No. 18-2186

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

NEW MEXICO HEALTH CONNECTIONS, A NEW MEXICO NON-PROFIT CORPORATION,
Plaintiff-Appellee,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES; CENTERS FOR MEDICARE AND MEDICAID SERVICES; ALEX M. AZAR, II, SECRETARY OF THE UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, IN HIS OFFICIAL CAPACITY; SEEMA VERMA, ADMINISTRATOR FOR THE CENTERS FOR MEDICARE AND MEDICAID SERVICES, IN HER OFFICIAL CAPACITY,
Defendants-Appellants.

On appeal from the U.S. District Court for the District of New Mexico

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BRIEF OF AMERICA'S HEALTH INSURANCE PLANS AND BLUE CROSS BLUE SHIELD ASSOCIATION AS *AMICI CURIAE* IN SUPPORT OF APPELLANTS

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CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 29(a)(4), counsel for *amici curiae* states that America's Health Insurance Plans and Blue Cross Blue Shield Association are trade associations whose members have no ownership interests.

America's Health Insurance Plans is incorporated in Delaware as America's Health Insurance Plans, Inc. It has no parent corporation. And because it has no stock, there is no publicly held corporation that owns 10% or more of its stock.

Blue Cross Blue Shield Association is unincorporated.

/s/Pratik A. Shah
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TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES:

STATUTES AND REGULATIONS:

OTHER AUTHORITIES:

STATEMENT OF INTEREST OF *AMICI CURIAE*[1]

America's Health Insurance Plans ("AHIP") is the national trade association representing the health insurance community. AHIP advocates for public policies that expand access to affordable health care coverage to all Americans through a competitive marketplace that fosters choice, quality, and innovation. Along with its predecessors, AHIP has over 60 years of experience in the industry. AHIP's members provide health and supplemental benefits through employer-sponsored coverage, the individual insurance market, and public programs such as Medicare and Medicaid. As a result, AHIP's members have broad experience working with hospitals, physicians, patients, employers, state governments, the federal government, pharmaceutical and device companies, and other health care stakeholders to ensure that patients have access to needed treatments and medical services. That experience gives AHIP extensive first-hand and historical knowledge about the Nation's health care and health insurance systems and a unique understanding of how those systems work.

The Blue Cross Blue Shield Association ("BCBSA") is the trade association that coordinates the national interests of the independent, locally operated Blue

[1] *Amici curiae* certify that no counsel for any party authored this brief in whole or in part, and that no party or other person other than *amici*, its members, or its counsel made a monetary contribution to the brief's preparation or submission. All parties have consented to the filing of this brief.

Cross and Blue Shield Plans ("Blue Plans"). Together, the 36 independent, community-based, and locally operated Blue Plans provide health insurance benefits to nearly 107 million people—almost one-third of all Americans—in all 50 states, the District of Columbia, and Puerto Rico. The Blue Plans offer a variety of insurance products to all segments of the population, including large public and private employer groups, small businesses, and individuals.

Health insurance issuers are among the entities most directly and extensively regulated by the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010), amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 ("ACA"). AHIP and BCBSA have participated as *amici curiae* in other cases to explain the practical operation of the ACA. *See, e.g.*, *King v. Burwell*, No. 14-114 (U.S.). Likewise here, AHIP and BCBSA seek to provide the Court with their unique expertise and experience regarding the operation of the individual and small group health insurance markets, the role of the risk adjustment program and transfer payments, and the potential consequences that would follow from the district court's judgment—particularly with respect to the vacatur remedy.

