[ORAL ARGUMENT REQUESTED]

No. 18-2186

IN THE UNITED STATES COURT OF APPEALS
FOR THE TENTH CIRCUIT

NEW MEXICO HEALTH CONNECTIONS,

Plaintiff-Appellee,

v.

UNITED STATES DEPARTMENT OF HEALTH & HUMAN SERVICES, et al.,

Defendants-Appellants.

On Appeal from the United States District Court
for the District of New Mexico, No. 1:16-cv-00878 (Judge Browning)

BRIEF FOR APPELLANTS

Of Counsel:

ROBERT P. CHARROW
General Counsel

KELLY M. CLEARY
Deputy General Counsel

H. ANTONY LIM
JULLIA CALLAHAN BRADLEY
Attorneys

U.S. Department of Health & Human Services

JOSEPH H. HUNT
Assistant Attorney General

JOHN C. ANDERSON
United States Attorney

ALISA B. KLEIN
JOSHUA REVESZ
Attorneys, Appellate Staff
Civil Division, Room 7235
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 514-1597
Alisa.klein@usdoj.gov

TABLE OF CONTENTS

Page(s)

TABLE OF AUTHORITIES

Cases: **Page(s)**

Statutes:

Regulations:

Other Authorities:

STATEMENT OF RELATED APPEALS PURSUANT TO CIR. R. 28.2(C)(1)

Counsel for appellants are not aware of any prior or related appeals.

GLOSSARY

ACA	Patient Protection and Affordable Care Act
AHIP	America's Health Insurance Plans
APA	Administrative Procedure Act
AR	Administrative Record
BCBSA	Blue Cross Blue Shield Association
CMS	Centers for Medicare & Medicaid Services
GAO	Government Accountability Office
HHS	U.S. Department of Health & Human Services
NMHC	New Mexico Health Connections

STATEMENT OF JURISDICTION

The district court had subject-matter jurisdiction under 28 U.S.C. § 1331. The district court entered final judgment on February 28, 2018. The government filed a timely motion to alter or amend the judgment under Rule 59(e) on March 28, 2018. The district court denied that motion on October 19, 2018, and the government filed a timely notice of appeal on December 14, 2018.

Pursuant to this Court's order of February 15, 2019, we address with specificity the issue of appellate jurisdiction. As we explain below, this Court has appellate jurisdiction under 28 U.S.C. § 1291. The judgment of the district court is final even though it included a remand to the agency for further proceedings.

Section 1343 of the Patient Protection and Affordable Care Act (ACA) required the U.S. Department of Health & Human Services (HHS) to establish a risk-adjustment program under which money is collected from insurers whose enrollees are healthier than average for a given State, and distributed to insurers whose enrollees are less healthy than average for that State. States have the option to operate the risk adjustment program, with HHS operating it on behalf of States that choose not to do so. Each year, in advance of the applicable benefit year, HHS sets its risk-adjustment methodology through notice-and-comment rulemaking, so that insurers can rely on that methodology when they set premiums. The district court set aside an aspect of the HHS risk-adjustment methodology in the rules for the 2014, 2015, 2016, 2017, and 2018 benefit years, on the ground that HHS failed to explain an underlying

decision to design the program as "budget neutral"—that is, funded solely by amounts collected from insurers rather than by an extrinsic source of funding. Among other rulings, the court rejected the agency's threshold argument that the challenge to the agency's budget-neutral approach had been waived because no commenter raised such an objection in the applicable rulemakings. The court also rejected the agency's argument that, to protect third-party reliance interests, any remand to HHS should be without vacatur or, alternatively, that any relief should be tailored to the plaintiff's injury.

Although there are circumstances in which a remand to an agency is not an appealable final order, those circumstances are not present here. This Court will "rarely take jurisdiction over appeals involving *private* litigants seeking immediate appeal of remand orders because the issues presented would be reviewable upon conclusion of the remand proceedings." *Western Energy Alliance v. Salazar*, 709 F.3d 1040, 1050 (10th Cir. 2013) (this Court's emphasis) (quotation marks omitted). By contrast, when this Court has "heard interlocutory appeals under the practical finality rule, central to [the Court's] analysis was a concern *the agency* likely would be foreclosed from future appellate review." *Id.* (this Court's emphasis) (quotation marks omitted). "Indeed," this Court has "reiterated many times" that it "review[s] orders to remand a matter to an administrative agency when it is necessary to ensure that we can review important legal questions which a remand may make effectively unreviewable,"

because the "agencies may be barred from seeking district court (and thus circuit court) review of their own administrative decisions." *Id.*

That is the case here. As we show in Part I of the Argument, the ground on which the district court relied in vacating an aspect of the HHS methodology—that the agency failed to explain why it designed the risk-adjustment methodology as budget neutral—was waived by the failure of any commenter to raise that objection during the applicable notice-and-comment rulemakings. To ensure meaningful relief, this Court must address that threshold legal issue now, because the very question is whether the agency has a duty to provide additional explanation.

Furthermore, this Court's decisions explain that the practice of deferring appeal until the end of administrative proceedings is "most appropriate in adjudicative contexts." *Western Energy Alliance*, 709 F.3d at 1047-48. This case does not involve an adjudication; the district court vacated an aspect of the agency's risk adjustment methodology established through notice-and-comment rulemaking. Moreover, the district court did so on a nationwide basis, rejecting the agency's request that the court protect third-party reliance interests by remanding without vacatur or tailoring its relief to the plaintiff's injury. Under these circumstances, the jurisdictional requirement of finality is plainly met.

STATEMENT OF THE ISSUES

1. Whether the plaintiff's challenge to the budget-neutral design of HHS's risk-adjustment methodology was waived because it was not raised by any commenter during the rulemakings for the benefit years at issue here.

2. Whether that challenge also fails on the merits.

3. Assuming that relief was appropriate, whether the district court should have protected third-party reliance interests by denying the equitable remedy of vacatur or tailoring its relief to the plaintiff's injury.

PERTINENT STATUTES AND REGULATIONS

Pertinent statutes and regulations are reproduced in the addendum to this brief.

STATEMENT OF THE CASE

A. The ACA's Risk-Adjustment Program

Congress enacted the ACA to expand coverage in the individual health insurance market. *See King v. Burwell*, 135 S. Ct. 2480, 2485 (2015). To that end, the Act prohibits insurance companies from denying coverage or charging higher premiums based on an individual's health. *Id.* at 2486.

Congress understood that, despite this prohibition, insurers could design their plans in ways that attract individuals who are healthier and therefore cheaper to insure. For example, a plan could offer lower premiums by excluding from its provider networks specialty hospitals and doctors that treat high-cost conditions. *See, e.g.*, Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20

KAN. J.L. & PUB. POL'Y 222, 224 (2011). Such plans would be attractive to healthier individuals due to their low costs, but unattractive to less healthy individuals who would not have access to the care they need. *Id.*

To counter the incentive for insurers to adopt such risk-avoidance techniques, section 1343 of the ACA (codified at 42 U.S.C. § 18063) directed HHS to establish a program known as "risk adjustment." Under the program, monetary charges are collected from plans with healthier-than-average enrollees in a given State, and payments are made to plans with sicker-than-average enrollees in that State, thereby distributing actuarial risk among plans. Risk adjustment reduces incentives for plans to avoid high-risk enrollees, and it levels the playing field for plans that enroll sicker people, reflecting "the premise that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,417 (Mar. 11, 2013).

Congress designed the risk-adjustment program to be administered by States. Section 1343 provides that "each State shall assess a charge" on insurers if "the actuarial risk of [their] enrollees . . . for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1). Likewise, section 1343 provides that "each State shall provide a payment" to insurers "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such

year." *Id.* § 18063(a)(2). Congress provided, however, that HHS would operate the risk-adjustment program in any State that opted not to do so itself. *See* 42 U.S.C. § 18041(c); *cf. King*, 135 S. Ct. at 2487 (describing a similar provision for the operation of the ACA's Exchanges). In practice, the only State to run its own risk-adjustment program was Massachusetts, which ran its program in the 2014, 2015, and 2016 benefit years and then ceded responsibility to HHS beginning in the 2017 benefit year. *See Minuteman Health, Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 181 (D. Mass. 2018) (*Minuteman*).

B. HHS's Risk-Adjustment Methodology

Congress assigned HHS, in consultation with the States, the complex task of devising a way to measure and compare actuarial risk among plans and then to distribute the costs of that risk among eligible plans in each risk pool in each State. *See* 42 U.S.C. § 18063(b). The implementing regulations require that insurers be given advance notice of the methodology to be used for a particular benefit year, so that insurers can rely on that methodology when they set their annual rates and benefits for that year. *See* 45 C.F.R. § 153.320(a); *see also, e.g.*, Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,223 (Mar. 23, 2012); 81 Fed. Reg. 94,058, 94,072 (Dec. 22, 2016) (explaining the importance of setting rules ahead of time and describing comments supporting that practice).

To initiate the annual rulemaking process, HHS generally publishes a proposed risk-adjustment methodology in November or December of the year two years prior

to the applicable benefit year. *See Minuteman*, 291 F. Supp. 3d at 182. After a public comment period, the final rule is generally published in February or March of the year prior to the applicable benefit year—for example, the final rule for the 2014 benefit year was published in March 2013. *See id.* That schedule allows insurers to take the risk-adjustment methodology into account when they set premiums, because premiums are typically approved by state insurance regulators during the summer or early fall before the start of the benefit year. *See, e.g.*, Aplt. App. 71, 114-15.

After the benefit year ends, plans must submit their risk-adjustment data to HHS, typically by April 30 of the following year. *See* 45 C.F.R. § 153.730. Charge and payment amounts are announced two months later, by June 30. *See id.* § 153.310(e). HHS then collects charges and uses those collections to make payments to issuers, typically within 30-60 days of collection.

Developing a risk-adjustment program is methodologically and operationally complex. *See* 77 Fed. Reg. at 17,230. In March 2013—after nearly two years of consideration that included input from state insurance commissioners, public meetings, expert analysis by HHS's contractor, the publication of a white paper entitled "Risk Adjustment Implementation Issues," and notice-and-comment rulemaking—HHS set forth its risk-adjustment methodology in painstaking detail in the rule for the 2014 benefit year. *See* HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,417-34 (Mar. 11, 2013).

In broad terms, the methodology involves three steps. First, the actuarial risk of each enrollee is calculated through models that use demographic and diagnostic data to determine the relative cost of insuring an enrollee. *See* 78 Fed. Reg. at 15,419. Second, risk scores for each enrollee in a plan are aggregated to determine the plan's average risk score. *See id.* at 15,432. Third, HHS multiplies the plan's average risk score by a statewide average premium, *see id.* at 15,430, and then makes certain additional adjustments, *see id.* at 15,430-34. Using this methodology, HHS is able to convert actuarial risk into charge or payment dollar amounts for particular plans in the State market risk pool. *See Minuteman*, 291 F. Supp. 3d at 198.

Since 2011, when the planning for the 2014 benefit year began, HHS has designed the risk-adjustment program to be "budget neutral," meaning that payments to higher-risk plans are funded entirely by the charges collected from lower-risk plans. *Minuteman*, 291 F. Supp. 3d at 184; *see also*, *e.g.*, 76 Fed. Reg. 41,930, 41,938 (July 15, 2011) ("risk adjustment is designed as a budget neutral activity"). The HHS transfer formula is accordingly designed so that the charges to plans with healthier members will equal the payments to plans with less-healthy members. *See Minuteman*, 291 F. Supp. 3d at 184.

After extensive analysis, HHS decided to use the statewide average premium (also called the State average premium) as the component of the transfer formula that converts a plan's actuarial risk into a dollar charge or payment amount. *See Minuteman*, 291 F. Supp. 3d at 198-99. In deciding to use the statewide average premium in the

transfer formula, HHS explained that its use results in balanced charges and payments, *i.e.*, charges and payments that net to zero. *See id.*; *see also*, *e.g.*, HHS, Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (explaining that "transfers net to zero when the State average premium is used as the basis for calculating transfers"). By contrast, other options that HHS considered—including use of a plan's own premium—could have resulted in funding shortfalls, which would have added uncertainty to the insurers' rate-setting process. *See Minuteman,* 291 F. Supp. 3d at 200, 202-03.

Every year since the publication of the rule for the 2014 benefit year (the first year of the program), HHS has republished the risk-adjustment methodology in advance of the benefit year to which the methodology will apply. HHS has used this annual notice-and-comment rulemaking as an opportunity to refine the HHS risk-adjustment models and methodology, but has not reconsidered the entire methodology anew each year, and thus has balanced the interest in gradual improvement against stakeholders' desire for model stability. *See* 78 Fed. Reg. at 15,418 ("[W]e seek to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data becomes available."). Use of the statewide average premium has been a consistent aspect of the HHS risk-adjustment methodology.

C. Prior Proceedings

1. Factual background and the summary judgment opinion

Plaintiff New Mexico Health Connections (NMHC) is a relatively new insurer that was created under the ACA's "CO-OP" program and funded by subsidized loans that it received from HHS. *See Minuteman*, 291 F. Supp. 3d at 181 (noting that Congress appropriated $6 billion for the CO-OP program, which makes federal loans available to new insurers). A trade association for CO-OP insurers urged Congress to relieve them of the obligation to make payments under the risk-adjustment program, but Congress did not do so.[1]

After Congress declined to exempt CO-OP insurers from the risk-adjustment program, NMHC and another CO-OP insurer called Minuteman Health filed materially identical complaints under the Administrative Procedure Act (APA), challenging various aspects of HHS's risk-adjustment methodology. The suits were filed in district courts in two different Circuits.

In the *Minuteman* litigation, the district court rejected all of Minuteman's arguments and upheld the challenged rules. Minuteman did not appeal to the First Circuit.

---

[1] *See* Testimony of Peter Beilenson, MD, MPH, CEO and President, Evergreen Health Cooperative Board Member, National Alliance of State Health CO-OPs Before the House Committee on Energy and Commerce Subcommittee on Oversight & Investigations (Nov. 5, 2015), *available at* https://docs.house.gov/meetings/IF/IF02/20151105/104146/HHRG-114-IF02-Wstate-BeilensonP-20151105.PDF

Subsequently, in this case, the district court rejected nearly all of NMHC's arguments but accepted one of its claims. *See New Mexico Health Connections v. U.S. Dep't of Health & Human Servs.*, 312 F. Supp. 3d 1164 (D.N.M. 2018) (*NMHC I*). The court set aside the use of the statewide average premium in the HHS methodology for the 2014-2018 benefit years, on the ground that HHS had failed to explain its reasons for adopting that measure. Specifically, the court concluded that HHS failed to explain its underlying decision to design the program as budget neutral, *i.e.*, funded entirely by amounts collected from insurers rather than by an extrinsic source of funding.

The district court here acknowledged that "nothing in the statute forbids budget neutrality" and that "designing risk adjustment to be budget neutral may be a reasonable policy choice." *NMHC I*, 312 F. Supp. 3d at 1210 (citing *Minuteman*, 291 F. Supp. 3d at 201). Indeed, the court recognized that "there may be excellent policy reasons for making the risk adjustment plan budget neutral." *Id.* "For example," the court observed that "HHS may not have the funding to make up the shortfall between the risk adjustment charges and credits." *Id.* The court also noted that a budget-neutral design would "allocate discretionary funds to other programs that more desperately need that funding." *Id.* But because HHS had not articulated such policy rationales in the rulemakings, the district court rejected reliance upon budget neutrality as a basis for using the statewide average premium and vacated the use of the statewide average premium in the HHS risk-adjustment methodology for the

2014-2018 benefit years, remanding to the agency for further proceedings. *See id.* at 1210-12.

2. The government's Rule 59(e) motion

HHS filed a timely motion under Rule 59(e) that asked the district court to alter or amend the judgment. *See* Dtk. No. 57. The motion explained that, as a threshold matter, the challenge to the budget-neutral design of HHS's risk-adjustment methodology was waived by the failure of any commenter to raise such an objection during the applicable rulemakings. The motion further explained that the challenge failed on the merits because there was no extrinsic funding source on which HHS could have relied when it designed its annual risk-adjustment methodology. HHS urged the district court, at a minimum, to protect third-party reliance interests and prevent disruption in the insurance markets by leaving the challenged rules in place while HHS provided additional explanation for the budget-neutral design of its methodology.

On June 21, 2018, the district court heard oral argument on the 59(e) motion. At that hearing, the court announced that it would not be in a position to act on the 59(e) motion until around Labor Day. Aplt. App. 65.

As a consequence, HHS informed the insurance industry that the district court's prior ruling would prevent HHS from making the then-impending collections and distributions of funds pursuant to the (vacated) 2017 benefit-year rule—amounts totaling $5.2 billion. *See* Aplt. App. 74. That announcement prompted America's

Health Insurance Plans (AHIP)—which is the national trade association representing health insurance plans—and the Blue Cross Blue Shield Association (BCBSA) to submit an amicus brief that urged the district court to grant the 59(e) motion expeditiously. *See* Aplt. App. 66-72.

