the 2014 and 2015 plan years, had risk adjustment transfers been based on average claims costs, NMHC's risk adjustment charges would have been far greater, and far less predictable, than they were.[4] In short, NMHC here once again proposes an alternative to the adjusted state average premium that actually performs *worse* along the dimensions it believes to be most important.[5]

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[4] This is evident in the risk corridors figures for these years, which (because they are based on a ratio of claims costs to premiums) show that aggregate claims costs exceeded aggregate premiums both nationwide and in New Mexico. Specifically, New Mexico exchange plans claimed net risk corridors payments of more than $12.6 million in 2014 and more than $32.4 million in 2015, demonstrating that aggregate claims costs among exchange plans exceeded aggregate premiums by millions of dollars in each year. *See generally* Ex. A, CMS, Risk Corridors Payment and Charge Amounts for Benefit Year 2014, at 18-19 (Nov. 19, 2015); Ex. B, CMS, Risk Corridors Payment and Charge Amounts for the 2015 Benefit Year, at 9 (Nov. 18, 2016). Of interest, Blue Cross Blue Shield Association ("BCBSA") of New Mexico, who NMHC has accused of inflating its premiums and thereby skewing the state average premium, requested risk corridors payments of more than $6.5 million in 2014 and more than $18.6 million in 2015, indicating that *even with the risk adjustment payments it received*, its premiums substantially undershot claims costs.

[5] NMHC's assertion that the state average premium "is not predictable at all" is, in any event, overstated. Pl.'s Reply at 16. While plans may not know the proposed premiums of other plans when developing their original rate proposals, those proposals are published during the rate review process and subject to subsequent adjustment. *See Health Insurance Rate Review: Review Process*, New Mexico Office of Superintendent of Insurance, http://nmhealthratereview.com/ReviewProcess.aspx (last visited Aug. 17, 2017) (showing steps

Possibly recognizing this failure, NMHC also intimates that it need not identify a viable alternative to the state average premium because the Court's only role is to undo the agency's hard work on this issue, not to act as a "super-agency rewriting the regulations itself." Pl.'s Reply at 9 n.11. This is an odd spin on the concept of deference. If NMHC cannot identify even one alternative that would meet the standard it says the methodology must meet, that is proof that the Department's approach is not unreasonable for failing to meet that supposed standard. It is not a license to invalidate the Department's approach.

Unable to show that an average premium is unreasonable (or even has a more reasonable alternative), NMHC next contends that the state average premium must be impermissible because certain CO-OPs were rendered insolvent when their risk adjustment charges for the 2014 and 2015 plan years were higher than budgeted for. But—again putting aside the fact that NMHC impermissibly relies on information that would not even come into existence until years after the agency adopted the state average premium—the cited materials do not suggest that the risk adjustment methodology, much less the state average premium, is to blame for CO-OP insolvency. The House of Representatives committee report on which NMHC relies opined that "CO-OPs were poorly situated to succeed from the very beginning," at 13, NMHC000904, were based on a "dying business model for health insurance," *id.* at 9, NMHC000900, and suffered numerous rudimentary problems that directly contributed to their insolvencies, such as "[e]nrollment [e]xtremes,"

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to rate review). NMHC's Chief Executive Officer recently noted that initial rate publications "don't really mean anything because [insurance companies] are all submitting a second round." Ex. C, Morgan Lee, *Health insurers propose rate increases in New Mexico*, Santa Fe New Mexican (June 27, 2017). Thus, if a plan seriously underestimated the state average premium in its original filings, it presumably could update those projections before finalizing its rates. By contrast, a plan would have no ability to correct its rates under the two alternative approaches suggested by NMHC.

"[d]elays in obtaining licenses to sell insurance," "management changes affecting ability to market and sell health plans," and "technical difficulties" such as "website crashes" and "long wait times" for consumers. *Id.* at 13-15, NMHC000904-06. The report also observed that all of the CO-OPs profiled were millions of dollars in the red *even before their risk adjustment charges were considered*. *Id.* at 21, NMHC000912. A July 2015 report by the Department's Office of Inspector General similarly found that "[m]ost of the 23 CO-OPs . . . had not met their initial program enrollment and profitability projections" and had "incurred net losses as of December 31, 2014," well before risk adjustment charges for the first year were announced.[6] The state average premium did not cause these problems.