INTRODUCTION AND SUMMARY OF ARGUMENT

The risk adjustment program is a statutorily mandated component of the Affordable Care Act ("ACA"), pursuant to which the Secretary of Health and Human Services ("HHS") is directed to "establish criteria and methods to be used in carrying out *** risk adjustment activities." 42 U.S.C. § 18063(b). The goal of the program is to "minimize the negative effects of adverse selection and help level the playing field between insurance companies, thereby fostering a stable, vibrant market in which issuers are rewarded for providing high-quality, affordable coverage, not for offering plans designed to attract the healthy and avoid the sick."[2] The "program therefore is designed to support plans offering a wide range of benefit designs that are available to consumers at an affordable premium,"[3] and thereby ensures that all individuals, regardless of health status, have the opportunity to attain affordable health coverage.

The mechanism by which HHS accomplishes this goal is by transferring funds from health plans—both large and small—that take on lower-than-average actuarial

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[2] CMS, *March 31, 2016, HHS Operated Risk Adjustment Methodology Meeting, Discussion Paper* 1 (March 24, 2016), https://www.cms.gov/CCIIO/Resources/Forms-Reports-and-Other-Resources/Downloads/RA-March-31-White-Paper-032416.pdf.

[3] CMS, *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year* 7 (July 9, 2018), https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf.

risk in a given state to plans that take on higher-than-average actuarial risk in that state. Per the ACA, risk adjustment requires, on a state-by-state basis, payments *from* "[l]ow actuarial risk plans" with healthier-than-average enrollees and payments *to* "[h]igh actuarial risk plans" with sicker-than-average enrollees. 42 U.S.C. § 18063(a)(1)-(2). At the program's inception in 2014, HHS specified in a rulemaking proceeding that risk adjustment "transfer payments" would be made in a budget-neutral manner. And each year since then, in final rules published in advance of the applicable benefit year, HHS has set forth the same budget-neutral methodology. That advance notice has allowed health plans, in reliance on this regulatory regime, to account for transfer payments when making business decisions, including rate-setting for plan premiums. HHS effected billions of dollars in transfer payments for the 2014-2017 benefit years using the published methodology, and will do so again for the 2018 benefit year during the pendency of this appeal.

Without the risk adjustment program, "plans that enroll a higher proportion of high-risk enrollees would need to charge a higher average premium (across all of their enrollees) to be financially viable."[4] As a result, health plans must make assumptions as to risk adjustment payments when setting their premiums, which in

[4] CMS, *Discussion Paper*, *supra* note 2, at 5.

turn means that a health plan's pricing is inextricably linked to risk adjustment transfer payments.

Given the foregoing, it should be no surprise that stability and predictability are central to the proper functioning of the risk adjustment program—much like health insurance markets more generally. For that reason, AHIP and BCBSA agree with HHS that the district court erred in finding the 2014-2018 rulemakings to be arbitrary and capricious for lack of an explanation regarding budget neutrality. In this brief, however, AHIP and BCBSA highlight for this Court the district court's further error: insisting that, while remanding to the agency, it must vacate the final rules under which HHS has effected transfer payments over the past five years. Vacatur is not only inequitable, but also unworkable. It needlessly and retrospectively pulls the rug out from under health plans that have relied on the final risk adjustment rules and the transfers made thereunder.

In the district court, AHIP and BCBSA underscored health plans' settled expectations concerning the risk adjustment methodology and past transfer payments. At that time, AHIP and BCBSA's most immediate concern was HHS's unanticipated announcement that it would freeze risk transfer payments for the 2017 benefit year in light of the district court's initial decision. That sudden payment freeze would have had serious and time-sensitive ramifications for the functioning of the markets for individual and small group health plans, including with respect to

health plans' calculation of 2019 rates and their decision whether to participate at all. Although HHS subsequently engaged in further rulemaking that facilitated transfer payments for the 2017 benefit year, health plans' broader concerns about vacatur persist.

The remedy question speaks directly to those concerns—particularly for the 2014-2016 benefit years. Vacating the final rules based on the budget-neutral methodology obviously upsets substantial expectation interests: HHS advised health plans that it would employ a budget-neutral methodology for making transfer payments; health plans evaluated whether to participate in markets and how to set rates based on HHS's statements; and HHS ultimately effected those transfers in the manner forecasted. The district court's decision breeds uncertainty and disruption by creating a regulatory vacuum and raising collateral questions about the legal status of billions of dollars in past transfer payments. Remand without vacatur would avoid that uncertainty and disruption: HHS could cure its purported failure to explain free of doubt as to the status of transfer payments made years ago.