Amici warned the district court that freezing billions of dollars in risk-adjustment transfers nationwide would have "serious and time-sensitive ramifications for the functioning of the market for individual and small group health plans." Aplt. App. 70. Amici emphasized that there was near-term urgency because of the summer and fall deadlines by which insurers were required to submit to state insurance regulators the terms of plans they would sell for the 2019 benefit year. Aplt. App. 71. And amici explained that although "targeted improvements to any program may be considered prospectively, all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions." Aplt. App. 70.

3. New rulemaking proceedings

To avert a crisis in the insurance markets while the 59(e) motion was pending, HHS issued a new rule for the 2017 benefit year on an emergency basis. That rule re-adopted the same risk-adjustment methodology that had been published in advance of the 2017 benefit year, and provided additional explanation for the agency's budget-neutral approach to the program. *See* Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and

Affordable Care Act for the 2017 Benefit Year, 83 Fed. Reg. 36,456, 36,457-59 (July 30, 2018). HHS found good cause to proceed without notice and comment or a delayed effective date, explaining that "immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets." *Id.* at 36,459; *see* 5 U.S.C. § 553(b)(3)(B).[2]

To prevent an analogous crisis in the summer of 2019, HHS separately issued a new proposed rule for the 2018 benefit year that proposed to adopt the same methodology that had been published in advance of the 2018 benefit year, and again provided additional explanation for its budget-neutral approach. *See* Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Proposed Rule, 83 Fed. Reg. 39,644 (Aug. 10, 2018).[3]

HHS informed the district court of these new rulemaking proceedings and relied on their additional explanation as further support for the pending 59(e) motion. *See* Dkt. Nos. 81, 84.

---

[2] NMHC filed a second suit that challenges HHS's new final rule for the 2017 benefit year, alleging (*inter alia*) that there was not good cause to proceed without notice and comment. *See New Mexico Health Connections v. U.S. Dep't of Health & Human Servs.*, No. 1:18-cv-00773 (D.N.M.) (Browning, J.). By agreement of the parties, proceedings in that suit are stayed pending the resolution of this appeal.

[3] HHS later finalized the proposed rule for the 2018 benefit year. *See* Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Final Rule, 83 Fed. Reg. 63,419 (Dec. 10, 2018). The 2018 rule has not been challenged.

4. The order denying the Rule 59(e) motion

On October 19, 2018, the district court issued an opinion and order denying the 59(e) motion. *See New Mexico Health Connections v. U.S. Dep't of Health & Human Servs.*, 340 F. Supp. 3d 1112 (D.N.M. 2018) (*NMHC II*). The court first rejected the government's argument that the challenge to the budget-neutral design of the HHS risk-adjustment methodology was waived because no commenter had raised such an objection during the applicable rulemakings. The district court recognized that "at no point during the 2014-2017 rulemakings did NMHC or any other commenter challenge or question" the agency's budget-neutral approach. *Id.* at 1130 (quoting the 59(e) motion). The court also acknowledged that "[i]f no commenter raises a potential problem," then "the agency has no duty to address that problem or to 'respond' to a non-existent comment." *Id.* at 1167. The court noted that "[t]he waiver rule does not apply, however, when an agency, for whatever reason, considers a potential issue." *Id.* at 1168. The court deemed that exception applicable because HHS had stated in 2013 that "[t]he Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers." *Id.* at 1169 (quoting 78 Fed. Reg. at 15,441). The court "inferred" from this sentence that "HHS believed that the ACA requires budget neutrality." *Id.* at 1165-66.

The district court acknowledged that when NMHC finally raised its objection to budget neutrality during the rulemaking proceedings for the 2018 benefit year, HHS explained that the budget-neutral design of its methodology reflected "the

absence of additional funding" for risk-adjustment payments. *See NMHC II*, 340 F. Supp. 3d at 1178 (quoting 81 Fed. Reg. at 94,101). But, adopting an argument that neither NMHC nor any other commenter had made in the rulemaking, the district court declared that HHS was wrong to conclude that there was no additional funding for risk-adjustment payments. *See id.* at 1170-75.

Specifically, the district court declared that HHS could have designed its annual risk-adjustment methodology to draw upon a lump sum that Congress typically appropriates to HHS for the management of programs operated by the Centers for Medicare & Medicaid Services (CMS), such as Medicare and Medicaid. The district court acknowledged that this annual, discretionary appropriation was not enacted until *after* the risk-adjustment methodology was finalized for the applicable benefit year. *See NMHC II*, 340 F. Supp. 3d at 1130 n.6. The court also recognized that it is unlawful for an agency to incur obligations "before an appropriation is made." *Id.* at 1174 (quoting the Anti-Deficiency Act, 31 U.S.C. § 1341(a)(1)). Nonetheless, the court declared that the potential availability of the lump sum meant that "HHS could have adopted a risk adjustment formula where risk adjustment payments might exceed risk adjustment charges," *id.*, and ruled that a remand was necessary because HHS did not "satisfactorily explain" why it had not chosen to rely on the lump sum, *id.* at 1175.

In addressing the question of remedy, the district court concluded that it was appropriate to vacate the use of the statewide average premium in the 2014-2018 benefit year methodologies, rather than remand to HHS without vacatur. In so ruling,

the court applied the two-part test set out in *Allied-Signal, Inc. v. Nuclear Regulatory Commission*, 988 F.2d 146, 150-51 (D.C. Cir. 1993), under which "[t]he decision whether to vacate depends on 'the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed.'" *NMHC II*, 340 F. Supp. 3d at 1177. The court regarded the deficiency in the original rulemakings as serious, even though HHS had since provided additional explanation for the budget-neutral design of its methodology. *See, e.g.*, 83 Fed. Reg. 39,644, 39,646-48 (Aug. 10, 2018). And the court denied that vacatur would be disruptive, because the court did not believe that insurers rely on the risk-adjustment methodology when they set premiums. *See NMHC II*, 340 F. Supp. 3d at 1182 (declaring that "risk adjustment is a non-factor in setting premiums"). The court did not address amici's contrary argument. *See, e.g.*, Aplt. App. 70, 71 (AHIP/BCBSA brief) (explaining that "all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions," and that "a health plan's pricing is inextricably linked to its risk adjustment transfers"). The court also refused to tailor its remedy to plaintiff's injury, because it believed that the APA gave it no choice but to vacate HHS's use of the statewide average premium in the 2014-2018 benefit year methodologies on a nationwide basis. *See NMHC II*, 340 F. Supp. 3d at 1183.

SUMMARY OF ARGUMENT

Section 1343 of the ACA required the U.S. Department of Health & Human Services to establish a risk-adjustment program under which money is collected from insurers whose enrollees are healthier than average for a given State, and distributed to insurers whose enrollees are less healthy than average for that State. Each year, in advance of the applicable benefit year, HHS establishes its risk-adjustment methodology through notice-and-comment rulemaking, so that insurers can rely on that methodology when they set premiums.

The district court set aside an aspect of the HHS risk-adjustment methodology in the rules for the 2014, 2015, 2016, 2017, and 2018 benefit years, on the ground that HHS failed to explain an underlying decision to design the program as "budget neutral," that is, funded solely by amounts collected from insurers rather than by an extrinsic source of funding. The premise of the district court's ruling is that there was an extrinsic source of funding—the lump sum in an annual appropriation for the management of CMS programs such as Medicare and Medicaid—on which HHS could have drawn to supplement the amounts collected from insurers under the risk-adjustment program. The district court vacated HHS's use of the statewide average premium in the methodology for the 2014-2018 benefit years, because HHS had not explained in the rulemakings why it did not consider using the lump sum in this way.

The judgment rests on errors of law. As a threshold matter, the ground on which the district court relied was forfeited because no commenter raised it during the applicable rulemakings. The judgment should be reversed for that reason alone.

On the merits, there are multiple legal problems with the funding approach that the district court envisioned (and it is thus unsurprising that no commenter proposed it). First, the lump sum for CMS program management is not appropriated until *after* HHS sets its risk-adjustment methodology for the applicable benefit year, which is too late for purposes of designing that methodology. Second, the lump sum is intended for *administrative* expenses, such as paying the contractors that run Medicare's fee-for-service programs. It is not intended for the program payments themselves (such as Medicare claims), and HHS has since made clear that it would not have used the lump sum for risk-adjustment payments even if it had discretion to do so. In any event, there were additional problems, independent of the need for budget-neutrality, with the approach that the plaintiff later advocated: using a plan's own premiums to calculate the amounts the insurer would pay or receive under the risk-adjustment program. As the *Minuteman* court explained in rejecting the same argument, that approach would have produced distorting effects on premiums, which was sufficient reason for HHS to reject it. *See* 291 F. Supp. 3d at 203.

Assuming that there was nonetheless a basis to grant relief in this case, the district court should have protected third-party reliance interests by remanding without vacatur or tailoring the relief to the plaintiff's injury. As the national trade

representative for health insurers emphasized, "all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions." Aplt. App. 70. The annual risk-adjustment methodology is announced in advance precisely so that insurers can rely on it, and there was no justification whatsoever to upset those settled expectations.

STANDARD OF REVIEW

The district court's summary-judgment order is subject to de novo review in this Court. *See, e.g.*, *Timmons v. White*, 314 F.3d 1229, 1232 (10th Cir. 2003). The court's denial of the government's motion for reconsideration is reviewed for an abuse of discretion. *See, e.g.*, *United States v. Randall*, 666 F.3d 1238, 1241 (10th Cir. 2011). The court necessarily abused its discretion if its ruling rested on an error of law. *See, e.g.*, *United States v. Ramirez*, 304 F.3d 1033, 1035 (10th Cir. 2002).

ARGUMENT

I. Plaintiff's Challenge to the Budget-Neutral Design of HHS's Risk-Adjustment Methodology Was Waived Because It Was Not Raised in the Rulemaking Proceedings.

A. No Commenter Urged HHS to Treat the Lump Sum for CMS Program Management as a Funding Source for Risk-Adjustment Payments.

"A reviewing court may not set aside an agency rule that is rational, based on consideration of the relevant factors and within the scope of the authority delegated to the agency by the statute." *Motor Vehicle Mfrs. Ass'n of the U.S., Inc. v. State Farm Mut. Auto. Ins.*, 463 U.S. 29, 42 (1983). Furthermore, it is a bedrock principle of

administrative law that "courts should not topple over administrative decisions unless the administrative body not only has erred but has erred against objection made at the time appropriate under its practice." *United States v. L.A. Tucker Truck Lines, Inc.*, 344 U.S. 33, 37 (1952). In the rulemaking context, "a party waives its right to appeal an issue if it fails to object through comments or documents in the record." *Nutraceutical Corp. v. Von Eschenbach*, 459 F.3d 1033, 1041 n.9 (10th Cir. 2006).

That waiver principle governs here and requires that the judgment of the district court be reversed. When HHS adopted the statewide average premium as a component of its risk-adjustment methodology, the agency explained that use of the statewide average premium would keep the program budget neutral, *i.e.*, ensure that collections from insurers and payments to insurers will automatically "net to zero." 77 Fed. Reg. 17,200, 17,139 (Mar. 23, 2012). By contrast, using a plan's own premium to determine the amount the insurer would pay or receive— the approach that NMHC later proposed—would "result[ ] in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero." *Id.*

The district court vacated the use of the statewide average premium because the court saw no need for the collection and payment amounts to balance, *i.e.*, net to zero. The court ruled that there was an extrinsic source of funding—the lump sum in the annual appropriation for management of CMS programs such as Medicare and Medicaid—on which HHS could have drawn to supplement the amounts collected from insurers under the risk-adjustment program. And the court remanded because

HHS had not explained in the applicable rulemakings why it did not consider using the lump sum as an additional source of funding for risk-adjustment payments.

In so ruling, the district court relied on an argument that no commenter had made in the rulemakings for the 2014-2018 benefit years. Although HHS repeatedly solicited comments on the proposed design of the risk-adjustment program, no commenter disputed "the need for inter-plan transfers that net to zero" during the rulemakings for the 2014-2017 benefit years. 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (proposed rule). Thus, as the *Minuteman* court correctly held, any objection to the budget-neutral design of the methodology was waived. *See Minuteman Health Inc. v. U.S. Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 202 (D. Mass. 2018) ("To the extent that plaintiff complains that HHS did not adequately explain its decision to run the program in a budget-neutral way, the claim must likewise fail. There is no evidence that there was any significant comment on the topic that HHS was required to address in 2014.").

Furthermore, even with respect to the 2018 benefit year, no commenter made the argument on which the district court relied. During the rulemaking for that year, the comments filed by NMHC and Minuteman vaguely asserted that "there is no requirement in Section 1343 that Risk Adjustment be budget neutral; no requirement that payments collected from one set of issuers be used to make full and complete payments to another set of issuers." Aplt. App. 25 (NMHC comment); Aplt. App. 44-45 (Minuteman comment). But neither NMHC nor Minuteman identified *any*

funding source other than the amounts collected from insurers. Neither commenter so much as hinted that HHS should rely on the lump sum for CMS program management as a potential funding source for risk-adjustment payments. Accordingly, when HHS responded to such comments, it explained: "In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner[.]" 81 Fed. Reg. 94,058, 94,101 (Dec. 22, 2016).

When the district court later ruled that HHS should have considered using the lump sum as a funding source for risk-adjustment payments, *see NMHC II*, 340 F. Supp. 3d at 1170-75, the court thus relied on an argument that no commenter had made. That was legal error. An agency has no obligation to address "imaginary complaints"; rather, it is generally expected to "respond in a reasoned manner *to the comments received*." *Rodway v. U.S. Dep't of Agric.*, 514 F.2d 809, 817 (D.C. Cir. 1975) (emphasis added).

This Court has long recognized that the "[f]ailure of a party to present its contentions properly to the agency precludes appellate review." *Rives v. Interstate Commerce Comm'n*, 934 F.2d 1171, 1176 (10th Cir. 1991). That principle reflects not only fairness to the agency, but also judicial restraint. Congress delegates rulemaking authority to federal agencies because the implementation of federal programs often depends on "the kind of thorough knowledge of the subject matter and ability to consult at length with affected parties that an agency . . . possesses." *Long Island Care*

at Home, Ltd. v. Coke, 551 U.S. 158, 167-68 (2007). Accordingly, "[a] court may not substitute its judgment for that of the agency when 'the agency has not had an opportunity to make a factual record or apply its expertise.'" *Rives*, 934 F.2d at 1176 (quoting *New Mexico Envtl. Improvement Div. v. Thomas*, 789 F.2d 825, 835 (10th Cir. 1986)). Arguments that NMHC "failed to present" to HHS "during rulemaking procedures when specifically asked to comment cannot now be urged [as] a basis for invalidation [of the rule]." *New Mexico Envtl. Improvement Div.*, 789 F.2d at 835 (quoting *American Frozen Food Institute v. Train*, 539 F.2d 107, 134 (D.C. Cir. 1976) (this Court's alterations)).

B. The Narrow Exception for Issues That an Agency Considered *Sua Sponte* Does Not Apply Here.

In deeming this waiver rule inapplicable, the district court relied on an exception that applies when an agency addresses an issue on its own initiative. *See NMHC II*, 340 F. Supp. 3d at 1168 ("The waiver rule does not apply, however, when an agency, for whatever reason, considers a potential issue.") (citing *Garcia-Carbajal v. Holder*, 625 F.3d 1233, 1238 (10th Cir. 2010) (Gorsuch, J.)). As this Court emphasized in the cited decision, however, that "rare exception" to the waiver rule does not apply unless "three preconditions" are met. *Garcia-Carbajal*, 625 F.3d at 1238. The agency must: "(1) clearly identify a claim, issue, or argument not presented by the petitioner; (2) demonstrate that the agency chose to exercise its discretion to entertain that

matter; and (3) explicitly decide that matter in a full explanatory opinion or substantive discussion." *Id.* at 1238-39.

None of those conditions was satisfied here. Because no one argued that there were additional sources of funding for risk-adjustment payments, HHS did not consider the issue. HHS never stated that it was examining the lump sum (or any other appropriation) to see if it might be used for risk-adjustment payments. Indeed, until the Government Accountability Office (GAO) issued an opinion regarding a different ACA program long after the risk-adjustment methodology was first designed, no one appears to have considered the lump sum as a potential source of funding for risk-adjustment payments at all. Contrary to the district court's premise, HHS's general statement that "[t]he Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers," *NMHC II*, 340 F. Supp. 3d at 1169 (quoting 78 Fed. Reg. at 15,441), is not the "full explanatory opinion or substantive discussion" of the lump sum or any other appropriation that would be required to overcome the waiver rule. *Garcia-Carbajal*, 625 F.3d at 1235.