Last, NMHC asserts that HHS's justifications for use of the state average premium "lack evidentiary basis" and are "implausible." Pl.'s Reply at 12. But NMHC does not actually try to show that the agency's extensive consideration of the state average premium was unreasonable, ill-considered, or lacking in evidence. *Compare* AR000134-149, AR004379-83, AR004395-422, AR004428-58, *with* Pl.'s Reply at 13. Instead, it simply dismisses the 70-plus pages of analysis and simulated scenarios the Department prepared on the issue as "an actuarial table and model that the agency ran" before circling back to the post-hoc opinions of its consultants. *Id.* at 13. NMHC's attack on the state average premium should be rejected.

[6] *See* Ex. D, Dep't of Health and Human Services, Office of Inspector General, *Actual Enrollment and Profitability Was Lower than Projections Made by the Consumer Operated and Oriented Plans and Might Affect their Ability to Repay Loans Provided under the Affordable Care Act* (July 2015), at ii.

II. The Department's Use of HCCs was Reasonable and the Department Adequately Responded to Concerns About Estimation Bias.

NMHC's next complaint is that the risk adjustment models in use during the 2014-2016 plan years underestimated the costs of enrollees without a Hierarchical Condition Category ("HCC") diagnosis and that, though the agency has since addressed this issue by adding preventive care costs to the models, those efforts are insufficient. Pl.'s Reply at 17. These claims fail as well.

First, with respect to the models contained in the 2014-2016 rules, NMHC's challenge fails at the threshold because it relies entirely on information post-dating those rules: specifically, the Department's observation, years after the models were first adopted, that the "models slightly underpredict risk for low-cost enrollees, and slightly overpredict risk for enrollees with high expenditures[.]" 2018 Proposed Rule, 81 Fed. Reg. at 61,472, AR009530.[7] It is firmly established that a "[p]laintiff cannot rely on information that was only before the agency after the promulgation of [a] rulemaking to impugn that rule." *Banner Health*, 126 F. Supp. 3d at 78.

In fact, the record before the Department when it adopted the models in 2013 pointed to the *opposite* concern: that the model would *over-predict* costs for healthy people and under-predict costs for those who were sick. *See* Ross Winkelman, et al., Society of Actuaries, *A Comparative Analysis of Claims-Based Tools for Health Risk Assessment* (April 20, 2007), at 24, AR001261

[7] In a separate portion of its brief, NMHC cites three comments it claims raised this concern during the "original rulemaking for 2014," but none did. Pl.'s Reply at 4 n.8. The first is an April 30, 2013 comment of the Blue Cross Blue Shield Association regarding amendments to the 2014 rule that postdates the Department's promulgation of the 2014 rule. The remaining two comments did not identify an estimation bias against healthy enrollees. Quite the contrary: both comments were concerned that the program would "not go far enough" to distribute the costs of *sicker* patients. Nat'l Ass'n of Cmty. Health Centers comment to 2014 proposed rule (Dec. 31, 2012), at 2-4, AR003187-3189 (expressing concerns about program's impact on "higher-risk populations"); Washington Ass'n Cmty. & Migrant Health Centers comment to 2014 proposed rule (Dec. 31, 2012), at 2-4, AR003415-3417 (same).

("risk adjusters generally underpredict costs for higher cost individuals"); BCBSA Comment to 2014 Rule (Dec. 28, 2012), at 52, AR003098 ("Generally, risk adjustment models tend to underestimate costs for high-risk claimants[.]"); ACAP, *supra* note 3, at 12, AR003181 ("Studies of risk adjustment systems generally show that they systematically over-predict costs for the least expensive individuals and under-predict costs for the most expensive."). NMHC's hindsight-based challenge to the 2014-2016 plan year models should be rejected.