Given that even the district court saw good reason for HHS to have made the risk adjustment program budget neutral, and acknowledged that there is no statutory impediment to structuring the program in that manner, this Court should take steps to limit any unnecessary fallout from a remand for the agency to supplement its explanation.

ARGUMENT

VACATUR WOULD NOT BE AN APPROPRIATE OR EQUITABLE REMEDY IN THIS CASE

Based on the fact that AHIP and BCBSA (sensibly) focused their *amici* statement below on the immediate consequences flowing from the surprise suspension in July 2018 of 2017-benefit-year risk adjustment transfer payments, the district court presumed that *amici* "do not seem to be concerned by th[e] issue of remedies." A195.[5] That presumption was both unfounded and incorrect. AHIP and BCBSA not only drew the district court's attention to health plans' interest in the preservation of the risk adjustment methodology that undergirded their business decisions during the 2014-2018 benefit years, but also weighed in on the remedy issue. AHIP and BCBSA expressly urged the district court to grant HHS's reconsideration motion "at least as to remedy," App. 67, *i.e.*, to remand for the agency to provide a budget neutrality explanation *without* vacating the 2014-2018 final rules. Assuming this Court does not reverse on the merits (as it should), that is the proper and equitable remedy here.

1. For several years now, health plans have relied on the risk adjustment methodology in place since 2014 in planning their business. As AHIP and BCBSA

[5] Citations beginning with "A" refer to the attachments to HHS's opening brief. Citations beginning with "App." refer to the separate appendix submitted in conjunction with HHS's opening brief.

explained to the district court, "the availability and design of the risk adjustment program *** factors into health plans' decision-making process regarding whether to participate in the individual and/or small group markets at all." App. 70. That is because risk adjustment transfer payments are a major factor in the calculation of plan premiums.

To flesh out the relationship between risk adjustment transfer payments and rates, AHIP and BCBSA pointed the district court to the fact that the Centers for Medicare & Medicaid Services ("CMS") had "computed that approximately $5.2 billion in risk adjustment payments in each direction are due to be made for the 2017 benefit year, and that the absolute value of risk adjustment transfers averaged 10 percent of premiums in the individual market and 5 percent of premiums in the small group market." App. 70-71. The figures are similar for the 2014-2016 benefit years. *See* note 8, *infra*. That makes "a health plan's pricing *** inextricably linked to its risk adjustment transfers," and "health plans must therefore make assumptions as to such transfers when setting their premiums." App. 71.

The district court nonetheless disregarded that business reality, declaring that "risk adjustment is a non-factor in setting premiums." A194. The court invoked the fact that risk adjustment transfer payments for a particular benefit year are made after that benefit year closes. But that payment timing hardly means that health plans do not rely on the methodology that HHS publishes—especially when that

methodology has remained unchanged from year to year. Health plans are well aware that the ACA requires risk adjustment to be performed each year, 42 U.S.C. § 18063(a), and that "[t]he risk adjustment methodology [will be] developed by HHS and published in advance of the benefit year in rulemaking," 45 C.F.R. § 153.320(a)(1). Conversely, HHS has "recognize[d] that issuers incorporate the applicable benefit year's risk adjustment methodology in their rate setting." 81 Fed. Reg. 94,058, 94,073 (Dec. 22, 2016); *see Minuteman Health, Inc. v. United States Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 182 (D. Mass. 2018) ("HHS sets the parameters ahead of the applicable benefit year, with the intention that insurers will be able to rely on the methodology to price their plans appropriately.").