The district court noted that when HHS developed its methodology for the 2014 benefit year, HHS explained that it was adopting a methodology under which transfers net to zero and rejecting methodologies that did not automatically result in balanced transfers. *NMHC II*, 340 F. Supp. 3d at 1168. Those statements are no basis to disregard the waiver rule: they simply *described* HHS's decision to adopt a methodology that would keep the program budget neutral. As then-Judge Gorsuch

emphasized, "[w]henever an agency states a conclusion . . . it impliedly rejects any number of unmade potential arguments," but "*that* doesn't mean the agency noticed those arguments, let alone considered and ruled on them." *Garcia-Carbajal*, 625 F.3d at 1239 (this Court's emphasis). Otherwise, every aspect of an agency's regulations would be open to later challenge, even though no objection was raised at the time. Thus, the judgment of the district court should be reversed on waiver grounds alone.

II. The Challenge to the Budget-Neutral Design of HHS's Risk-Adjustment Methodology Is Meritless.

The district court was also wrong to conclude that HHS reasonably could have relied on the lump sum when it designed its annual risk-adjustment methodology. Although the district court deemed it arbitrary and capricious for HHS to fail to consider using the lump sum, there are multiple, independent problems with the funding approach envisioned by the district court. It is thus unsurprising that the sophisticated stakeholders who provided comments on the proposed methodology—including state insurance regulators and insurers—never suggested that the risk-adjustment program should be funded by the lump sum. It was eminently reasonable for HHS not to consider using the lump sum *sua sponte*, given the problems that reliance on that funding source would have caused.

A. The Timing of the Lump-Sum Appropriation Meant That HHS Could Not Have Relied on It When HHS Designed Its Risk-Adjustment Methodology for a Given Benefit Year.

As an initial matter, the timing of the lump-sum appropriation meant that HHS could not have depended on it when HHS designed its risk-adjustment methodology for any particular benefit year.

The lump sum is a discretionary, annual appropriation that Congress provides for the administration of CMS programs. Although there is no requirement that Congress enact the same language each fiscal year, the appropriations acts for HHS typically state that "except as otherwise provided," the lump sum is available for "carrying out" enumerated programs such as Medicaid and Medicare and "other responsibilities" of CMS. *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, tit. II, 128 Stat. 2130, 2477 (Dec. 16, 2014) (appropriating funds for fiscal year 2015). The lump sum is typically used for administrative expenses such as paying the contractors that administer the Medicare program. *See, e.g.*, Dkt. No. 57-3 (illustrative budget requests).

The district court concluded that risk-adjustment payments are among the "responsibilities of CMS" and, for that reason, it ruled that HHS could have designed its risk-adjustment methodology in a way that would treat the lump sum as an additional source of funding for risk-adjustment payments. But the court's conclusion does not follow from its premise. Even assuming that risk-adjustment payments fell within the *substantive* scope of the lump-sum appropriation (but see point B, *infra*), the

timing of that annual appropriation meant that HHS could not have relied on it when it designed its risk-adjustment methodology for a given benefit year.

Since the inception of the program, HHS regulations—unchallenged here—have required that insurers be given advance notice of the risk-adjustment methodology for a particular benefit year, so that insurers can rely on that methodology when they set their annual rates and benefits for that year. *See* 45 C.F.R. § 153.320(a) (setting out the requirement that the methodology be "published in advance of the benefit year in rulemaking"). As the government's 59(e) motion explained, the lump-sum appropriation for a particular fiscal year was not enacted until long *after* the final risk-adjustment methodology was published for the corresponding benefit year. *See* Dkt. No. 57 at 16 & n.5. For example, the full-year program-management appropriation for fiscal year 2015 (which, NMHC alleged, HHS could have used to fund the 2014 risk-adjustment program) was not enacted until December 2014—more than twenty months after HHS finalized its methodology for that year. *See* Pub. L. No. 113-235, 128 Stat. 2130, 2477 (Dec. 16, 2014).

Because of the timing and uncertainty of the appropriations process, HHS could not reasonably have designed its risk-adjustment methodology to draw on the lump sum for risk-adjustment payments. It is a basic principle of appropriations law that "[a]gencies may not spend, or commit themselves to spend, in advance of . . . appropriations." GAO, *Principles of Federal Appropriations Law*, at 1-8 (4th ed. 2016 rev.). The Anti-Deficiency Act makes it unlawful for an officer or employee of the

federal government to incur an obligation for the payment of money "before an appropriation is made." 31 U.S.C. § 1341(a)(1)(B).

The district court recognized as much. The court acknowledged that "the lump sum appropriation for each year was enacted *after* the applicable Benefit Rule authorizing payments for that year." *NMHC II*, 340 F. Supp. 3d at 1130 n.6 (quoting the 59(e) motion). And the court acknowledged that it is unlawful for an agency to incur obligations "before an appropriation is made," *Id.* at 1174 (quoting the Anti-Deficiency Act). Under these circumstances, the court's pronouncement that HHS could have designed its risk-adjustment methodology to draw on the lump sum is inexplicable.

The district court's reliance on the Federal Circuit's decision in *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311 (Fed. Cir. 2018), was entirely misplaced. *See NHMC II*, 340 F. Supp. 3d at 1172-73. That case involved the temporary risk-corridors program established under section 1342 of the ACA, which was in place for the 2014-2016 benefit years. The risk-corridors program differed from the risk-adjustment program in a key respect: risk-corridors payment amounts were determined by a statutory formula set out in section 1343, rather than through a methodology that is developed annually. *See Moda*, 892 F.3d at 1314-15. Before the first set of payments came due, Members of Congress asked the GAO to identify the potential funding sources that HHS might use to make risk-corridors payments. *See id.* at 1318. In addition to identifying the funds that would be collected from insurers,

the GAO indicated that HHS might use the lump sum for CMS program management if Congress were to reenact, in subsequent appropriations acts, the same language it had used in the appropriations act for fiscal year 2014. *See id.* In response, Congress specified in the subsequent appropriations acts that HHS could *not* use the lump sum for risk-corridors payments. *See id.* at 1318-19. In other words, faced with the possibility that HHS might use taxpayer dollars (the lump sum) to make payments to insurers, Congress prohibited HHS from doing so. *See id.* at 1318-19, 1325.

There is every reason to think that Congress would have done the same for risk-adjustment payments if, as the district court envisioned, HHS had designed its risk-adjustment methodology in a way that anticipated making payments to insurers from the lump sum. It was eminently reasonable for HHS to decline to take that risk. Although the district court declared—in hindsight—that the lump sum could have been used for risk-adjustment payments, HHS does not make rules with the benefit of hindsight. At the time that HHS developed its annual risk-adjustment methodology, HHS did not know the terms of the yet-to-be-enacted annual appropriation. Treating the lump sum as a potential funding source thus would have produced significant uncertainty in the HHS risk-adjustment program, because insurers would not have known when they set premiums whether the lump sum would actually be available when the time to make payments arrived. Nor would they know how much of that lump sum, if any, would have been available for risk-adjustment payments after CMS's essential administrative functions were funded. And as the *Minuteman* court

emphasized, reducing uncertainty about such payments was a central objective of the program's design. *See Minuteman*, 291 F. Supp. 3d at 202-03. Indeed, HHS rejected the approach that NMHC and Minuteman later proposed—using a plan's own premium to determine the amount it should pay or receive—in part because the risk of funding shortfalls could "add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer estimates)." *Id.* (quoting 77 Fed. Reg. at 73,139). Reliance on a contingent, annual appropriation would have exacerbated the uncertainty that the agency was seeking to minimize.

B. The Substantive Limits on the Lump-Sum Appropriation Meant That the Lump Sum Was Not Available for Risk-Adjustment Payments.

Independent of the problem of timing discussed above, the district court was also wrong to conclude as a substantive matter that the lump sum was available for risk-adjustment payments. For the fiscal years at issue here, the annual appropriations acts stated that "except as otherwise provided," the lump sum was available for carrying out enumerated programs such as Medicaid and Medicare, and other responsibilities of CMS. *See, e.g.*, Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, div. G, title II, 128 Stat. 2130, 2477 (Dec. 16, 2014). Just as Congress "otherwise provided" for Medicare and Medicaid benefits through separate appropriations, Congress "otherwise provided" for risk-adjustment payments by allowing the amounts collected from insurers to be used to

fund those payments. Thus, risk-corridors payments could not properly have been made from the lump sum. Indeed, if the lump sum were used for Medicaid grants, Medicare payments, risk-adjustment payments and the like, HHS would not have had funding available for the important administrative expenses for which the lump sum was requested—such as paying the contractors that administer Medicare's fee-for-service programs. *See, e.g.*, Dkt. No. 57-3 (illustrative budget requests).

In stating that the lump sum could have been used for risk-adjustment payments, the district court relied on the opinion that the GAO had issued in the context of the risk-corridors program. *See NMHC II*, 340 F. Supp. 3d at 1172-74. The GAO, however, did not address the "except as otherwise provided" limitation in the lump-sum appropriation, which prevents HHS from using the lump sum for payments for which Congress has otherwise made an appropriation. *See Dep't of Health and Human Servs.-Risk Corridors Program*, B-325630, 2014 WL 4825237 (Comp. Gen. Sept. 30, 2014). The Federal Circuit likewise had no occasion to consider that limiting language, because Congress responded to the GAO opinion by specifically prohibiting use of the lump sum for risk-corridors payments, and thus made the limiting language academic. In any event, the GAO's conclusion as to the substantive reach of the lump sum has no practical impact here, given the independent problem of timing that we described in point A above.

C. The Risk-Adjustment Program Was Meant to Be Administered By States, Which Could Not Have Drawn on the Lump Sum for CMS Program Management.

A further problem with the funding approach envisioned by the district court is that Congress designed the risk-adjustment program to be administered by States, which indisputably cannot draw on the lump sum. Section 1343 of the ACA provides that "each State shall assess a charge" on insurers if "the actuarial risk of [their] enrollees . . . for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1). Likewise, section 1343 provides that "each State shall provide a payment" to insurers "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year." *Id.* § 18063(a)(2).

Section 1343 did not appropriate any extrinsic funding for risk-adjustment programs run by the States. As the *Minuteman* court noted, it "therefore stands to reason that absent any appropriation, Congress expected the states to run budget-neutral risk-adjustment programs, and for HHS to set its federal regulations to allow it to certify such programs." 291 F. Supp. 3d at 202 (citing 45 C.F.R. § 153.310).

The district court did not suggest that States could draw upon the lump sum when they administer their own risk-adjustment programs. Instead, the court suggested that HHS was required to develop a distinct methodology for use when HHS administers a risk-adjustment program on a State's behalf. *See NMHC II*, 340 F. Supp. 3d at 1171 (declaring that "HHS must rely on the CMS program management

appropriation to fund risk adjustment payments *when HHS implements risk adjustment on behalf of the states*") (emphasis added). But section 1343 did not direct HHS to develop a separate methodology for HHS-administered programs; section 1343 provided that HHS, "in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section." 42 U.S.C. § 18063(b).

HHS "interpret[ed] this provision to mean that HHS will establish a baseline methodology to be used by a State, or HHS on behalf of the State, in determining plan average actuarial risk," and explained that the methodology would encompass "the risk adjustment model, the calculation of plan average actuarial risk, and the calculation of payments and charges." 77 Fed. Reg. 17,220, 17,232-33 (Mar. 23, 2012). HHS indicated that it "intend[ed] to make its Federal risk adjustment methodology available for use by States, in its entirety or to help a State develop its own methodology." Aplt. App. 4 (HHS bulletin). That approach was well within HHS's discretion, particularly given the burdens associated with developing a risk-adjustment methodology. *See* 77 Fed. Reg. at 17,230 ("Developing a risk adjustment program is methodologically and operationally complex."). Nothing in the ACA required HHS to foist such burdens on the States. And given that HHS reasonably adopted a single methodology for its own use and use by the States, HHS was constrained to design a methodology that could be employed by the States without a source of extrinsic funding.

D. Using A Plan's Own Premium To Calculate Charge And Payment Amounts Would Have Distorted Premiums.

There were also additional problems, independent of the need for budget neutrality, with the approach that NMHC later advocated. As HHS explained and the *Minuteman* court recognized, using a plan's own premium to calculate the amounts it would pay or receive under the risk-adjustment program would have produced distorting effects on premiums. *See Minuteman*, 291 F. Supp. 2d at 203.

The premise of the risk-adjustment program is that "premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population." 78 Fed. Reg. 15,410, 15,417 (Mar. 11, 2013). But if risk-adjustment payments were based on a plan's own premium, then higher-risk plans would have an incentive to raise premiums, so as to increase their risk-adjustment payments. "Specifically, HHS explained in the white paper that '[f]or plans with a sicker than average risk mix, a lower premium plan would receive less in payments than a higher premium plan, even if the two plans have the same risk level," which "could create disincentives for high-risk plans to operate efficiently or set lower prices." *Minuteman*, 291 F. Supp. 3d at 203 (quoting the 2011 white paper).

"HHS also explained that using the average premium 'disconnects each plan's risk-adjustment compensation from its choice of what premium to charge.'" *Minuteman*, 291 F. Supp. 3d at 203 (quoting the 2011 white paper). In other words, the white paper made clear the concern "that issuers would price their plans to game

the risk-adjustment calculation or that individual plans' pricing decisions could have an outsize effect on the total funds available or required for the risk-adjustment program in a given year." *Id.* And as the *Minuteman* court concluded, these "other reasons HHS gave for choosing the statewide average premium are sufficient to show that it considered the relevant comments and rationally chose to use the statewide average premium based on the evidence before it." *Id.*

III. The District Court Should Have Protected Third-Party Reliance Interests by Denying the Equitable Remedy of Vacatur or Tailoring the Relief to Plaintiff's Injury.

For the reasons discussed above, the judgment of the district court should be reversed on waiver grounds or, alternatively, on the merits. No commenter urged HHS to use the lump sum as a funding source for risk-adjustment payments, and the problems with such an approach were apparent. But assuming that the argument had not been waived, and assuming that additional explanation for the budget-neutral design of HHS's risk-adjustment methodology was needed, the district court should have protected third-party reliance interests by denying the equitable remedy of vacatur or by tailoring the relief to plaintiff's injury. There was no reason to disrupt the risk-adjustment program at all, much less to do so on a nationwide basis.

A. Vacatur Was Unjustified.

As the district court recognized, vacatur is a form of equitable relief that is not appropriate in all cases. *See NMHC II*, 340 F. Supp. 3d at 1176. It is axiomatic that equitable relief "does not follow from success on the merits as a matter of course,"

but rather is subject to "equitable discretion." *Winter v. Natural Res. Def. Council, Inc.*, 555 U.S. 7, 32 (2008). Accordingly, courts must consider "the balance of equities" and "the public interest" in assessing the propriety of injunctive relief. *Id.* These principles apply with equal force to APA litigation, as courts "do not lightly assume that Congress has intended to depart from established principles" regarding equitable discretion. *Weinberger v. Romero-Barcelo*, 456 U.S. 305, 313 (1982); *see Hecht Co. v. Bowles*, 321 U.S. 321, 327-28 (1944) (court has discretion to withhold equitable relief even where statute required that a "permanent or temporary injunction, restraining order, or other order be granted").

As the district court observed, "[t]he decision whether to vacate depends on 'the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed.'" *NMHC II*, 340 F. Supp. 3d at 1177 (quoting *Allied-Signal, Inc. v. Nuclear Regulatory Comm'n*, 988 F.2d 146, 150-51 (D.C. Cir. 1993)). "Vacatur typically is inappropriate where it is 'conceivable' that the [agency] can, if given the opportunity, create a supportable rule." *Prometheus Radio Project v. FCC*, 824 F.3d 33, 52 (3d Cir. 2016).

Here, the "deficiency" that the district court identified was HHS's failure to explain why it had designed its risk-adjustment methodology as budget neutral. The court emphasized that it did not "take issue with the substance of HHS' decision; instead, it conclude[d] that HHS fails to satisfactorily explain its decision's rationale."

NMHC II, 340 F. Supp. 3d at 1175. And in the district court's initial decision, it recognized that the deficiency could easily be cured. The court expressly acknowledged that "nothing in the statute forbids budget neutrality"; that "designing risk adjustment to be budget neutral may be a reasonable policy choice"; and that "there may be excellent policy reasons for making the risk adjustment plan budget neutral." *NMHC I*, 312 F. Supp. 3d at 1210.

By the time the district court issued its opinion on the Rule 59(e) motion, HHS had already provided additional explanations for its budget-neutral approach. These explanations were given during the summer of 2018, when—to avert a crisis in the insurance markets caused by the district court's initial opinion—HHS re-adopted the same methodology that had been published in advance of the 2017 benefit year, and proposed to do the same for the 2018 benefit year. *See* 83 Fed. Reg. 36,456, 36,457-59 (July 30, 2018) (final rule for 2017 benefit year); 83 Fed. Reg. 39,644, 39,646-47 (Aug. 10, 2018) (proposed rule for the 2018 benefit year).