NMHC's challenge to the 2017 and 2018 plan year models is equally flawed. As explained in the Department's opening brief, upon observing the models' performance in the program's first year, the Department promptly added preventive services to the models to bolster their predictive capacity with respect to non-HCC enrollees. NMHC contends that "HHS agreed that this is a minor tweak which will not make a material dent in the estimation bias flaw." Pl.'s Reply at 17. But NMHC mischaracterizes what the Department said. While recognizing that the incorporation of preventive services does not "*overall* [have] . . . a very large effect," the Department observed that "*it does have a noticeable effect on certain demographic subgroups, resulting in more accurate payments for enrollees without HCCs*." HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,218 (Mar. 8, 2016), AR007762 (emphasis added). In the 2016 White Paper, the Department further explained that the relative rise in risk score coefficients for non-HCC enrollees as a result of incorporating these preventive services would be most pronounced in lower metal tiers (Bronze and Silver) and in age/sex ranges with higher preventive services expenditures. 2016 White Paper at 33, AR009757. Thus, "the risk scores of healthy enrollees . . . will likely rise relative to the risk scores of the less healthy . . . , especially in bronze and silver plans." *Id.* The incorporation of preventive services, therefore, was expressly designed

to confront the precise issue that NMHC now contends the Department should have addressed. Moreover, the bias itself was "slight[]," *see* 2018 Proposed Rule, 81 Fed. Reg. at 61,468, AR009526, and therefore a heavy-handed change was not in order. And other than the Department's own statements, which NMHC has taken out of context, NMHC provides no reason to believe the incorporation of preventive health costs are insufficient to address this issue.

Finally, NMHC contends that the Department did not adequately address the comment of former Centers for Medicare & Medicaid Services ("CMS") Chief Actuary Richard Foster, who proposed an *ad hoc* adjustment to plan liability risk scores as a stop gap solution for plan years 2015 and 2016. But as the Department explained in its opening brief, it did respond to Foster's proposal even though it was not required to,[8] and indeed, NMHC essentially concedes as much. *See* Mem. of Law in Supp. of NMHCs' Mot. for Summ. J. at 36 n.13, ECF No. 33 (recognizing that "HHS did note . . . that it had considered some unspecified methodology . . . [to] 'directly adjust plan liability risk scores outside of the model[.]'"); Pl.'s Reply at 18 (quoting same).

NMHC's argument thus boils down to a quibble with the fact that, in addressing Mr. Foster's proposal, the Department did not reference his name or fully elaborate upon the reasons for rejecting his proposal. But this type of detailed response to the hundreds of suggestions

[8] NMHC dismisses the fact that Foster's proposal was only proffered as a stop gap solution for the years 2015 and 2016 as counsel's "post hoc rationalization." But the Department's statements on this point come directly from Foster's own words in the comment at issue. *See* Mem. from Richard S. Foster to CHOICES Exec. Comm. (July 15, 2016), at 1, 12, NMHC000219, NMHC000230 (stating that his proposal "could be used on a practical basis by State insurance departments *for the 2015 and 2016 plan years*"; noting that "[i]n the meantime" while CMS develops longterm "improvements in the HHS-HCC risk adjustment model[,]" Foster's approach could be used "for 2015 and 2016"). And as explained, because the Department was clear that it was not considering retroactive changes to the risk adjustment model for the 2015 and 2016 Rules, it was not required to respond to Mr. Foster's proposals for those years, *see* 2018 Rule, 81 Fed. Reg. at 94,073, A.R.009610, though it did respond to NMHC's suggestion that they be applied to future years.

received during the rulemaking process was neither feasible nor required. *See Ariz. Pub. Serv. Co. v. U.S. EPA*, 562 F.3d 1116, 1123, 1128-29 (10th Cir. 2009) (agency's "less-than-ideal explanation" is not grounds to invalidate its action). Rather, the Department was only required to provide enough detail so that its "decisionmaking process may reasonably be discerned[.]" *Id.* (holding that agency adequately responded to a proposal by "address[ing its] substance," although not "address[ing it] explicitly"); *see also Pub. Citizen, Inc. v. FAA*, 988 F.2d 186, 197 (D.C. Cir. 1993) (explaining that the response to comments need only allow court "to see what major issues of policy were ventilated and why the agency reacted to them as it did" (citation omitted)).