Accordingly, there can be no question that health plans *did* factor the 2014-2018 risk adjustment methodology into their business decisions. Health plans should not be expected to have anticipated that, years down the road, a court might invalidate previously relied upon final rules setting forth the methodology for those transfer payments—without maintaining the status quo while HHS cured an explanatory deficiency on remand. Health plans' reliance interests must be taken into account when considering whether vacatur is an appropriate and equitable remedy in this case. *See Allied-Signal, Inc. v. United States Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-151 (D.C. Cir. 1993) (requiring consideration of "disruptive consequences") (citation and quotation marks omitted); *see also Schell*

v. OXY USA Inc., 814 F.3d 1107, 1117 (10th Cir. 2016) (recognizing that "vacatur is an equitable doctrine" that cannot be applied in a "rigid fashion") (citation and quotation marks omitted).

2. Reliance interests are particularly acute with respect to transfer payments made for the 2014-2016 benefit years. Even the district court recognized as much, *see* A193, and for good reason. Consideration of the potential effects on those past benefit years helps crystallize why vacatur is such an improper remedy here.

Vacatur would create a regulatory vacuum in which there would be no final rule underlying the 2014-2016 transfer payments.[6] The law, however, does not permit that vacuum. The ACA unequivocally instructs that HHS "*shall* establish" a risk adjustment methodology for *each* year, with payments assessed against and provided to health plans pursuant to that methodology. 42 U.S.C. § 18063(a)(1)-(2), (b) (emphasis added). Consequently, as a legal matter, the bell could not be un-rung for transfer payments made for 2014-2016—not to mention for billions of dollars in other intertwined ACA payments that rely (either directly or indirectly) on the calculation of transfer payments as a predicate. For example, risk adjustment payments must be made before and factor into the amount of risk corridor payments; risk adjustment and risk corridor figures, in turn, bear on the calculation of a health

[6] Transfer payments were effectuated for 2017, and will be effectuated for 2018, under new final rules issued after the district court's judgment.

plan's "medical loss ratio" (the portion of premium dollars spent on claims and health care quality improvement), which triggers other ACA payment requirements (such as rebates to certain enrollees).[7]

Nor could such a feat be accomplished as a practical matter—at least without causing disruption on a portentous scale. The risk adjustment program involved over 700 issuers and totaled roughly $5 billion in payments each year—with AHIP's and BCBSA's members among companies on both sides of the risk adjustment ledger.[8]

In light of those realities, it is inconceivable that HHS would respond to vacatur by creating an entirely new risk adjustment methodology for the 2014-2016 benefit years. Nothing would upset health plans' settled expectations more:

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[7] For exemplary deadlines for the 2014 benefit year, see CMS, *Key Dates in 2015: QHP Certification in the Federally-Facilitated Marketplaces; Rate Review; Risk Adjustment, Reinsurance, and Risk Corridors*, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/2015-Key-Dates-QHP-Certification-in-the-FFM-Rate-Review-and-3Rs-final.pdf.

[8] *See* CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2014 Benefit Year* (June 30, 2015), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-2014.pdf; CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2015 Benefit Year* (June 30, 2016), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/June-30-2016-RA-and-RI-Summary-Report-5CR-063016.pdf; CMS, *Summary Report on Transitional Reinsurance Payments and Permanent Risk Adjustment Transfers for the 2016 Benefit Year* (June 30, 2017), https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/Summary-Reinsurance-Payments-Risk-2016.pdf.

premiums set for those years could not be retroactively repriced based on the new methodology, and health plans could not claw back the medical-loss-ratio rebates paid to members either. The effects of a new methodology would be felt beyond the risk adjustment program as well, due to the interplay with risk corridor and medical-loss-ratio payments noted above. *See* pp. 10-11, *supra*. And if that were not enough, a different methodology would assuredly embroil the new 2014-2016 final rules in litigation on the ground that HHS had pulled a bait-and-switch on the industry years after the fact.