These explanations left no doubt that reliance on the lump sum would have added significant uncertainty to a program in which predictability is a key objective. For example, HHS explained that if it had "elected to adopt a risk adjustment methodology that was contingent on appropriations from Congress through the annual appropriations process," such as the lump sum, that "would have created uncertainty for issuers regarding the amount of risk adjustment payments they could expect for a given benefit year." 83 Fed. Reg. at 39,646-47. HHS emphasized that

"[t]hat uncertainty would have undermined one of the central objectives of the risk adjustment program, which is to assure issuers in advance that they will receive risk adjustment payments if, for the applicable benefit year, they enroll a higher-risk population compared to other issuers in the state market risk pool." *Id.* at 39,647.

Furthermore, HHS explained that it would not have chosen to use the lump sum for risk-adjustment payments for additional policy reasons. *See* at 83 Fed. Reg. at 39,647 n.9. HHS explained that its purpose in requesting the annual lump sum is to pay the administrative costs of CMS programs such as Medicare, Medicaid, and the Children's Health Insurance Program, and that "CMS would have elected to use the lump sum for these important program management expenses even if CMS had discretion to use all or part of the lump sum for risk adjustment payments." *Id.* The district court itself recognized that an agency's choice regarding how to spend a lump sum is committed to agency discretion by law and not subject to judicial review. *See NMHC II*, 340 F. Supp. 3d at 1174 ("HHS is correct that courts cannot substantively review an agency's choices regarding how to spend lump sum appropriations." (citing *Lincoln v. Vigil*, 508 U.S. 182, 192 (1993) ("The allocation of funds from a lump-sum appropriation is another administrative decision traditionally regarded as committed to agency discretion.")).

The district court refused to consider these policy reasons for the budget-neutral design of HHS's methodology, because these explanations were given after the initial rules were promulgated for the 2014-2018 benefit years. Without discussing the

substance of the agency's additional explanations, the court pronounced that it "does not appreciate HHS attempting to rationalize budget neutrality only now when it should have provided a conscious explanation when it proposed the formula in the first instance." *NMHC II*, 340 F. Supp. 3d at 1179.

The district court's refusal to consider the agency's explanations is difficult to comprehend. The court vacated the use of the statewide average premium on the ground that HHS had failed to explain why it designed its methodology as budget neutral, and the court remanded to HHS for further proceedings. The agency could not, of course, go back in time to provide a contemporaneous explanation for the previously issued methodology. And as discussed above, the agency had no reason to do so contemporaneously because no commenter had taken issue with the budget-neutral approach. The rationales that HHS subsequently identified apply to all program years, and the district court did not suggest otherwise. The court could not properly ignore these additional explanations, which HHS specifically called to the court's attention in support of the pending 59(e) motion. *See* Dkt. Nos. 81, 84.

The district court was equally wrong to declare that vacatur would be non-disruptive. The premise of that ruling is that insurers do not rely on the risk-adjustment methodology that is published in advance of each benefit year. The court explained that it did "not believe that vacating the rules for 2014-2018 will create uncertainty for insurance companies as to rate-setting or cause them to raise premiums" because, in the court's view, an academic article "shows that insurance

companies are already unclear as to how the risk adjustment program affects them." *NMHC II*, 340 F. Supp. 3d at 1181 (citing Daniel J. Perlman & David M. Liner, Milliman, *Financial Analysis of ACA Health Plan Issuers* 3 (Feb. 2016)). The district court declared that "risk adjustment is a non-factor in setting premiums." *NMHC II*, 340 F. Supp. 3d at 1182.

That cavalier disregard for a central purpose of the risk-adjustment program would be impermissible even if it had substantial empirical support. In fact, the Milliman article on which the district court relied was simply a retrospective analysis of the program's first year. Insurers have repeatedly emphasized the role that a predictable risk-adjustment formula plays in setting premiums. AHIP, which is the national trade representative for health plans, specifically warned the district court that "a health plan's pricing is inextricably linked to its risk adjustment transfers and health plans must therefore make assumptions as to such transfers when setting their premiums." Aplt. App. 71. AHIP emphasized that "all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions." Aplt. App. 70. The district court did not even acknowledge these industry concerns. By contrast, HHS has recognized and accommodated them since the inception of the program. As the *Minuteman* court explained, "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." *Minuteman*, 291 F. Supp. 3d at 182.[4]

The district court could not properly substitute its views for those of the agency. This Court and the Supreme Court have recognized that deference to an agency is at its apex when, as here, an agency's policy reflects technical judgments informed by the comments of stakeholders. *See WildEarth Guardians v. U.S. Fish & Wildlife Serv.*, 784 F.3d 677, 683 (10th Cir. 2015) ("Our deference to the agency is more substantial when the challenged decision involves technical or scientific matters within the agency's area of expertise."); *Long Island Care at Home, Ltd. v. Coke*, 551 U.S. 158, 167-68 (2007) (explaining that the resolution of policy questions "may well turn upon the kind of thorough knowledge of the subject matter and ability to consult at length with affected parties that an agency" possesses).

Nor could vacatur be justified by the district court's belief that the risk-adjustment "program itself has harmed insurers and the insured, with exorbitant charges forcing some insurers to close their doors, decreasing market competition, and increasing premiums." *NMHC II*, 340 F. Supp. 3d at 1182. As the *Minuteman*

[4] *See also, e.g.*, 81 Fed. Reg. at 94,072-73 (noting the concerns of commenters that "making any changes to the methodology after rate setting and close to the beginning of the benefit year could create uncertainty"); *id.* at 94,073 ("We recognize that issuers incorporate the applicable benefit year's risk adjustment methodology in their rate setting."); 78 Fed. Reg. at 15,418 ("[W]e seek to balance stakeholders' desire for a stable model in the initial years with introducing model improvements as additional data becomes available.").

court recognized, that is a "very-much-disputed" claim. *Minuteman*, 291 F. Supp. 3d at 195. More fundamentally, the role of a court is "not to sit in judgment on the wisdom of the law." *Id.* at 171. The district court's belief that the risk-adjustment program is poor policy does not give it license to undermine the program through a vacatur order.

B. The District Court Should Have Tailored Its Relief to Plaintiff's Injury.

For the reasons discussed above, there was no basis for the district court to disrupt the risk-adjustment program at all. But assuming that relief was appropriate, the court should have limited the disruption by confining its relief to plaintiff alone or to the application of the challenged methodology in New Mexico.

In rejecting the argument for tailored relief, the district court declared that it "does not know how a court vacates a rule only as to one state, one district, or one party," and indicated that it "cannot, in an intellectually honest manner, limit vacatur of the rules to the state of New Mexico." *NMHC II*, 340 F. Supp. 3d at 1183. For support, the court emphasized that "the APA's text indicates that vacatur is the mandatory remedy for arbitrary and capricious agency action." *Id.* at 1175-76 (quoting 5 U.S.C. § 706 ("The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusion found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law.")).

As discussed above, however, the APA does not displace the traditional rule that equitable relief must comport with "what is necessary, what is fair, and what is workable," *North Carolina v. Covington*, 137 S. Ct. 1624, 1625 (2017) (per curiam), and that such relief must be "narrowly tailored to remedy the harm shown," *Garrison v. Baker Hughes Oilfield Operations, Inc.*, 287 F.3d 955, 962 (10th Cir. 2002). In this case, the "agency action" that aggrieved NMHC was the imposition of risk-adjustment charges *against it*. This case is not a class action, and NMHC does not have standing to seek relief on behalf of other insurers. The Supreme Court recently reaffirmed that a court's "constitutionally prescribed role is to vindicate the individual rights of the people appearing before it," and "[a] plaintiff's remedy must be tailored to redress the plaintiff's particular injury." *Gill v. Whitford*, 138 S. Ct. 1916, 1933, 1934 (2018). The application of the risk-adjustment methodology to NMHC is the only proper subject of review, *see Lujan v. National Wildlife Fed'n*, 497 U.S. 871, 891 (1990), and thus the outer limit of any relief.

Nor was there reason to believe that other insurers shared NMHC's desire to vacate an aspect of the risk-adjustment methodology that was in place for prior benefit years. On the contrary, although "AHIP's and BCBSA's members also include many health plans that must *pay* risk adjustment transfers," amici emphasized that "all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions." Aplt. App. 70 (amici's emphasis).

Furthermore, the risk-adjustment program is operated on a State-by-State basis, and there was no justification for the district court to grant relief outside the State of New Mexico. *See, e.g.*, Aplt. App. 5 (explaining that to "ensure equity within any State's risk adjustment program, HHS will treat each State's risk adjustment charges and payments as separate accounts" and "will not offset charges for an issuer for one State based on payments due to that same issuer in another State"). Just as the *Minuteman* court's decision does not dictate the law in New Mexico, neither should the district court's decision here dictate the law in any other State. Contrary to the district court's premise, "[n]othing in the language of the APA" required it "to exercise such far-reaching power," which would "in effect be imposing [its] view of the law on all the other circuits." *Virginia Soc'y for Human Life, Inc. v. Federal Election Comm'n*, 263 F.3d 379, 393-94 (4th Cir. 2001), overruled on other grounds by *The Real Truth About Abortion, Inc. v. Fed. Election Comm'n*, 681 F.3d 544 (4th Cir. 2012).

CONCLUSION

The judgment of the district court should be reversed.

Respectfully submitted,

JOSEPH H. HUNT
Assistant Attorney General

JOHN C. ANDERSON
United States Attorney

s/ Alisa B. Klein

ALISA B. KLEIN
JOSHUA REVESZ
Attorneys, Appellate Staff
Civil Division, Room 7235
U.S. Department of Justice
950 Pennsylvania Avenue NW
Washington, DC 20530
(202) 514-1597
Alisa.klein@usdoj.gov

Of Counsel:

ROBERT P. CHARROW
General Counsel

KELLY M. CLEARY
Deputy General Counsel

H. ANTONY LIM
JULLIA CALLAHAN BRADLEY
Attorneys

U.S. Department of Health & Human Services

March 2019

REQUEST FOR ORAL ARGUMENT

The district court vacated on a nationwide basis the risk-adjustment methodologies established by HHS for the 2014-2018 benefit years. In light of the importance of this case, the government respectfully requests oral argument.

REQUIRED 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.

(4) This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 11,316 words. This brief complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

(5) On March 19, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Tenth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Alisa B. Klein
Alisa B. Klein

ADDENDUM: STATUTE AND REGULATIONS

TABLE OF CONTENTS

42 U.S.C. § 18063 – ACA § 1343

(a) In general

(1) Low actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall assess a charge on health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974 [29 U.S.C. 1001 et seq.]).

(2) High actuarial risk plans

Using the criteria and methods developed under subsection (b), each State shall provide a payment to health plans and health insurance issuers (with respect to health insurance coverage) described in subsection (c) if the actuarial risk of the enrollees of such plans or coverage for a year is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year that are not self-insured group health plans (which are subject to the provisions of the Employee Retirement Income Security Act of 1974).

(b) Criteria and methods

The Secretary, in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities under this section. The Secretary may utilize criteria and methods similar to the criteria and methods utilized under part C or D of title XVIII of the Social Security Act [42 U.S.C. 1395w-21 et seq., 1395w-101 et seq.]. Such criteria and methods shall be included in the standards and requirements the Secretary prescribes under section 18041 of this title.

(c) Scope

A health plan or a health insurance issuer is described in this subsection if such health plan or health insurance issuer provides coverage in the individual or small group market within the State. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.

45 C.F.R. § 153.320

(a) General requirement. Any risk adjustment methodology used by a State, or HHS on behalf of the State, must be a Federally certified risk adjustment methodology. A risk adjustment methodology may become Federally certified by one of the following processes:

(1) The risk adjustment methodology is developed by HHS and published in advance of the benefit year in rulemaking; or

(2) An alternate risk adjustment methodology is submitted by a State in accordance with § 153.330, reviewed and certified by HHS, and published in the applicable annual HHS notice of benefit and payment parameters.

(b) Publication of methodology in notices. The publication of a risk adjustment methodology by HHS in an annual HHS notice of benefit and payment parameters or by a State in an annual State notice of benefit and payment parameters described in subpart B of this part must include:

(1) A complete description of the risk adjustment model, including—

(i) Draft factors to be employed in the model, including but not limited to, demographic factors, diagnostic factors, and utilization factors, if any, the dataset(s) to be used to calculate final coefficients, and the date by which final coefficients will be released in guidance;

(ii) The qualifying criteria for establishing that an individual is eligible for a specific factor;

(iii) Weights assigned to each factor; and

(iv) The schedule for the calculation of individual risk scores.

(2) A complete description of the calculation of plan average actuarial risk.

(3) A complete description of the calculation of payments and charges.

(4) A complete description of the risk adjustment data collection approach.

(5) The schedule for the risk adjustment program.

(c) Use of methodology for States that do not operate a risk adjustment program. HHS will specify in the annual HHS notice of benefit and payment parameters for the applicable year the Federally certified risk adjustment methodology that will apply in States that do not operate a risk adjustment program.

(d) State flexibility to request reductions to transfers. Beginning with the 2020 benefit year, States can request to reduce risk adjustment transfers in the State's individual, small group or merged markets by up to 50 percent in States where HHS operates the risk adjustment program.

(1) State requests. State requests for a reduction to transfers must include:

(i) Supporting evidence and analysis demonstrating the State-specific factors that warrant an adjustment to more precisely account for the differences in actuarial risk in the State market;

(ii) The adjustment percentage of up to 50 percent requested for the State individual, small group or merged market; and

(iii) A justification for the reduction requested demonstrating the State-specific factors that warrant an adjustment to more precisely account for relative risk differences in the State individual, small group or merged market, or demonstrating the requested reduction would have de minimis impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.

(2) Timeframe to Submit Reduction Requests. States must submit requests for a reduction to transfer in the individual, small group or merged market by August 1 of the year, 2 calendar years prior to the applicable benefit year in the form and manner specified by HHS.

(3) Publication of Reduction Requests. HHS will publish State reduction requests in the applicable benefit year's HHS notice of benefit and payment parameters proposed rule and make the supporting evidence available to the public for comment. HHS will publish any approved State reduction requests or denied State reduction requests in the applicable benefit year's HHS notice of benefit and payment parameters final rule.

(4) HHS approval.

(i) Subject to paragraph (d)(4)(ii) of this section, HHS will approve State requests if HHS determines, based on the review of the information submitted as part of the State's request, along with other relevant factors, including the premium impact of the transfer reduction for the State market, and relevant public comments:

(A) That State-specific rules or other relevant factors warrant an adjustment to more precisely account for relative risk differences in the State individual, small group or merged market and support the percentage reduction to risk adjustment transfers requested; or

(B) That State-specific rules or other relevant factors warrant an adjustment to more precisely account for relative risk differences in the State's individual, small group or merged market and the requested reduction would have de minimis impact on the necessary premium increase to cover the transfers for issuers that would receive reduced transfer payments.

(ii) HHS may approve a reduction amount that is lower than the amount requested by the State if the supporting evidence and analysis do not fully support the requested reduction amount. HHS will assess other relevant factors, including the premium impact of the transfer reduction for the State market.

ADDENDUM: OPINIONS AND ORDERS

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS,
a New Mexico Non-Profit Corporation,

Plaintiff,

vs. No. CIV 16-0878 JB/JHR

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE AND MEDICAID SERVICES; SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, in her official capacity and ANDREW M. SLAVITT, Acting Administrator for the Centers for Medicare and Medicaid Services, in his official capacity,

Defendants.

MEMORANDUM OPINION AND ORDER

THIS MATTER comes before the Court on: (i) the Plaintiff's Motion for Summary Judgment, filed April 13, 2017 (Doc. 32)("Health Connection's Motion"); and (ii) the Defendants' Cross-Motion for Summary Judgment, filed June 1, 2017 (Doc. 34)("Defendants' Motion"). The Court held a hearing on January 22, 2018. The primary issues are: (i) whether the Administrative Procedure Act, 5 U.S.C. § 702 ("APA"), waives sovereign immunity for all of Plaintiff New Mexico Health Connections' claims; (ii) whether incorporating statewide average premiums in Defendant United States Department of Health and Human Services' ("HHS") [1] risk-adjustment formula is contrary to law or arbitrary and capricious; (iii) whether HHS' approach to predicting costs for hierarchal condition category ("HCC") and non-HCC

[1]HHS is not the only Defendant in this case, but Health Connections challenges the agency's actions, so the Court will refer to HHS only, for simplicity's sake.

eligible enrollees is arbitrary and capricious; (iv) whether HHS' decisions regarding partial year enrollees and the use of prescription drug data in its risk adjustment model are arbitrary and capricious; and (v) whether HHS' risk adjustment formula effectively bans bronze health insurance plans and is contrary to law. The Court concludes that: (i) the APA waives sovereign immunity for all of the claims presented, thereby giving the Court subject-matter jurisdiction; (ii) HHS' use of statewide average premiums in its risk adjustment methodology is not contrary to law, but is arbitrary and capricious; (iii) HHS' approach to predicting costs for HCC and non-HCC eligible enrollees is not arbitrary and capricious; (iv) HHS' decisions regarding partial year enrollees and the use of prescription drug data in its risk adjustment model are not arbitrary and capricious; and (v) HHS' risk adjustment formula does not, in effect, ban bronze health insurance plans. Accordingly, the Health Connection's Motion is granted in part and denied in part. The Defendants' Motion is granted in part and denied in part. The Court sets aside and vacates the agency action as to the statewide average premium rules and remands the case to the agency for further proceedings. It otherwise dismisses Health Connections' remaining claims with prejudice.