Here, the Department's path is easily discernible. The Department referred to proposals, of which Mr. Foster's was one, to "directly increas[e] low plan liability risk scores and directly reduc[e] high plan liability risk scores in order to better match the relative risks of these subpopulations." HHS Notice of Benefit and Payment Parameters for 2018 ("2018 Rule"), 81 Fed. Reg. 94,058, 94,083, AR009620. The Department then articulated its common sense concern that merely increasing or decreasing risk scores without changing the model could "unintentionally worsen model performance along other dimensions[.]" *Id.* The Department also stated that while commenters expressed a spectrum of opinions about whether and how to address the estimation bias issue (including those that did not support any adjustments), "[m]ost commenters did not support an adjustment outside the model." *Id.*; *see, e.g.*, Ex. E, Florida Blue comment to 2018 proposed rule (Sept. 30, 2016), at 9 (explaining that such an approach was problematic because "[w]ithout properly diagnosing the reason for a deficiency, any change could easily overcorrect or create perverse incentives and new problems"). The Department thus explained not only its own concerns about Mr. Foster's proposal to adjust risk scores directly (*i.e.*, "outside the model") but

also that it lacked the support of other stakeholders. The Department's "path may reasonably be discerned," *Alaska Dep't of Envtl. Conservation v. EPA*, 540 U.S. 461, 497 (2004), and that is all that is required under the APA.

III. HHS's Approach to Identifying Risk Was Reasonable in All Years.

NMHC next claims that the methodology was arbitrary and capricious because it did not include prescription drug data as a supplementary indicator of HCC status, and though it addressed partial year enrollment in several ways, did not specifically adjust for partial year enrollment in the manner that NMHC, in hindsight, would have liked. These claims fail as well.

A. The Department's Concerns Regarding Prescription Drug Data Were Overwhelmingly Substantiated and Wholly Reasonable.

As detailed in its opening brief, the Department thoroughly considered whether to incorporate pharmacy data in the model as a measure of HCC status. To recount that process in brief: the Department first sought comment from the public on the issue in September 2011. *See* Center for Consumer Information & Insurance Oversight, Risk Adjustment Implementation Issues (Sept. 12, 2011) ("2011 White Paper") at 9-10, AR004375-76 (seeking comment on whether "pharmacy data [should] be used" and how to "minimize incentives to alter prescribing patterns in ways that are not clearly clinically beneficial to patients"). Three months later, in December 2011, the Department's consultant RTI prepared an analysis opining that including pharmacy data in the models had certain advantages but would create the potential for "distortion of provider decisions toward pharmaceutical therapies" and disincentives to enroll populations with lower drug adherence. RTI Mem. to CMS re Prior Drug Use in Risk Adjustment Modeling (Dec. 15, 2011) ("RTI Prescription Drug Mem."), at 4-5, AR000838-39. RTI further observed that modeling risk on prescription data presented significant methodological challenges because prescribing patterns

change quickly and frequently do not map one-to-one with specific diagnoses. *Id.* at 6, AR000840. And RTI concluded that "[a]dding drug flags to a specification that already includes full [] specification of diagnoses . . . adds very little to the model's explanatory power." *Id.*

Based on this analysis and the commentary received in response to its 2011 White Paper, the Department proposed a methodology for the 2014 benefit rule that did "not . . . include prescription drug use as a predictor" of risk because "inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing." 77 Fed. Reg. at 73,128, AR000123. The Department acknowledged however that, "use of particular prescription drugs may be useful for predicting expenditures" and stated that it would continue to evaluate "possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives." *Id.*; *see also* 2014 Rule, 78 Fed. Reg. at 15,419, AR000236. Consistent with these remarks, after the 2014 program results were published, the Department reevaluated the issue with input from the public and decided to incorporate a small number of prescription drugs in the model beginning with the 2018 benefit year. 81 Fed. Reg. at 94,074-94,080, AR009611-17.