The only tenable scenario is that HHS instead would offer an explanation for budget neutrality and re-adopt the vacated final rules for those years. Indeed, HHS has already chosen that path for the 2017 and 2018 benefit years. A departure from that methodology for the 2014-2016 benefit years would be completely at odds not only with HHS's continuing defense of budget neutrality in litigation, but also with its statement (Br. 38) that "predictability is a key objective" of the risk adjustment program.

Accordingly, vacatur accomplishes nothing—except inviting regulatory disruption, uncertainty about the legal status of 2014-2016 transfer payments, and potential litigation over any new rulemakings themselves.[9] And that is no

[9] This legal morass could also include questions relating to the intertwined calculations relating to risk corridors and medical loss ratio, as discussed above (pp. 10-11, *supra*).

hypothetical: plaintiff has already challenged the emergency final rule that HHS issued to facilitate 2017 risk transfer payments. *See New Mexico Health Connections v. United States Dep't of Health & Human Servs.*, No. 18-cv-773 (D.N.M.).

3. The fundamental takeaway is that a remand without vacatur—the typical remedy for curing any inadequate explanation—would ward off such unnecessary uncertainty and disruption. *See Black Warrior Riverkeeper, Inc. v. United States Army Corps of Eng'rs*, 781 F.3d 1271, 1290 (11th Cir. 2015) ("In circumstances like these, where it is not at all clear that the agency's error incurably tainted the agency's decisionmaking process, the remedy of remand without vacatur is surely appropriate."). For the 2014-2016 benefit years, the currently vacated final rules would be reinstated while HHS provides the (purportedly) missing explanation as to budget neutrality. Similarly, for the 2017 benefit year, the original final rule would be reinstated, thereby mooting the separate litigation challenging the emergency final rule.[10]

That is the correct and equitable—not to mention, most workable—result in this case. *See North Carolina v. Covington*, 137 S. Ct. 1624, 1625 (2017) (per curiam)

[10] As HHS recounts (Br. 14 & n.3), HHS also issued a new proposed rule and then a final rule for the 2018 benefit year. That rule is not currently being challenged, and remand without vacatur in this case would ensure that it does not become the subject of litigation.

(explaining that "an equitable weighing process" undertaken "to select a fitting remedy for the legal violations *** identified" must "tak[e] account of what is necessary, what is fair, and what is workable") (citations and internal quotation marks omitted). As the district court recognized, "nothing in the statute forbids budget neutrality," and "designing risk adjustment to be budget neutral may be a reasonable policy choice." A73. Indeed, "there may be excellent policy reasons for making the risk adjustment plan budget neutral." *Id.* An explanation for budget neutrality, moreover, is easily supplied—and, in fact, has already been set forth in the new 2017 and 2018 final rules (as well as the 2019 final rule). *See* HHS Br. 13-14, 37-38. Such facts counsel overwhelmingly in favor of a remand without vacatur.

CONCLUSION

This Court should reverse the district court's judgment on the merits. If not, this Court should at least direct remand to the agency without vacatur.

Respectfully submitted,

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March 29, 2019

CERTIFICATE OF COMPLIANCE

The foregoing brief is in 14-point Times New Roman proportional font and contains 3,084 words, and thus complies with the type-volume limitation set forth in Rules 29(a)(5) and 32(a)(5) of the Federal Rules of Appellate Procedure.

/s/Pratik A. Shah
Pratik A. Shah

REQUIRED TENTH CIRCUIT CERTIFICATIONS

I hereby certify that:

(1) All required privacy redactions have been made.

(2) Any required paper copies to be submitted to the court are exact copies of the version submitted electronically.

(3) The electronic submission was scanned for viruses with the most recent version of a commercial virus scanning program, and is free of viruses.

/s/Pratik A. Shah
Pratik A. Shah

CERTIFICATE OF SERVICE

I hereby certify that, on March 29, 2019, I served the foregoing brief upon counsel of record by filing a copy of the document with the Clerk through the Court's electronic docketing system.

/s/Pratik A. Shah
Pratik A. Shah