FACTUAL BACKGROUND

Health Connections seeks APA review of agency action, so rule 56 of the Federal Rules of Civil Procedure does not apply even though both Health Connections and HHS ostensibly filed motions for summary judgment. See Olenhouse v. Commodity Credit Corp., 42 F.3d 1560, 1580 (10th Cir. 1994)("Reviews of agency action in the district courts must be processed *as appeals*." (emphasis in original))("Olenhouse"); id. ("[M]otions for summary judgment are conceptually incompatible with the very nature and purpose of an appeal."). See also Jarita Mesa Livestock Grazing Ass'n v. U.S. Forest Serv., 305 F.R.D. 256, 281 (D.N.M.

2015)(Browning, J.). Accordingly, district courts reviewing agency action do not determine whether a "genuine dispute as to any material fact" exists, Fed. R. Civ. P. 56, and instead "engage in a substantive review of the record to determine if the agency considered relevant factors or articulated a reasoned basis for its conclusions," Olenhouse, 42 F.3d at 1580. See Jarita Mesa Livestock Grazing Ass'n v. U.S. Forest Serv., 305 F.R.D at 281 ("District courts may not entertain motions for summary judgment or any other procedural devices that shift the appellant's substantial burden -- arbitrary-or-capricious review for questions of fact and Chevron deference for questions of statutory interpretation -- onto the agency."). While engaging in that substantive review, "the district court should govern itself by referring to the Federal Rules of Appellate Procedure." Olenhouse, 42 F.3d at 1580. To be clear, the Court recounts the following undisputed facts as a comprehensive factual background for its APA review and not as a summary-judgment analysis.[2]

[2]The Court's approach when reviewing agency action is importantly different from its summary-judgment approach, because "judicial review of agency action is normally restricted to the administrative record." Lee v. U.S. Air Force, 354 F.3d 1229, 1242 (10th Cir. 2004). See Camp v. Pitts, 411 U.S. 138, 142 (1973)("[T]he focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court."). The original administrative record before the Court, see Defendants' Notice of Manual Filing of Administrative Record, filed February 22, 2017 (Doc. 25), inadvertently omits some documents, however, see Stipulation Concerning Administrative Record ¶ 1, at 1, filed March 15, 2017 (Doc. 29), and "[i]f anything material to either party is omitted from or misstated in the record by error or accident, the omission or misstatement may be corrected and a supplemental record may be certified," Fed. R. App. P. 10(e)(2). Health Connections filed a "Supplemental Appendix of record materials," Plaintiff New Mexico Health Connections' Notice of Manual Filing of Supplemental Appendix at 1, filed April 13, 2017 (Doc. 31). The Court will cite that supplemental appendix as "NMHC."

Health Connections argues that the Court should further supplement the administrative record by taking judicial notice of certain documents. See Plaintiff's Reply and Opposition to Defendants' Cross-Motion for Summary Judgment at 11 n.13, filed July 13, 2017 (Doc. 40). Those documents include newspaper articles, state agency websites, federal agency reports, and congressional reports. See Exhibit 5, filed April 13, 2017 (Doc. 33-2)(congressional report); Exhibit 13, filed April 13, 2017 (Doc. 33-6); Exhibit 14, filed April 13, 2017 (Doc. 33-7)(state agency website; Exhibit A, filed July 13 2017 (Doc. 40-2)(newspaper article).

1. The Affordable Care Act.

Congress enacted The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)(codified at 42 U.S.C. §§ 300gg-1 to -19, 18001-18022)("ACA") "to expand coverage in the individual health insurance market." King v. Burwell, 135 S. Ct. 2480, 2485 (2015)(Roberts, C.J.). To effect that goal, the ACA: (i) bars insurers from considering pre-existing medical conditions when deciding whether to sell insurance and determining prices; (ii) requires individuals to make an individual shared responsibility payment to the Internal

---

Rule 201 of the Federal Rules of Evidence permits judicial notice of facts that are "not subject to reasonable dispute," because those facts are either "generally known" or "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned." Fed. R. Evid. 201(b). The United States Court of Appeals for the Tenth Circuit's precedent indicates that the ordinary evidentiary rules regarding judicial notice apply when a court reviews agency action. See New Mexico ex. rel. Richardson v. Bureau of Land Mgmt., 565 F.3d 683, 702 n.21 (10th Cir. 2009)(citing Fed. R. Evid. 201(b))("We take judicial notice of this document, which is included in the record before us in [another case]."); id. at 702 n.22 ("We conclude that the occurrence of Falcon releases is not subject to reasonable factual dispute and is capable of determination using sources whose accuracy cannot reasonably be questioned, and we take judicial notice thereof."). In contrast, the United States Courts of Appeals for the Ninth and Eleventh Circuits have held that taking judicial notice is inappropriate in APA reviews absent extraordinary circumstances or inadvertent omission from the administrative record. See Compassion Over Killing v. U.S. Food & Drug Administration, 849 F.3d 849, 852 n.1 (9th Cir. 2017); National Min. Ass'n v. Secretary U.S. Dep't of Labor, 812 F.3d 843, 875 (11th Cir. 2016).

The Court will not use rule 201 of the Federal Rules of Evidence to add the documents that Health Connections identifies to the administrative record, because rule 201 permits the Court to take judicial notice of facts and not documents. That a document exists is a fact and, with respect to the documents that Health Connections filed with the Court, it is a fact susceptible to judicial notice. See Graham v. Catamaran Health Solutions, LLC, 2017 WL 3613328, at *2 n.1 (8th Cir. 2017)("[W]e may take judicial notice of filings of public record and the fact (but not the veracity) of parties' assertions therein."); In re Santa Fe Natural Tobacco Company Marketing & Sales Practices and Products Litig., __ F. Supp. 3d __, 2017 WL 6550897, at *61 (D.N.M. 2017)(Browning, J.)("Indeed, any party can file a document in a proceeding, but that does not mean that the document's contents are beyond reproach."). It does not follow from a document's existence, however, that it contains facts that are "not subject to reasonable dispute." Fed. R. Evid. 201(b). See Stephen A. Saltzburg et al., FEDERAL RULES OF EVIDENCE MANUAL § 201.02[3], at 201-08 ("[A] court can take judicial notice that court filings contained certain allegations . . . , [b]ut the truth of these allegations and findings are not proper subjects of judicial notice.").

Revenue Service unless they maintain health-insurance coverage; and (iii) gives certain individuals tax credits to make health insurance more affordable for them. See King v. Burwell, 135 S. Ct. at 2485; 26 U.S.C. § 5000A (describing the individual shared responsibility payment requirement).

Additionally, the ACA establishes Health Benefit Exchanges ("Exchanges"), online marketplaces where individuals can purchase health insurance and potentially obtain federal subsidies. See 42 U.S.C. §§ 18031-18033. Qualified health plans sold on the Exchanges must provide bronze-level, silver-level, gold-level, or platinum-level coverage. See 42. U.S.C. § 18021(a)(1)(defining a qualified health plan); 42 U.S.C. § 18022(d)(1)(setting out four coverage levels). Bronze-level plans are designed such that, on average, the insurance company pays sixty percent of its policyholders' covered healthcare costs; that percentage increases to seventy, eighty, and ninety percent for silver-, gold-, and platinum-level plans, respectively. See 42 U.S.C. § 18022(d)(1); The 'Metal' Categories: Bronze, Silver, Gold & Platinum, HEALTHCARE.GOV, http://www.healthcare.gov/choose-a-plan/plans-categories/. Consequently, bronze-level plans tend to attract individuals who anticipate fewer healthcare needs, i.e., healthier people, whereas gold-level and platinum-level plans tend to attract individuals who anticipate more healthcare needs, i.e., sicker individuals. See State Health Insurance Exchange Risk Adjustment and Plan Metals Level Memorandum at 3 (dated December 15, 2011)(A.R.000811); Risk Adjustment Implementation Issues, Draft for Discussion Purposes at 31 (dated September 12, 2011)(A.R.004397).

The ACA also establishes the Consumer Operated and Oriented Plan ("CO-OP") program. 42 U.S.C. § 18042(a). The CO-OP program provides loans and grants to new nonprofit health-insurance issuers, which fosters competition in the individual health-insurance

market. 42 U.S.C. § 18042(a)-(b). See also Memorandum of Law in Support New Mexico Health Connections' Motion For Summary Judgment ¶ 19, at 10, filed April 13, 2017 (Doc. 33)("Plaintiff Mem.")("Congress created the CO-OP program to enhance competition.").[3] To receive these loans or grants, however, insurers must offer their health-insurance plans on the Exchanges. See 45 C.F.R. § 156.515(c). See also Plaintiff Mem. ¶ 21, at 10.

The ACA expands healthcare access, but it also increases health-insurance-industry risk. That the ACA requires insurers to cover all individuals, healthy or otherwise, means an unlucky insurer could end up providing coverage to a particularly sickly group of customers. See 42 U.S.C. § 300gg-1(a)("[E]ach health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage."). The ACA makes things even worse for those unlucky insurers by prohibiting them from responding to the increased cost of providing healthcare coverage to sicker individuals by charging those individuals higher prices. See 42 U.S.C. § 300gg(a)(prohibiting price discrimination based on factors other than geography, age, tobacco use, and whether coverage extends to an individual to a family). Taken together, those two ACA requirements "threaten to impose massive new costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 548 (2012).

The ACA contemplates three kinds of programs -- two temporary and one permanent -- that ameliorate the risks it creates. See 42 U.S.C. §§ 18061-18063. First, under transitional reinsurance programs, which operate only from 2014 to 2016, insurers make payments to "an applicable reinsurance entity," typically HHS, and reinsurance entities use those funds to provide

[3]Health Connections' arguments supporting its motion are all in the Plaintiff Mem. See Plaintiff Mem. at 1.

"reinsurance payments" to insurers that cover "high risk individuals." 42 U.S.C. § 18061(b)(1). According to HHS, "[t]he reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (dated March 11, 2013)(A.R.000227-28)("2014 Final Rule"). "Each State is eligible to establish a reinsurance program," but "HHS will establish a reinsurance program for each State that does not elect to establish its own reinsurance program." 45 C.F.R. § 153.210(a), (c). Second, under the temporary risk corridor program, which also operates only from 2014 to 2016, sufficiently profitable insurers must make payments to HHS while HHS must make payments to sufficiently unprofitable insurers. See 42 U.S.C. § 18062. Those payments, HHS predicts, "will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R.000228).

Third, under permanent risk adjustment programs, "each State shall assess a charge" on insurers "if the actuarial risk of [their] enrollees . . . for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1). Likewise, "each State shall provide a payment" to insurers "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year." 42 U.S.C. § 18063(a)(2). Risk adjustment programs are "intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees." 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R.000228).

2. Risk Adjustment Implementation.

While the ACA refers to "States" assessing charges and providing payments in risk

adjustment programs, 42 U.S.C. § 18063(a), it also tells HHS to, "in consultation with States, shall establish criteria and methods to be used in carrying out the risk adjustment activities," 42 U.S.C. § 18063(b), and HHS regulations state that it will implement PRA programs for "[a]ny State that does not elect to operate an Exchange, or that HHS has not approved to operate an Exchange," 45 C.F.R. § 153.310(a)(2), for "[a]ny State that elects to operate an Exchange but does not elect to administer risk adjustment," 45 C.F.R. § 153.310(a)(3), and for, "[b]eginning in 2015, any State that is approved to operate an Exchange and elects to operate risk adjustment but has not been approved by HHS to operate risk adjustment," 45 C.F.R. § 153.310(a)(4). Only Massachusetts, however, elected to operate its own PRA program, see HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,759 (dated February 27, 2015)(A.R. 005691)("2016 Final Rule"), and that program did not last long, see HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,230 (dated March 8, 2016)(A.R.007774)("2017 Final Rule")("We are not recertifying the alternate State methodology for use in Massachusetts for 2017 risk adjustment. Massachusetts and HHS will begin the transition that will allow HHS to operate risk adjustment in Massachusetts in 2017.").

HHS thus implements New Mexico's -- and forty-nine other states' -- risk adjustment program. See 2017 Final Rule, 81 Fed. Reg. at 12,230 (dated March 8, 2016)(A.R.007774)("HHS will operate risk adjustment in all States for the 2017 benefit year."). In doing so, HHS annually publishes its risk adjustment methodology. See 45 C.F.R. § 153.320 ("HHS will specify in the annual HHS notice of benefit and payment parameters for the applicable year the Federally certified risk adjustment methodology that will apply in States that do not operate a risk adjustment program."). HHS' published risk adjustment methodology must describe: (i) how HHS calculates individual risk scores, see 45 C.F.R. § 153.320(b)(1), which are

"a relative measure of predicted health care costs" for particular individuals, 45 C.F.R. § 153.20; (ii) how HHS determines a plan's average actuarial risk from individual risk scores, see 45 C.F.R. §§ 153.20, .320(b)(2); and (iii) how HHS uses a plan's average actuarial risk to determine the plan's risk adjustment payments and charges, see 45 CFR §§ 153.20, .320(b)(3).

HHS' risk adjustment methodology[4] "predict[s] plan liability for an enrollee based on that person's age, sex, and diagnoses (risk factors), producing a[n individual] risk score." 2014 Final Rule, 78 Fed. Reg. at 15,419. HHS calculates a health plan's average risk score by averaging its enrollees' individual risk scores; each individual risk score is weighted by the number of months the relevant individual was enrolled in the health plan. See 2014 Final Rule, 78 Fed. Reg. at 15,432. HHS multiplies the "State average premium" by several plan-cost factors, "relative measures that compare how [a] plan[] differ[s] from the market average," including the plan's average risk score to produce to produce a plan-premium estimate. 2014 Final Rule, 78 Fed. Reg. at 15,430-31. "Multiplying the plan['s] average risk score by the State average premium shows how a plan's premium would differ from the State average premium based on the risk selection experienced by the plan." 2014 Final Rule, 78 Fed. Reg. at 15,431. HHS also produces a second plan-premium estimate by multiplying the state average premium by plan-cost factors other than the plan's average risk score. 2014 Final Rule, 78 Fed. Reg. at 15,430. HHS' payment transfer formula takes the first plan-premium estimate and subtracts the second, which "provides a per member per month (PMPM) transfer amount for a plan." 2014

[4]The Court refers to HHS' published risk adjustment methodology in general terms even though HHS has five different published risk adjustment methodologies, one for each year from 2014 to 2018, because, while those methodologies differ in detail, they have the same basic structure. See, e.g., 81 Fed. Reg. 12,330 (dated March 8, 2016)("Although we did not propose to change the payment transfer formula from what was finalized in the 2014 Payment in its entirety, since, as noted above, we are recalibrating the HHS risk adjustment model."). Where the differences between HHS' five payment methodologies are important, the Court will be more specific.

Final Rule, 78 Fed. Reg. at 15,431. Finally, HHS multiplies a plan's per member, per month transfer amount by its number of "billable member months . . . to calculate the plan's total risk adjustment payment." 2014 Final Rule, 78 Fed. Reg. at 15,431.

Each year, HHS monitors and updates the risk adjustment model "with more recent data," but it does not "reconsider[] the entire methodology anew each year." Defendant Mem. ¶ 14, at 13. See Defendant Mem. ¶ 15, at 13; Plaintiff Mem. ¶ 7, at 5-6. There is a lag between HHS' promulgation of annual risk adjustment formula rules and the data it received from issuers, so, "[b]y the time results for the program's first year (2014) were announced," HHS had already promulgated its annual rules for 2015 and 2016. Defendant Mem. ¶¶ 4-6, 16, at 10, 14 (noting that it takes two calendar years between publication of a benefit rule and the announcement of risk adjustment payments under that rule). See Plaintiff Mem. ¶ 11, at 7. For its 2017 rule, HHS updated its methodology for future years based on data it had collected from its 2014 results. See Defendant Mem. ¶ 16, at 14 (citing 2017 Final Rule, 81 Fed. Reg. at 12,218-20 (A.R.007762-64)). HHS adjusted its 2018 rule to account for partial-year enrollees and began using limited pharmaceutical data to help measure individuals' relative healthiness. Defendant Mem. ¶ 18, at 14 (citing HHS Notice of Benefit and Payment Parameters of 2018, 81 Fed. Reg. 94,058, 94,072-76 (dated December 22, 2016)(A.R.009609-13)("2018 Final Rule")). Health Connections supported the partial-year enrollee adjustment, but urged HHS to apply the adjustment retroactively to risk adjustment transfers for 2014 and 2015. See Declaration of Martin Hickey, MD ¶ 98, at 24 (dated October 5, 2016)(NMHC000886)("Hickey Declaration").