Unable to dispute that the Department considered this issue at length, NMHC asserts that the Department's concerns about incentives to overprescribe were "dreamt up" and based on "pure fantasy." Pl.'s Reply at 21. But like so many of NMHC's other contentions, this is meritless. For starters, the Department's concerns were informed by the analysis of RTI, whose opinions regarding the potential for adverse incentives were substantiated by several cited authorities. *See* RTI Prescription Drug Mem. at 6, AR000840 ("Previous research addresses the problem of gaming in drug-based risk adjustment models." (citing Fishman *et al.* 2003)); *id.* ("[T]here is a vast range

of drugs that would be susceptible to gaming.") (citing Gilmer & Kronick *et al.* 2001)). RTI also noted that the State of Massachusetts decided against the use of prescription drugs in its own risk adjustment program due to identical concerns. *See id.* at 7, AR000841 ("drug-based risk adjustment was considered and rejected by the Massachusetts Connector program . . . [due to] the incentive effects"). And numerous commenters acknowledged and shared these same concerns. *See, e.g.*, Kaiser Permanente comment to 2014 proposed rule (Dec. 21, 2012), at 6, AR003463 (agreeing "that the inclusion of prescription drug information will not improve the model's predictability *while introducing concerns about adverse incentives*."); Center on Budget and Policy Priorities comment to 2014 proposed rule (Dec. 20, 2012), at 3, AR002749 ("Relying on pharmacy data for purposes of risk adjustment could . . . lead to plans encouraging health care providers to use prescription drug treatments, rather than . . . behavioral modification.").[9] Indeed, NMHC has not cited a single source to suggest the Department's apprehensions on this issue were unreasonable. And of course, even if there were such differing viewpoints, they would not render unreasonable the Department's facially valid and fully substantiated concerns. *See Anna Jacques Hosp. v. Burwell*, 797 F.3d 1155, 1170-72 (D.C. Cir. 2015). [10]

[9] These concerns were reiterated in future rulemakings. *See, e.g.*, Am. Academy of Actuaries comment to 2017 proposed rule (Dec. 20, 2015), at 2, AR008137 ("pharmacy data are more susceptible to gaming than diagnosis-based data"); CVS Health comment to 2017 proposed rule (Dec. 18, 2015), at 9, AR008356 (noting the need "to protect beneficiaries from . . . overprescribed and inappropriately monitored prescriptions" under a prescription drug model); *see also* Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 Kan. J.L. & Pub. Pol'y 222, 232 (Spring 2011) ("using pharmacy data creates worrisome incentives for insurers to encourage treatment changes that increase risk scores" (citing Wynand P.M.M. Van De Ven & Randal P. Ellis, *Ch. 14: Risk Adjustment in Competitive Health Plan Markets* 802-03 (2000))).

[10] NMHC is similarly wrong to discredit the complexity of these issues by continuing to suggest that the Department's eventual decision to include prescription drug data somehow renders its original decision irrational. Pl.'s Reply at 20. As the Department has acknowledged from the

NMHC also argues that "burden and complexity are not sufficient justifications to ignore a proposed solution to a problematic methodology," Pl.'s Reply at 20-21, but this assertion is not even responsive, much less accurate. The Department did not "ignore" the possibility of adding pharmacy data, it simply decided the issue differently than NMHC would have liked. And its central concern was not about burden but about distorting the prescribing behavior of doctors nationwide. Nor does NMHC's cited case, *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 660 (9th Cir. 2011), suggest that burden and complexity are insufficient justifications for a methodological decision that Congress has delegated to an agency. It held only that those factors cannot overcome an unambiguous statutory command under *Chevron* step 1 analysis. *Id.* That holding is inapplicable here, where Congress said nothing about how the Department was required to evaluate risk. NMHC's pharmacy data arguments should be rejected.

B. The Department Reasonably Addressed Partial Year Enrollment.

NMHC's hindsight-based attack on the Department's approach to partial year enrollment also should be rejected. As explained in its opening brief, the Department addressed partial year enrollment in its original methodology in three separate ways: it (1) included enrollee diagnosis from the time of enrollment, (2) calculated risk score coefficients based on enrollment duration of the sample set, and (3) used a concurrent modeling approach rather than a prospective approach. *See* Defs.' Mem. at 29-30. NMHC has identified nothing that would have led the Department to