3. Health Connections.

Health Connections is a CO-OP program participant, and it has operated in New Mexico since 2014. See Hickey Declaration ¶ 27, at 5 (NMHC000867). Health Connections signed a

loan agreement with HHS to fund Health Connections' initial formation and New Mexico operations. See Hickey Declaration ¶ 28, at 5 (NMHC000867). Health Connections began enrolling members in October, 2013 and providing coverage in January, 2014. See Hickey Declaration ¶ 27, at 5 (NMHC000867). Health Connections has grown from 14,000 members in 2014, to 44,500 members in 2016. See Hickey Declaration ¶ 33, at 6 (NMHC000868).

Health Connections offers -- and has offered since its inception -- the lowest or second-lowest cost health insurance plan in New Mexico. See Hickey Declaration ¶ 31, at 6 (NMHC000868). It has offered such affordable plans even while serving unhealthy enrollees; New Mexico has the highest prevalence of Hepatitis C in the nation, and Health Connections enrolled many members of that population in its plans. See Patient Protection and Affordable Care Act Comments to HHS Notice of Benefit and Payment Parameters for 2018 at 19-20 (dated October 6, 2016)(NMHC0000853-54)("2018 Comments"). At a meeting of the National Association of Insurance Commissioners, the Superintendent of Insurance of New Mexico stated that Health Connections' entry into the health-insurance marketplace increased competition and saved New Mexicans over half a billion dollars. See Hickey Declaration ¶ 36, at 7, (NMHC000869).

While many health-insurance companies aim for a profit margin between two and five percent of their premiums, see Hickey Declaration ¶ 19, at 4 (NMHC000866), for 2014, many small health-insurance companies were required to pay over ten percent of their premiums as risk-adjustment charges, see Centers for Medicare & Medicaid Services, United States Department of Health and Human Services, Choices at 2 (dated April 22, 2016)(NMHC001018)("Choices"). For that year, HHS assessed Health Connections a $6,666,798.00 risk-adjustment charge, which is equal to 21.5% of Health Connections' 2014

premiums. See Hickey Declaration ¶ 17, at 3, (NMHC000865). For 2015, HHS assessed Health Connections a $14,569,495.74 risk-adjustment charge, which is equal to 14.7% of Health Connections' 2015 premiums. See Hickey Declaration ¶ 18, at 4 (NMHC000866).

Risk-adjustment charges have, thus, forced several CO-OP program participants to close their doors. See 2018 Comments at 3 (NMHC000837); U.S. House of Representatives Committee on Energy and Commerce, Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program at 19-22 (dated September 13, 2016)(NMHC000910-13); Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans at 11-13, (NMHC001000-02); Connecticut Insurance Department, Insurance Department Places HealthyCT Under Order of Supervision, at 1-2 (dated September 26, 2016)(NMHC001351-52)). Several state insurance commissioners have expressed concern about the risk adjustment program. For example, Maryland's Insurance Commissioner testified to Congress:

> Over the past few years, new innovative health insurance plans have been created that are providing enhanced competition and patient care. And it is working. For year-end 2014, Carefirst had a 91% market share of the individual market in Maryland. Today, it is 57%, due in part to a more competitive marketplace. These carriers have the potential to continue but their ability to do so is severely jeopardized by the adverse and perhaps fatal financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs.
>
> . . . .
>
> The risk adjustment formula is of concern to state regulators because it has proven to place newer carriers at a distinct disadvantage. For example, the risk adjustment formula quantifies an enrollee's health status based on age and diagnoses recorded during the course of the year. New carriers have very limited information on the health status or previous claims history of the applicants. Therefore, the carrier's population may appear healthier than it actually is if some diagnoses are not captured which may result in improper risk adjustment payments.

See Written Testimony of Mr. Al Redmer, Jr., Commissioner Maryland Insurance

Administration at 1 (NMHC001331). The New York Superintendent of Financial Services had similar concerns:

> DFS [Department of Financial Services] is concerned that the risk adjustment program has created inappropriately disparate impacts among health insurance issuers in New York and unintended consequences. Specifically, it is DFS's understanding that, based on the data accumulated by CMS for the upcoming report on June 30, 2016, new and smaller issuers generally are considered to have had relatively healthy members than their larger and more established competitors. CMS's anticipated determination appears to be unduly impacted by the dates of diagnoses or recording of diagnoses of members' medical conditions rather than actual relative health of the members. This disparity may be because the new and smaller health insurers have not been in operation long enough to have amassed the long term data and records management systems that have helped to allow the large, established health insurers to convince CMS that their members are relatively unhealthy and, concomitantly, will allow them to receive large payments from the risk adjustment program.

Letter from Maria T. Vullo, Superintendent of Financial Services of the State of New York, to Sylvia M. Burwell, Secretary of Health and Human Services, and Andrew Slavitt, Acting Administrator for the Centers for Medicare and Medicaid Services at 1-2 (dated June 28, 2016)(NMHC001335-36).

PROCEDURAL BACKGROUND

Health Connections filed its initial complaint on July 29, 2016. See Complaint for Declaratory and Injunctive Relief, filed July 29, 2016 (Doc. 1). Health Connections subsequently filed an amended complaint. See Amended Complaint for Declaratory and Injunctive Relief at 1, filed January 12, 2017 (Doc. 21)("Complaint"). Health Connections alleges that HHS violated "Section 1343 of the ACA and the APA, 5 U.S.C. § 706." Complaint at 54. Health Connections filed the Health Connections' Motion on April 13, 2017, see Health Connections Motion at 1, and HHS filed the Defendants' Motion on June 1, 2017, see Defendants' Motion at 1.

1. The Plaintiff Mem.

Health Connections argues that using of the state average premium when calculating risk adjustment transfer payments exceeds HHS' authority under the ACA and is arbitrary and capricious. See Plaintiff Mem. at 24. Health Connections observes that, under the ACA, "an issuer may only be assessed a charge under the [risk adjustment] program 'if the actuarial risk of the enrollees of such plans or coverage for a year is less than the average actuarial risk of all enrollees in all plans or coverage in such State for such year.'" Plaintiff Mem. at 24 (quoting 42 U.S.C. § 18063(a)(1)). It follows, according to Health Connections, that "risk adjustment assessments cannot be based on factors other than actuarial risk, and HHS is mandated to follow this clear statutory text." Plaintiff Mem. at 24.

Health Connections contends that HHS' use of the state average premium when calculating risk adjustment transfer payments is contrary to that statutory mandate, because the state average premium "is very different than relative actuarial risk." Plaintiff Mem. at 25. According to Health Connections, health-insurance companies base their premiums -- and, by extension, the state average premium -- "upon not only whether the population of insureds are healthier or sicker, but also on whether an issuer can control its costs by paying lower prices to hospitals and doctors, by doing a better job managing its members' medical care, by reducing administrative overhead, and by controlling other costs." Plaintiff Mem. at 25. Health Connections adds that using the state average premium is particularly unfair, because the state average premium is weighted by each insurer's marketshare, so insurers "with dominant market positions -- such as BCBS [Blue Cross Blue Shield] in New Mexico -- drive the statewide average premium through their own prices, which are typically quite high." Plaintiff Mem. at 17. Health Connections contends that, instead of the state average premium, HHS should

calculate each insurer's risk adjustment transfer payment using that insurer's average premium. See Plaintiff Mem. at 17-18.

Health Connections then addresses why, in its view, HHS' proffered justifications for using the state average premium are unavailing. See Plaintiff Mem. at 29. Health Connections asserts that HHS gave two justifications for using state average premiums: (i) doing so assures that risk adjustment is budget neutral; and (ii) doing so provides a straightforward and predicable benchmark. See Plaintiff Mem. at 21-22. "The agency's main point was that use of the statewide average premium would be easy from an administrative standpoint, and the agency could achieve budget neutrality without having to make further adjustments or calculations." Plaintiff Mem. at 22.

Health Connections argues that, contrary to HHS' first justification, budget neutrality does not justify using the state average premium, because "there is no statutory requirement that risk adjustment be budget neutral," i.e., that risk adjustment payments that insurers make to HHS must equal the risk adjustment payments that HHS makes to insurers. Plaintiff Mem. at 22. Health Connections argues that the Court should not defer to HHS' budget-neutrality determination, because "HHS has no specialized expertise in budgeting and appropriations, and thus its views on budget neutrality are entitled to no deference." Plaintiff Mem. at 22 (citing King v. Burwell, 135 S. Ct. 2480, 2489 (2015)). Health Connections also argues that deference is inappropriate, because "HHS has never explained why it believes the program must be budget neutral," and "[t]his Court owes no deference to naked assertions by agencies that lack reasoned explanation." Plaintiff Mem. at 22.

Health Connections continues by explaining why the Court -- when construing the ACA's language concerning risk adjustment for itself and not deferring to HHS -- should

conclude that risk adjustment need not be budget neutral. See Plaintiff Mem. at 22-23. Health Connections notes that there is no explicit ACA language requiring budget neutrality for risk adjustment, see Plaintiff Mem. at 22, whereas 42 U.S.C. § 18061(b)(1)(B)'s language regarding reinsurance -- which is, essentially a temporary version of risk adjustment -- "expressly made payments out subject to issuer's payments in," Plaintiff Mem. at 23. See 42 U.S.C. § 18061(b)(2)(B)("[T]he applicable reinsurance entity collects payments under subparagraph (A) and uses amounts so collected to make reinsurance payments to health insurance issuers described in subparagraph (A) that cover high risk individuals in the individual market . . . ."). "The lack of such a budget neutrality provision in the risk adjustment provision of the ACA strongly suggests that Congress intentionally omitted it and meant for the programs to be administered differently." Plaintiff Mem. at 23.

Health Connections also finds it significant that the risk corridors program, like the risk adjustment program, contains no explicit budget neutrality requirement, but HHS concluded that the risk corridor program does not need to be budget neutral, and "the GAO [Government Accountability Office] opined that the general appropriation to HHS for carrying out its 'other responsibilities' would be available for risk corridors program liabilities." Plaintiff Mem. at 23. Health Connections reasons that HHS could likewise fund risk adjustment through its general appropriations if HHS implements risk adjustment in a way that is not budget neutral. See Plaintiff Mem. at 24. Health Connections adds that, even "if HHS's agency budget lacked sufficient appropriations, underpaid issuers could sue in the Court of Federal Claims and recover any unpaid monies from the Judgment Fund." Plaintiff Mem. at 24. Health Connections also argues, in the alternative, that even if the risk-adjustment program must be budget neutral, HHS need not use "a formula in which it will be mathematically impossible for payments in and out to

ever be imbalanced," Plaintiff Mem. at 24, because HHS could still base assessments and payments on each issuer's own premium, and make any necessary *pro rata* adjustments if there is a shortfall of payments in," Plaintiff Mem. at 25.

Turning to HHS' second justification for using the state average premium when calculating risk adjustment payments, i.e., that doing so provides a straightforward and predicable benchmark, Health Connections asserts that HHS has "no explanation or backup data for this statement." Plaintiff Mem. at 25. Health Connections explains, on the contrary, that the state average premium "is a black box for smaller issuers like NMHC," because larger insurers' pricing decisions "drive the statewide average." Plaintiff Mem. at 25. Health Connections also explains why it cannot predict its risk-adjustment liability for one year by looking at its liability in the previous year: "NMHC must set its premiums for a given benefit year in the previous calendar year, so that, for example, it had to finalize 2015 premiums in 2014[, but] NMHC does not lean of its risk adjustment liability [for a given benefit year] until well into the following year." Plaintiff Mem. at 25-26.

Health Connections then turns its focus from the substance of HHS' risk-adjustment regulations to HHS' rulemaking process. Health Connections states that, "[i]n response to HHS's December 2, 2015 publication of proposed rulemaking for the 2017 benefit year, NMHC and numerous others submitted voluminous comments attacking the agency's use of the statewide average premium." Plaintiff Mem. at 27-28.[5] According to Health Connections, HHS refused to respond directly to those comments when it published its final rule on March 8, 2016,

[5]Health Connections explains that it, and other insurers, did not submit these comments earlier, because "[t]he first risk adjustment results, for benefit year 2014, were published by HHS on June 30, 2015," and those results "made clear that the system is broken," but by the time those results were published "HHS had already promulgated regulations governing risk adjustment for 2015 and 2016, maintaining the same use of the statewide average premium." Plaintiff Mem. at 27.

because that that final rule states only: "'We did not propose changes to the transfer formula, and therefore, are not addressing comments that are outside the scope of this rulemaking.'" Plaintiff Mem. at 28 (quoting 2017 Final Rule, 81 Fed. Reg. at 12,230 (A.R.007774)). Again according to Health Connections, "[t]his refusal to respond to detailed, reasoned comments from stakeholders is the very epitome of arbitrary and capricious behavior." Plaintiff Mem. at 28. Health Connections observes that, when "HHS next published its proposed new rulemaking for the 2018 benefit year on September 6, 2016," HHS sought comments on removing some administrative expenses from the state average premium when calculating risk-adjustment payments. Plaintiff Mem. at 29. Health Connections also observes that HHS' final rule for the 2018 benefit year reduces the state average premium by 14 percent when calculating risk adjustment payments to reflect the portion of an insurer's administrative costs that do not vary in response to how healthy or sickly the insurer's customers are. See Plaintiff Mem. at 30.

Health Connections maintains, however, that this modification is "too little and too late," because it only applies prospectively and it does not address all of Health Connections' concerns. Plaintiff Mem. at 30. Health Connections contends that HHS' 2018 rule "admit[s] that it was inflating risk adjustment assessments in 2014 and 2015 -- and will do so again for 2016 and 2016 -- by not applying this 14% adjustment," but does nothing to address that inflation. Plaintiff Mem. at 30. Health Connections argues that, "[a]t a minimum, if the agency has determined that its formula was overstating actuarial risk by a calculated percentage, then that correction must be made for all years of the program." Plaintiff Mem. at 30. Health Connections also argues that, notwithstanding HHS' modification of the risk adjustment transfer formula to account for administrative costs, the agency "ignores that there are factors driving premium levels that are not either risk selection or administrative costs" -- such as "NMHC's innovative medical

management" and its "success in securing lower prices from hospitals and doctors" -- so "HHS is therefore still assessing charges based on factors other than actuarial risk." Plaintiff Mem. at 31.

Health Connections next argues that, regardless of HHS' use of state average premiums, HHS inaccurately measures actuarial risk in the first place. See Plaintiff Mem. at 40. According to Health Connections, HHS' risk adjustment formula "begins by calculating a risk score for each enrollee." See Plaintiff Mem. at 40. Health Connections argues that the risk score reflects the relative health, and thus, the predicated healthcare costs, of each enrollee. See Plaintiff Mem. at 40. According to Health Connections, to calculate this risk score, an enrollee first receives a coefficient based on age and gender. See Plaintiff Mem. at 40. It continues that the coefficient is increased if the enrollee has been diagnosed with what HHS calls a HCC, which includes diseases like diabetes or HIV/AIDS. See Plaintiff Mem. at 41. Essentially, according to Health Connections, the HCC number is added to the age/gender number to calculate an enrollee's risk score. See Plaintiff Mem. at 41.

Health Connections believes this risk score calculation system is flawed for several reasons. First, Health Connections argues that this system under-predicts "the costs of enrollees who do not qualify for an HCC." Plaintiff Mem. at 41. For example, it contends that an individual without an HCC could still catch the flu, break a bone, or utilize preventive care services, none of which the HCC coefficient captures. See Plaintiff Mem. at 41. Health Connections therefore concludes that HHS underestimates health care costs for enrollees without an HCC. See Plaintiff Mem. at 41. According to Health Connections, this risk score calculation produces an absurd result, because Health Connections tries to improve its members' health so that they do not develop HCC conditions, but if Health Connections' enrollees do not have HCC conditions, then Health Connections loses money. See Plaintiff Mem. at 42. Insurance carriers

are, therefore, according to Health Connections, given financial incentives not to improve their enrollees' health, which was not what Congress intended. See Plaintiff Mem. at 42.

Health Connections contends that, to fix this problem, it submitted a proposal explaining a solution authored by former Centers for Medicare and Medicaid Services Chief Actuary Rick Foster. See Plaintiff Mem. at 44 (citing Richard S. Foster, Method to Address Estimation Bias in the HHS-HCC Risk Adjustment Model, at 1 (dated, July 15, 2016)(NMHC001042)("Foster Memorandum")). According to Health Connections, HHS did not respond to this proposal at all. See Plaintiff Mem. at 44 (citing 2018 Final Rule, 81 Fed. Reg. at 94,082-83 (dated December 22, 2016)(A.R.009619-20)). Health Connections contends that ignoring this proposal, submitted as a response to HHS' proposed rules, is arbitrary and capricious, see Plaintiff Mem. at 44 (citing Allied Local and Regional Mfrs. Caucus v. U.S. E.P.A., 215 F.3d at 79-80), because "the protections of notice and comment rulemaking under the APA are meaningless if the agency were free to simply ignore comments from the public." Plaintiff Mem. at 44-45 (citing Home Box Office, Inc. v. F.C.C., 567 F.2d 9, 35 (D.C. Cir. 1977)).

A second flaw with HHS' risk adjustment formula, according to Health Connections, is that it does not accurately identify enrollees who should qualify for an HCC. Plaintiff Mem. at 45. Health Connections contends that the inaccuracy occurs for two reasons; first HHS does not account for "partial year enrollees" and, second, HHS does not use prescription drug data when calculating risk scores. Plaintiff Mem. at 45. Regarding the first criticism, a partial year enrollee is one who is not enrolled in a given carrier's health insurance plan for the full calendar year. See Plaintiff Mem. at 45. According to Health Connections, if a partial year enrollee has an HCC condition but receives his or her diagnosis during the part of the year in which he or she is not on the given carrier's plan, then "the enrollee's risk score will be understated because the

plan cannot report the HCC score." Plaintiff Mem. at 45. (citing Hickey Declaration ¶¶ 94-95, at 22-23 (NMHC000884-85)).

Health Connections' contends that its second criticism, HHS' failure to use prescription drug data, is related to the first. See Plaintiff Mem. at 46. According to Health Connections, because individuals do not always receive an HCC diagnosis during their enrollment periods, using prescription drug data, according to Health Connections, is a good factor to use in calculating an enrollee's risk score. See Plaintiff Mem. at 46. Health Connections argues that, for example, an enrollee may have been diagnosed with diabetes before enrolling in a given carrier's health insurance plan. See Plaintiff Mem. at 46. According to Health Connections, that enrollee, however, regularly fills insulin prescriptions. See Plaintiff Mem. at 46. According to Health Connections, if HHS were to use that information, then it could accurately capture the enrollee's otherwise missed diagnosis. See Plaintiff Mem. at 46. Health Connections asserts that it "is particularly hard hit by the exclusion of prescription drug data, because NMHC prevents unnecessary hospital and physician encounters by proactively engaging with its members to take their medications." Plaintiff Mem. at 47.

According to Health Connections, HHS finally addressed the issues of partial year enrollees and prescription drug data in the spring of 2016. See Plaintiff Mem. at 49. Health Connections argues, however, that HHS did not fix the partial year enrollment problem until 2017 and will not begin to use prescription drug data until 2018. See Plaintiff Mem. at 49. Health Connections asserts that HHS should apply these changes retroactively. See Plaintiff Mem. at 50 (citing National Fuel Gas Supply Corp. v. F.E.R.C., 59 F.3d 1281 (D.C. Cir. 1995)).

Finally, Health Connections argues that HHS has de facto banned bronze health insurance plans in violation of the ACA. See Plaintiff Mem. at 50. According to Health

Connections, in the ACA exchanges, four types of insurance plans exist. See Plaintiff Mem. at 50 (citing Hickey Declaration ¶ 73, at 17 (NMHC000879)). Health Connections contends that bronze plans require the issuer to cover sixty percent of the insured's health care costs, seventy percent in silver plans, eighty percent in gold plans, and ninety percent in platinum plans. See Plaintiff Mem. at 50 (citing Hickey Declaration ¶ 74, at 17, (NMHC000879)). A bronze plan, therefore, has the lowest premium, but the highest deductible. See Plaintiff Mem. at 50 (citing Hickey Declaration ¶ 74, at 17, (NMHC000879)). According to Health Connections, consumers who do not have significant health care costs or who have limited financial resources often purchase bronze plans, because bronze plans have the lowest premiums. See Plaintiff Mem. at 50 (citing Hickey Declaration ¶ 74, at 17 (NMHC000879)). Health Connections argues that, "[b]ecause bronze plans are low-priced and attract a healthier population, the use of the state average premium and the underestimation bias against healthier enrollees particularly hammer these products." Plaintiff Mem. at 50. Essentially, Health Connections contends that HHS' risk adjustment formula makes it hard for bronze plans to be profitable. See Plaintiff Mem. at 51. Because the ACA expressly provides for bronze plans to be available, see Plaintiff Mem. at 51 (citing 42 U.S.C. 18022(d)(1)(A)), Health Connections concludes that Congress must have intended that insurers be able to issue bronze plans without losing money. See Plaintiff Mem. at 51-52. Health Connections thus asks the Court to remand this case to the agency so that HHS can "grapple with the question of how the agency can prevent the risk adjustment program from gutting Congress's intent to have viable bronze product offerings." Plaintiff Mem. at 52. In conclusion, Health Connections requests the Court to enter an order vacating HHS' risk adjustment regulations for the years 2014-2018, and order HHS to revise its regulations consistent with the Court's judgment. See Plaintiff Mem. at 52.

2. The Defendant Mem.

HHS filed the Defendant Mem. First, HHS argues that all of Health Connections' claims fail, because HHS' methodology is an "eminently reasonable and well-considered approach [to] an exceptionally complex actuarial challenge," and that its methodology "easily satisfies the APA's standard of review." Defendant Mem. at 15. According to HHS, Health Connections "erroneously combines its challenges to the 2014-2018 Rules in a single, multi-year attack" even though APA review is based on "the record before the agency at the time it made its decision." Defendant Mem. at 18. HHS contends that the Court should conduct its analysis according to HHS' record at the time of the 2014 benefit year "and then proceed to consider whether the modifications prosed in subsequent years alter that assessment for those years." Defendant Mem. at 18. HHS asserts that its use of the state average premium is consistent with the statutory text and is reasonable. See Defendant Mem. at 18. It argues that § 1343 does not bar the use of state average premiums, because that section's only specific requirement is for the program to assess a charge on program-eligible plans if the enrollees' actuarial risk is less than the state's average actuarial risk and to make a payment to such plans if the actuarial risk of their enrollees is greater than the state's actuarial risk. See Defendant Mem. at 18-19. According to HHS, Congress "did not impose any requirements as to the methodology for determining the *amounts* of charges or payments." Defendant Mem. at 19. Moreover, HHS asserts, it is not methodologically possible to "devise a transfer formula that reflects only actuarial risk, as NMHC suggests," because, even if HHS could "perfectly isolate actuarial risk from other confounding variables . . . , a formula based solely on actuarial risk would yield only a raw risk score," and a raw risk score "measures the expected *relative* cost of a particular pool of enrollees compared to the state-wide average, but it does not predict actual expenditures." Defendant Mem. at 19. Consequently, HHS asserts, its methodology had to consider cost factors. See

Defendant Mem. at 19. HHS contends that

> NMHC's proposed alternative to the state average premium (use of a plan's own premium) would suffer the exact same purported flaw as the Department's approach: it would not "be based solely upon actuarial risk." Rather, it would be based on pricing choices made by individual insurance plans reflecting the very same factors that NMHC suggests are improper, such as issuer costs, administrative overhead, efficiency factors, and the like. But under NMHC's approach, risk adjustment transfers would vary based on pricing choices made by individual plans, whereas the Department's approach adopts a weighted average of all such pricing in a state, thereby ensuring that the formula is uniform and stable and minimally distorted by any extreme or inaccurate pricing decisions by individual insurance plans. Because Congress said nothing about how risk adjustment transfers must be calculated, NMHC's statutory argument should be rejected.

Defendant Mem. at 19-20 (citations omitted).

Next, HHS argues that the state average premium is not arbitrary and capricious for three reasons. See Defendant Mem. at 20. First, plan premiums contain a risk-selection element, because "'healthier' plans can charge less than 'sicker' plans" given that healthier members consume less health care. Defendant Mem. at 20. HHS contends that "a risk adjustment transfer based on a healthier plan's lower premium might not fully capture the cost of treating sicker enrollees or adequately compensate sicker plans for their sicker membership." Defendant Mem. at 20-21. Second, HHS argues that a risk adjustment charge based on a healthy plan's lower premium "might not adequately capture the higher cost of treating sicker members" and would, therefore, not fulfill the program's objective to "reduce incentives for plans to avoid high risk enrollees." Defendant Mem. at 21 (citing 2014 Final Rule, 78 Fed. Reg. at 15,411 (dated March 11, 2013)(A.R.0000228)). HHS argues that the state average premium more accurately measures and distributes the costs of insuring all individuals in a risk pool. See Defendant Mem. at 21. Third, HHS argues that, because the risk adjustment program is "self-funded and budget neutral," payments and charges must balance, but using a plan's own premium for transfer calculations would make that impossible. Defendant Mem. at 22. If healthy plans pay lower

charges, and sicker plans receive higher payments, HHS argues,

> [b]ridging the gap between payments and charges therefore would require one of three after-the-fact adjustments: (1) reduce payments to sicker plans, (2) increase charges to healthier plans, or (3) split the difference between sicker and healthier plans. NMHC does not appear to advocate or the latter two options, see Pl.'s Mot. at 24-25, but in any event, each option has drawbacks. Reducing payments to sicker plans would likely result in sicker plans raising their premiums to offset the anticipated expense of their sicker membership. Increasing charges for healthier plans would eliminate the incentives of sicker plans to control costs. And finally, splitting the difference between healthier and sicker plans (by increasing charges and decreasing payments) would be similar to using the state average premium, but it would require an after-the-fact adjustment that would not be known until the program year concluded.

Defendant Mem. at 22-23 (citations omitted). HHS contends that, given the advantages of using state average premiums, "[t]he record thus amply demonstrate[s] that the Department considered the relevant policy choices and rationally elected to use a state-wide average." Defendant Mem. at 23.

HHS disputes Health Connections' arguments in opposition to using state average premiums. See Defendant Mem. at 23-26. First, HHS contends that using the state average premium does not encourage gaming by large insurers, because HHS' transfer formula "does not directly reflect a plan's actual premiums at all; rather, it calculates the difference between the plan's expected costs with risk selection and the plan's expected costs without risk selection, using the state average premium on *both* sides of the equation as an estimation of average cost." Defendant Mem. at 23-24 (emphasis in original). HHS contends that its approach "neither penalizes cost-cutting nor rewards inefficiency," but rather "strikes a middle ground" by assuming an average level of efficiency. Defendant Mem. at 24. According to HHS, Health Connections' proposed system "would encourage sicker plans to charge higher premiums to increase their payments and healthier plans to charge lower premiums to reduce their charges" because "plans with the same risk score would owe or receive different amounts based on

individual pricing decisions." Defendant Mem. at 24. Second, HHS asserts that using the state average premium does not penalize cost-cutting plans, because its regulations require providing advance notice of risk adjustment formula so that an issuer can "price any expected payments or charges into their rates." Defendant Mem. at 24. Third, HHS contends that it provided considerable information, data, and research related to its decision, which "amply demonstrate[s] the Department's rationale for adopting the state average premium." Defendant Mem. at 25. Additionally, HHS contends that it must "only provide a 'rational connection between the facts found and the choice made,' such that the 'path may reasonably be discerned.'" Defendant Mem. at 26 (quoting Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125.)

Next, HHS contends that its use of HCCs is reasonable. See Defendant Mem. at 26-28. HHS asserts that its risk adjustment model is not meant to transfer risk of random events like accidents, but rather is meant to compensate plans for enrollees' predicable medical conditions that could influence enrollment decisions. See Defendant Mem. at 27. HHS also contends that its model already incorporates costs of treating random events. See Defendant Mem. at 27-28. HHS also argues that its approach to capturing HCCs is reasonable, because, HHS contends, HHS "considered and reasonably addressed" whether to adjust its methodology for partial year enrollment and incorporate prescription drug data. Defendant Mem. at 28-29. See Defendant Mem. at 29-34. HHS further contends that the program's approach to its bronze plans is reasonable. See Defendant Mem. at 34-37. HHS asserts that it "grappled with" the relationship between state exchange actuarial values and its risk adjustment program, ultimately "adopting different risk score models for each metal level plan and catastrophic plan." Defendant Mem. at 35. HHS explains that it

> also included an adjustment for actuarial value in the transfer formula so that the program does not compensate plans for differences in actuarial value that are

> already reflected in the premiums charged by such plans. However, the Department reasonably elected not to adopt separate risk pools for the different metal level plans because "this approach would fail to correct for systematic risk selection across 'metal levels[.'] That is, low risk enrollees would tend to migrate to plans with a lower actuarial value . . . which would then gain a premium advantage attributable to risk selection. This result would not address the mandate of the ACA, which requires that transfer payments be made between plans based on the[] actuarial risk of their enrollees." Thus, to the extent NMHC suggests that the Department has not already exhaustively "grappled" with the relationship between metal levels and risk adjustment, it is wrong.

Defendant Mem. at 35 (citations omitted)(quoting State Health Insurance Exchange Risk Adjustment and Plan Metals Level at 6 (dated December 15, 2011)(A.R.000814-15). HHS also disputes Health Connections' contention that HHS' methodology is arbitrary and capricious for not relieving bronze plans of the financial consequences of risk adjustment, arguing that: (i) bronze plans typically have healthier enrollees, and § 1343 requires those enrollees to pay risk adjustment charges; and (ii) "administrative review is not based on hindsight and it does not appear that Health Connections raised this outcome-oriented critique until the 2018 rulemaking." Defendant Mem. at 36.

HHS also contends that the 2015-2017 rules are consistent with the statute and are reasonable. See Defendant Mem. at 36. According to HHS, it was not arbitrary and capricious to not respond to comments addressing issues beyond the scope of proposed rules, because HHS was "not obligated to reconsider methodological choices it already had exhaustively considered or to respond anew to comments questioning those choices." Defendant Mem. at 36.

Next, HHS asserts that the 2018 rule is consistent with the statute and is reasonable. See Defendant Mem. at 37-40. HHS notes that it has addressed many of Health Connections complaints by adopting a downward adjustment to the state average premium and preventative health costs, including additional partial year enrollment factors, and making limited use of

prescription drug data. See Defendant Mem. at 37. As to Health Connections' "remaining grievances," HHS asserts that: (i) the adjustment to the state average premium is reasonable, because "there is nothing arbitrary and capricious about using a mean to approximate overall health costs in a state nor does section 1343 require risk adjustment transfers" to certain individuals, Defendant Mem. at 38; (ii) HHS reasonably addressed a particular proposed formula adjustment concerning estimation bias; and (iii) its methodology does not make it impossible for bronze plans to be profitable, and its internal process to improve its models means that "judicial relief is unnecessary," Defendant Mem. at 40-41.

HHS also argues that no basis for Health Connections' requested relief exists. See Defendant Mem. at 41-44. First, HHS asserts that the Court lacks jurisdiction to award primarily monetary relief. See Defendant Mem. at 41. HHS contends that "although NMHC nominally seeks an injunction requiring the Department to revise its risk adjustment formula . . . the thrust of its suit is for a refund of money already paid to the Department." Defendant Mem. at 41. Second, HHS argues that, even if the sought refunds are not considered money damages, "vacatur should still be denied because vacating the risk adjustment methodology for all prior years would harm plans that enrolled sicker than average enrollees." Defendant Mem. at 43.

3. The Plaintiff Reply.

Health Connections replied. See Plaintiff's Reply and Opposition to Defendant's Cross-Motion for Summary Judgment at 1, filed July 13, 2017 (Doc. 40)("Plaintiff's Reply"). Health Connections first argues that HHS "has no discretion to ignore real world developments." Plaintiff's Reply at 8. Specifically, Health Connections contends that "under HHS's logic because the only rulemaking that should be reviewed is the original one for the 2014 benefit year . . . the only evidence the Court should review is what was before the agency in 2012/2013

during that first rulemaking." Plaintiff's Reply at 8 (citing Defendant Mem. at 12-13, 17-18, 27, 36-37). Health Connections contends that this logic is incorrect, because "'when there is a known or significant change in the data underlying an agency decision, the agency must either take that change or trend into account, or explain why it relied solely on data pre-dating that change or trend.'" Plaintiff's Reply at 8 (quoting Zen Magnets, LLC v. Consumer Prod. Safety Comm'n, 841 F.3d 1141, 1149 (10th Cir. 2016)). Health Connections asserts that HHS knew about the flaws in its risk adjustment formula shortly after the program began, but did not change the formula. See Plaintiff's Reply at 9-10. Health Connections thus avers that, when an agency ignores new data without adequate explanation, which it believes HHS did, such conduct is arbitrary and capricious. See Plaintiff's Reply at 8-9 (citing Magnets, LLC v. Consumer Prod. Safety Comm'n, 841 F.3d at 1149).

Health Connections next re-asserts its argument that HHS' use of the state average premium in its risk adjustment formula violates the ACA. See Plaintiff's Reply at 12. Health Connections argues that, because the ACA provides that the risk adjustment program should assess a charge on insurers based on actuarial risk, see Plaintiff's Reply at 12 (citing 42 U.S.C. § 18063(a)(1)-(2)), and HHS assesses a charge based on "multiplying relative actuarial risk against the statewide weighted average premium," HHS violates the ACA. See Plaintiff's Reply at 12. Health Connections adds that nothing in the ACA's text indicates charges and payments should be based on any factor other than actuarial risk. See Plaintiff's Reply at 13 (citing 42 U.S.C. § 18063(a)(1)-(2)).