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start, pharmacy data is a mixed bag: it has the potential to add accuracy to the model, but it also adds methodological complexity and the potential for harmful prescribing behaviors. 2014 Proposed Rule, 77 Fed. Reg. at 73,128, AR000123. The Department was perfectly reasonable in waiting to see how the model performed before reassessing whether the potential for improved accuracy outweighed the increased complexity and potential for adverse incentives. *See Anna Jacques Hosp.*, 797 F.3d at 1170-71 (change in agency approach not evidence that prior approach was unreasonable).

believe that these measures were insufficient, much less unreasonable, to address partial year enrollment. Its only response is the unhelpful refrain that "the proof is in the data" and a citation to information published in 2016, three years after the initial methodology was adopted. Pl.'s Reply at 23. But as previously discussed, APA review is not based on hindsight; information post-dating the Department's action by several years is utterly insufficient to show that the Department "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." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 43 (1983); *see also Anna Jacques Hosp.*, 797 F.3d at 1170-71. This claim should be rejected.

IV. The Department's Approach to Bronze Plans was Reasonable.

The Court also should reject NMHC's vague and unsupported argument that the risk adjustment methodology is arbitrary and capricious *vis a vis* Bronze plans. First, NMHC has yet to provide any evidence of the central premise of this claim: that risk adjustment is driving Bronze plans out of existence. In fact, New Mexico health insurers proposed more than 20 different Bronze plans for the 2018 benefit year, including several offered by NMHC, showing that insurance companies continue to believe that Bronze plans are viable.[11] Second, NMHC fails to challenge any specific action or inaction of the Department; it merely gripes about the program's purported effects. *See Banner Health*, 126 F. Supp. 3d at 72 (holding that "plaintiffs' failure to "pinpoint explicit decisions [under attack]. . . would be enough, without more, to make [their

[11] *See* Ex. F (New Mexico rate filings for 2018).

claims] fail"). Third, as the Department explained in its opening brief, it is already monitoring the effects of the program on Bronze plans, and therefore, NMHC's request for the Department to "grapple" with the issue is moot. *See* 2018 Rule, 81 Fed. Reg. at 94,083, AR009620 (noting concerns regarding Bronze plans and ongoing evaluation of options "for various subgroups").

V. NMHC's Remaining Arguments Fail.

Having failed to identify anything arbitrary, capricious, or contrary to statute about any methodological decision made by the Department, NMHC falls back on a variety of ancillary arguments that are equally meritless.

A. The Department Did Not Sit Idly or Ignore Real World Developments.

First, NMHC contends that the Department "ignore[d] [r]eal [w]orld [d]evelopments" and "s[a]t on its hands" after critiques of the program emerged in late 2015. Pl.'s Reply at 3. This assertion could not be further from the truth. Within a year after the results of the program's first year were published, the Department had undertaken an analysis of the results, published a 100-page white paper setting forth that analysis, invited comment from the public, convened a two day meeting on the risk adjustment program, and commenced a series of measures devoted to improving the risk adjustment program, including but not limited to: (1) adding preventive care costs to improve the models' ability to project risk for individuals without HCCs, (2) adding a partial year adjustment factor to improve predictions for partial year enrollees, (3) adding a pharmacy model to better capture risk status, and (4) reducing state average premium by fourteen percent in the transfer formula to ensure that risk adjustment transfers do not compensate for

administrative costs that do not vary with risk. Defs.' Mem. at 14, ¶¶ 16-18. NMHC's suggestion that the Department "sat idly" and ignored real world developments is meritless.[12]

B. The Department Properly Denied Retroactive Relief.

NMHC also suggests that the Department was arbitrary and capricious for declining to retroactively modify rules that had already been promulgated after the results of the program's first year had been released. But NMHC has not demonstrated that the Department was even authorized to retroactively change its rules, much less required to do so. *See Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208-09 (1988) ("rulemaking authority will not, as a general matter, be understood to encompass the power to promulgate retroactive rules").

In any event, the Department has repeatedly made clear that it was not open to retroactively changing its methodology because the methodology had been relied upon by insurance plans when they set their rates and premiums. *See, e.g.*, 2018 Rule, 81 Fed. Reg. at 94,073, AR009610 (explaining that "[w]e did not propose to, and are not changing, the risk adjustment methodology for the 2014, 2015, and 2016 benefit years" because doing so would not "provide advance notice to permit issuers to incorporate the [changes] in their rate setting."). There is nothing unreasonable about conforming to an approach already adopted by the agency after notice and comment.

NMHC also argues—for the first time—that the Department was required to provide a more extensive response to its request for retroactive relief because its comment to the 2018

[12] The cases on which NMHC relies also are off point. Each involved a situation where an agency undertook a new decision, but relied on inaccurate or outdated information in doing so. *See* Pl.'s Reply at 3-4 (citing cases). Here, by contrast, NMHC attacks the agency for declining to retroactively change decisions it had already made simply because it later acquired new information. If an agency were required to change its regulations retroactively any time it came into the possession of new information, the administrative state would be in constant flux and the rule that APA review is not based on hindsight would be meaningless.

proposed rule was actually a "petition" for a rulemaking under 5 U.S.C. § 553(e). First, a claim under 5 U.S.C. § 553(e) is not pled anywhere in NMHC's complaint, was never mentioned in its opening brief, and lacks any support in the record whatsoever. NMHC's comment to the 2018 proposed rule clearly identified itself as a "*comment to the . . . Proposed Rule* published in the Federal Register on September 6, 2016[,]" not a petition. NMHC000835 (emphasis added). Second, NMHC's comment did not ask the Department to undertake a rulemaking. Rather, the Department was already engaging in a rulemaking, and NMHC asked the agency to apply the changes proposed *in that* rulemaking to periods of time governed by prior rules. *See id.* at 16, NMHC000850 ("[HHS] need[s] to . . . apply [the aforementioned changes] retroactively to benefit years 2014 and 2015"). The Department was not required to treat NMHC's comments on matters outside of the scope of the proposed rulemaking differently from the hundreds of other suggestions received merely because NMHC's counsel has now reframed it as a petition. *See, e.g.*, *Biggerstaff v. FCC*, 511 F.3d 178, 184-86 (D.C. Cir. 2007).

In any event, even if NMHC's request could be construed as a petition (it cannot), the Department's refusal to retroactively change prior rules or initiate immediate changes outside the scope of the proposed rule would be entitled to the broadest deference. *See, e.g.*, *Maier v. U.S. EPA*, 114 F.3d 1032, 1039-40 (10th Cir. 1997) (deference to an agency decision not to initiate rulemaking is "at the high end" because of "[s]ubstantial prudential concerns" in reviewing such a decision). "Such a refusal is to be overturned only in the rarest and most compelling of circumstances." *Am. Horse Prot. Ass'n, Inc. v. Lyng*, 812 F.2d 1, 5 (D.C. Cir. 1987) (citation omitted); *WildEarth Guardians v. Salazar*, 741 F. Supp. 2d 89, 104 (D.D.C. 2010) ("an agency's refusal to initiate rulemaking is evaluated with a deference so broad as to make the process *akin to*

nonreviewability" (emphasis added) (citation omitted). The Department's reasoned explanation for its refusal to initiate immediate drastic changes to the risk adjustment methodology more than meets this low bar. NMHC's brand new legal theory under 5 U.S.C. § 553(e) is untimely and meritless, and it should be rejected.

C. NMHC's Attempt to Pin Broad Problems in the Health Care Markets on Risk Adjustment is Legally Irrelevant and Factually Incorrect.

Finally, NMHC's suggestion that the risk adjustment program is to blame for broader problems in the ACA exchange markets is not only irrelevant to the Court's limited review but also meritless. Pl.'s Reply at 1-2. First, the news articles, press releases, and other hindsight-based materials on which NMHC relies are not part of the administrative record, were not before the Department when it was making the decisions challenged here, and are irrelevant to whether the Department's decisions are legally permissible under the deferential standard of review. NMHC's attempts to inject them into this lawsuit are wholly improper.[13]

Second, risk adjustment did not cause the wider problems in the insurance markets and none of the cited materials suggest it did.[14] Rather, the materials overwhelmingly opine that the

[13] To the extent NMHC suggests that the settled doctrine limiting judicial review under the APA to the record before the agency can be circumvented through judicial notice, Pl.'s Reply at 11 n.13, that suggestion is squarely refuted by the first case on which it relies. *See Banner Health*, 126 F. Supp. 3d at 62 ("Plaintiffs cannot evade [the APA's] strict standard by appealing to the standard for judicial notice."). The other cited cases merely hold that a court may take judicial notice of certain government materials. None hold that a court can take judicial notice of hearsay reported in newspaper articles, much less that a Court can base its review under the APA on such articles.

[14] In fact, only two of the nine documents cited by NMHC even mention the risk adjustment program. The first is a May 2017 article in which three Massachusetts-based insurance plans and the Massachusetts Division of Insurance blame proposed rate increases on the risk adjustment program (even though one insurer noted that "despite the increase, it still has the lowest insurance on the market"). *See* Pl.'s Reply, Ex. G at 1, ECF No. 40-8. But Massachusetts ran its own risk adjustment program for 2014-2016, and the results for the 2017 year will not be known for almost

fundamental problems facing issuers are an imbalanced risk pool, the high costs associated with "covering an older, sicker consumer population," and "more people using healthcare services, higher healthcare and prescription drug costs and overall uncertainty in the healthcare market." *See* Pl.'s Reply, Exs. A-C & F, ECF Nos. 40-2-40-4, 40-7. NMHC's suggestion that the antidote to these problems is reducing assessments on issuers that serve healthy members is baseless.

VI. The Court Should Deny Retroactive Relief.

Finally NMHC continues to make light of the fundamental limitations on the authority of both this Court and the Department to effectuate the largely retroactive monetary relief it seeks.

First, NMHC denies that this is a "secret damages case." Pl.'s Reply at 24. But as discussed at length above, the Department has already adopted the majority of the reforms that NMHC has requested. Moreover, NMHC's claim for injunctive relief is not limited to future years but rather seeks to vacate the program back to its inception. Therefore, it is reasonable to infer that NMHC's primary motivation for bringing this case is not to correct the program moving forward, but to obtain money for past years. Indeed, NMHC has made no secret of its quest to obtain retroactive relief. *See* NMHC comment to 2018 proposed rule, at 6, NMHC000840 ("Risk Adjustment [improvements] . . . *should be . . . applied retroactively to 2014 and 2015*" (emphasis added); *id.* at 8, NMHC000842 ("the changes proposed by CMS . . . *should be applied retroactively to 2014 and 2015*." (emphasis added)); *see also id.* at 10, 13, NMHC000844, NMHC000847. And NMHC's reply brief confirms that it hopes to leverage any favorable

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a year so this article does not even appear to pertain to the Department's program. The second article is a January 2016 Washington Post article that merely reports on the same opinions NMHC has expressed in this lawsuit as well as the Department's countervailing views. *See* Pl.'s Reply, Ex. I, ECF No. 40-10. It does not suggest that risk adjustment is to blame for larger problems in the insurance markets.

equitable relief obtained in this case so that "HHS can issue [a] refund or NMHC can sue in the Court of Federal Claims." Pl.'s Reply at 24. Thus, NMHC does not deny that a central thrust of this lawsuit is to obtain money from the Department for prior years. To the extent this is so, the APA does not waive the government's sovereign immunity for such a remedy.

Second, even if Plaintiff's claim is proper under the APA, NMHC has not met its burden to show that the relief it seeks is either equitable or achievable. The risk adjustment program has moved hundreds of millions of dollars between insurance plans since 2015 in order to more fairly distribute the costs of insuring society's sickest individuals, who—it turned out—were far more costly than anticipated to the insurance plans that covered them. Yet NMHC, who did not insure its share of sick individuals, seeks to undo the payments to those who did merely because the risk adjustment methodology—though performing well within the predictive ratios of other similar models—was not perfect. Such relief—to the extent it can even be achieved—would be deeply disruptive to other insurance plans, a fact NMHC cannot (and has not even tried to) deny.

CONCLUSION

For the foregoing reasons and those stated in their Cross-Motion for Summary Judgment and accompanying Memorandum, ECF Nos. 34, 35, Defendants respectfully request that the Court grant their Cross-Motion for Summary Judgment, deny Plaintiff's Motion for Summary Judgment, ECF No. 32, and dismiss this case with prejudice.

Dated: August 17, 2017

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on the 17th day of August, 2017, 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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