Health Connections then re-asserts that HHS' use of state average premiums is arbitrary and capricious. See Plaintiff's Reply at 15. Specifically, HHS contends that the one factor which Congress directed HHS to consider in developing a risk adjustment program was actuarial

risk, but HHS' use of state average premiums considers other factors unrelated to actuarial risk, such as "how effectively a plan negotiates prices with hospitals and physicians, how well it manages its members' medical care, and how ably it controls administrative expenses." Plaintiff's Reply at 16. Health Connections adds that, contrary to HHS' assertion, premiums are not a proxy for actuarial risk. See Plaintiff's Reply at 18 (citing Defendant Mem. at 16-21).

Health Connections then responds to HHS's contention that the use of state average premiums "'reduce[s] incentives for plans to avoid high risk enrollees.'" Plaintiff's Reply at 19 (quoting Defendant Mem. at 21). To this contention, Health Connections rejoins that the ACA has separate statutory provisions "forbidding carriers from denying coverage or raising premiums for sicker enrollees," Plaintiff's Reply at 19 (citing 42 U.S.C. § 300gg-3), and that "nothing in the text of the ACA . . . suggests that Congress intended risk adjustment to somehow be the enforcement mechanism for these provisions." Plaintiff's Reply at 19. Health Connections then largely repeats its arguments that HHS' justifications for state average premiums, i.e., budget neutrality and predictability, are flawed. See Plaintiff's Reply at 20-21.

Next, Health Connections avers that "HHS fails to account for the actual health care costs of healthier enrollees." Plaintiff's Reply at 21. Health Connections asserts that HHS "nowhere addresses the evidence that the formula just flat out does not work in predicting the costs of medical care." Plaintiff's Reply at 22. Health Connections adds that HHS failed to respond to a comment from Health Connections about this problem and that, when an agency receives "'critical commentary,'" it must "'respond in a reasoned manner'" to that comment. Plaintiff Reply. at 23-24 (quoting FMBE Bank Ltd. v. Lew, 209 F. Supp. 3d 299, 333 (D.D.C. 2016)).

Health Connections then re-alleges that HHS "violates Congressional Intent to have a robust market in bronze plans." Plaintiff's Reply at 24. Health Connections repeats that

Congress intended for bronze plans to be available in the ACA exchanges, but that HHS' risk adjustment formula makes it difficult for bronze plans to be profitable. See Plaintiff's Reply at 24. Health Connections adds that HHS did not respond to Health Connections' comments on this point during the 2018 rulemaking period. See Plaintiff's Reply at 24.

Health Connections then re-asserts its arguments that HHS wrongfully excluded prescription drug data from its risk adjustment formula before 2018, see Plaintiff's Reply at 25-27, and that HHS' formula does not account for partial year enrollees, see Plaintiff's Reply at 27-28, before addressing a new point -- HHS' jurisdictional argument, see Plaintiff's Reply at 28. Health Connections asserts that "HHS contends that NMHC seeks only money damages for past risk adjustment calculations and thus this action belongs in the Court of Federal Claims." Plaintiff's Reply at 28. Health Connections rejoins that this argument is meritless, because "the Prayer for Relief in NMHC's Amended Complaint requests only declaratory and injunctive relief . . . [and] asserts only one count under the APA, which only permits declaratory and injunctive relief." Plaintiff's Reply at 28 (alteration added)(citing Complaint at 56; 5 U.S.C. §§ 702, 706). Health Connections also emphasizes that it seeks only equitable relief, and not damages, for its claims relating to the years 2014-2016. See Plaintiff's Reply at 24. Specifically, Health Connections asserts that it does not ask the Court to refund any charges for those years, but rather, to invalidate regulations used during those years so that HHS can then fix its regulatory scheme. See Plaintiff's Reply at 29. Health Connections then avers that, if under HHS' fixed scheme, HHS owes back money to Health Connections, either HHS can pay Health Connections or Health Connections can sue in the Court of Federal Claims. See Plaintiff's Reply at 29. Health Connections concludes that the Court should grant its motion for summary judgment, deny HHS' cross-motion, and vacate HHS' risk adjustment regulations. See Plaintiff's Reply at

30. Alternatively, Health Connections requests that the Court remand the matter to HHS without a vacatur.[6]

4. The Defendants' Reply.

HHS replied to the Plaintiff's Reply. See Defendants' Reply in Support of Cross-Motion for Summary Judgment, filed August 17, 2017 (Doc. 41)("Defendants' Reply"). First, HHS argues that, to prevail, Health Connections must show that Congress unambiguously and directly addressed how HHS should measure costs in its transfer formula, but that Congress has offered no such directive. See Defendants' Reply at 3-4. HHS contends that, contrary to Health Connections' assertions: (i) HHS' transfer formula incorporates actuarial risk; (ii) the important question is whether Congress unambiguously and directly prohibits HHS from using weighted average premiums to approximate costs; (iii) it is irrelevant whether the state average premium inflates risk adjustment charges; and (iv) Health Connections paying a large percentage of its premiums in risk adjustment charges is consistent with Congressional intent. See Defendants' Reply at 4-5. HHS revisits its argument that HHS' use of a state average premium is reasonable, because it "preserves incentives to control costs while also meeting the health needs of sicker enrollees." Defendants' Reply at 6. See Defendants' Reply at 6-10.

Second, HHS argues that its use of HCCs is reasonable and that HHS adequately responded to concerns about estimation bias. See Defendants' Reply at 11-15. HHS argues that

[6]Health Connections later filed a short Notice of Supplemental Authority, filed September 18, 2017 (Doc. 44)("Notice"). The notice mentioned a recent case, American College of Emergency Physicians v. Price, 264 F. Supp. 3d 89 (D.D.C. 2017)(Kollar-Kotelly, J.), in which the United States District Court for the District of Columbia held that HHS acted arbitrarily and capriciously "by failing to 'seriously respond' to public comments regarding a proposed rule pertaining to" the ACA. Notice at 1 (quoting American College of Emergency Physicians v. Price, 264 F. Supp. 3d at 94). Health Connections briefly asserts that American College of Emergency Physicians v. Price is analogous to this case. See Notice at 1 ("Just like *Price*, this case involves, *inter alia*, APA claims challenging HHS' failure to meaningfully respond to public comments regarding rules issued pursuant to the ACA.").

(i) Health Connections impermissibly bases its arguments on information that did not exist before HHS enacted the rule that Health Connections challenges, see Defendants' Reply at 11-12; (ii) Health Connections' challenge to the 2017 and 2018 plan year models is flawed, because HHS added preventative services to its models to improve predictability vis-à-vis non-HCC enrollees, see Defendants' Reply at 12; and (iii) HHS adequately addressed the former Chief Actuary of the Centers for Medicare and Medicaid Services, Richard Foster's, proposal to adjust plan liability risk scores, see Defendants' Reply at 13-15.

Third, HHS again argues that its approach to identifying risk has been reasonable in all relevant years. See Defendants' Reply at 15-19. HHS contends that: (i) it thoroughly considered whether to incorporate pharmacy data in its model as a measure of HCC status, seeking comments conducting analyses, see Defendants' Reply at 15-18; and (ii) it reasonably addressed partial year enrollment and Health Connections "has identified nothing that would have led the Department to believe that [its approach was] insufficient, much less unreasonable, to address partial year enrollment," Defendants' Reply at 18-19.

Fourth, HHS asserts that its approach to bronze plans is reasonable. See Defendants' Reply at 19-20. HHS contends that: (i) Health Connections has not provided evidence that "risk adjustment is driving bronze plans out of existence," Defendants' Reply at 19; (ii) Health Connections "fails to challenge any specific action or inaction" of HHS, Defendants' Reply at 19; and (iii) HHS is "already monitoring the effects of the program on bronze plans, and, therefore, NMHC's requests for the Department to 'grapple' with the issue is moot," Defendants' Reply at 20.

Fifth, HHS asserts that Health Connections' remaining arguments fail. See Defendants' Reply at 20-24. HHS argues that: (i) it did not ignore criticisms against the program, but rather

analyzed results and sought public comments to improve it, see Defendants' Reply at 20; (ii) it properly "declin[ed] to retroactively modify rules that had already been promulgated," Defendants' Reply at 20-21; and (iii) Health Connections' suggestions that HHS' risk adjustment program created broader problems in the ACA market are irrelevant and meritless, see Defendants' Reply at 23-24.

Sixth, and finally, HHS argues that the Court should deny retroactive relief. See Defendants' Reply at 24-25. HHS contends that it has "already adopted the majority of the reforms that NMHC has requested." Defendants' Reply at 24-25. According to HHS, Health Connections seeks in part "to vacate the program back to its inception," which means that 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." Defendants' Reply at 24. HHS also argues that, even if Health Connections' claim is proper under the APA, "NMHC has not met its burden to show that the relief it seeks is either equitable or achievable." Defendants' Reply at 25.[7]

5. The Hearing.

The Court held a hearing. See Draft Transcript of Motion Proceedings (taken January 22, 2018)("Tr.").[8] Health Connections took to the podium first and argued that HHS'

[7]HHS also responds to Health Connections' Notice of Supplemental Authority. See Defendants' Response to Plaintiff's Notice of Supplemental Authority, filed September 22, 2017 (Doc. 45). HHS argue that American College of Emergency Physicians v. Price does not help Health Connections' position, because that case determined that the agencies did not seriously respond to concerns about its methodology and ignored proposed alternative methodologies, whereas HHS seriously considered all the issues raised in this case and has not ignored any alternative proposals. See Defendants' Response to Plaintiff's Notice of Supplemental Authority at 1-2 (citing American Coll. of Emergency Physicians v. Price, 2017 WL 3836045, at *4).

[8]The Court's citations to the hearing transcript refer to the court reporter's original, unedited version. Any final transcript may contain slightly different page and/or line numbers.

use of a statewide premium average in its actuarial risk calculation does not accurately capture actuarial risk, so HHS' use of that premium average violates 42 U.S.C. § 18063's plain language. See Tr. at 4:17-23 (Bassman, Court); id. at 5:6-9 (Bassman). Health Connections continued that the statute is not lengthy, but its command is "pretty clear": an issuer makes a payment if the "actuarial risk is below average in this state." Tr. at 11:18-22 (Bassman). Health Connections explained that there are two steps to HHS' actuarial risk calculation: (i) HHS calculates your relative actuarial risk by measuring whether your enrollees' health is above or below the state average; and (ii) HHS multiplies that amount by the statewide average premium. See Tr. at 5:14-22. Health Connections contends that both steps of that two-step process are arbitrary, capricious, and contrary to law. See Tr. at 5:22-25 (Bassman).

The Court challenged Health Connections' characterization of the statute and noted that the statute allows HHS to consider factors beyond actuarial risk. See Tr. at 13:15-20 (Court). Health Connections rejoined that "the statutory text . . . speaks of actuarial risk" and not of other factors. Tr. 14:11-13 (Bassman). It also argued that the proper premium against which to measure is the issuer's own premium, because an issuer's own premium captures efficiencies and costs more effectively. Tr. at 15:1-4 (Bassman).

The Court asked whether using the issuer's premiums "undercut[s] your statutory language argument," because it signals that HHS' use of the statewide average premium calculation is not arbitrary and capricious. See Tr. at 15:6-18 (Court). Health Connections rejoined that Congress' "mandate is to get as close to actuarial risk as you can" and that a healthcare issuer's own premium is a far closer approximation of actuarial risk than the statewide average premium. Tr. at 15:22-16:4 (Bassman). Health Connections added, however, that, even setting the statute aside, HHS was not reasonable in using a statewide average. See 16:9-12

(Bassman)("[T]hat's the second part of our attack . . . ."). The Court rejoined that the analysis for which Health Connections is looking for is "much more rigorous . . . than [] courts normally do" under the APA. Tr. at 16:17-22 (Court). Health Connections argued that, under arbitrary and capricious review, HHS must look at "appropriate factors in making its rational decisions," and Health Connections contended that HHS did not analyze actuarial risk as a factor, the one factor it had to consider under the statute. Tr. at 17:2-14 (Bassman).

Responding to HHS' argument from the briefing that using an issuer's own premium incentivizes manipulating the premium, Health Connections argued that it could not manipulate its rates for beneficial effect, because: (i) issuers cannot unilaterally set their prices; and (ii) the federal and state governments may disapprove premium if they are too high or too low. See Tr. at 17:21-18:11 (Bassman). Health Connections added that manipulation would not work, because the risk adjustment charge is unpredictable, based on their enrollees' health and their competitor's premiums. See Tr. at 18:21-19:11 (Bassman).

The Court asked whether the predictability issue was a "flaw in the statute." Tr. at 20:20-21 (Court). Health Connections admitted that "certainly [the] predict[ability] problem is partly baked into the statute." Tr. at 20:23-24 (Bassman). The Court responded that if the predictability problem is in the statute, how could HHS have been acting arbitrarily and capriciously. Tr. at 21:2-3 (Court). Health Connections rejoined, somewhat circularly, that HHS could still have acted arbitrarily and capriciously, because there is a better method of calculating actuarial risk: the "issuers own premium." Tr. at 21:4-7 (Bassman).

Health Connections continued that the second reason HHS has acted arbitrarily and capriciously is that, in promulgating their rules, HHS reasons that it should act in a budget neutral way. See Tr. at 21:17-19 (Bassman). Health Connections argued that budget neutrality

is not an appropriate factor upon which to rely, because the statute is not budget neutral. Tr. at 22:4 (Bassman). Health Connections argued that several sections in the statute are expressly budget neutral, but the risk adjustment section is not, so Congress could not have intended for the risk adjustment provision to be budget neutral. See Tr. at 22:12-23:5 (Bassman). The Court responded that "budget neutrality is at least reasonable. It may not be the best reading of the statute, but [it] seems . . . at least reasonable." Tr. at 25:4-9. Health Connections rejoined that budget-neutrality could not be reasonable, because Congress appropriated bridge funds, and, in other programs, such as reinsurance, HHS accounted for reductions in some years which extra funds would make up for in later years. See Tr. at 26:23-27:4 (Bassman); id. at 28:1-6 (Bassman).

HHS responded. See Tr. at 35:14-15 (Powers). It argued that the statute gives "broad discretion to determine the methods and standards . . . applicable to the risk adjustment activities." Tr. at 39:24-40:1 (Powers). It added that it used the statewide average premium, because "it reflects the cost of insuring [the] sickest people" as it reflects all premiums in the calculation. Tr. at 40:9-13 (Powers). It continued that "[s]tatewide average premium incorporates elements of actuarial risk selection, including administrative expense contained there, and so it is consistent with the status to use statewide average premium[s] as a cost factor in conjunction with the risk score." Tr. at 40:19-24 (Powers).

HHS admitted that the "statute does not require budget neutrality," Tr. at 44:3-5 (Powers), but it contended, however, that requiring budget neutrality is a reasonable interpretation of the statute given that the agency is "not permitted to obligate the Government in the absence of appropriations," Tr. at 44:8-16 (Powers). HHS also argued that it was likely that Congress thought this should be budget neutral, because "Congress in the first instance assumed

that states would appropriate these risk adjustment program[s]," and it would be "quite strange to think that Congress was obligating [states] . . . to make up the shortfall or difference in payments and transfers." Tr. at 45:14-20 (Powers).

HHS noted Health Connections' argument that taking into account all premiums "sweeps in other factors more than actuarial risk," but contended that "us[ing] an issuers own premium" sweeps in the same non-actuarial risk factors" Tr. at 46:23-47:6 (Powers). HHS contended that Health Connections calculation is not focused on actuarial risk, as the statute commands, but is focused on "efficiency." Tr. at 47:9 (Powers). HHS argued that "competition and efficiency" is not present in the risk adjustment portion of the statute. Tr. at 48:8-10 (Powers)(citing 42 U.S.C. § 18063). It acknowledged that the "statute has a goal of increasing access to quality and affordable health insurance, so that contains elements of both . . . increasing competition and therefore bringing down prices, but also assuring that, regardless . . . of health status, [people] have [access] to health plans that can satisfy their health needs." Tr. at 48:12-18 (Powers). HHS further conceded that there is "nuance" in the statute, but that "[t]he agency is entitled in the first instance to w[eigh] these various policies particularly where the statute just gives the agency broad discretion to spe[cify] standards applicable for the program." Tr. at 48:22-49:2 (Powers).

Health Connections took the podium again and argued that HHS' methodology for calculating the enrollees' risk scores is arbitrary and capricious. See Tr. at 61:4-9 (Bassman). It argued that each enrollee's risk score is calculated with three inputs: age, gender, and an HCC code, which is given to an enrollee if he or she has a serious chronic condition. See Tr. at 61:9-15 (Bassman). Health Connections argued that the HCC code is defective, because it misses a lot of people who have serious conditions, but do not qualify for an HCC code, such as people with chronic lower back pain. See Tr. at 61:16-22 (Bassman). Health Connections

continued that people who have chronic diseases who do not have an HCC code cost an issuer just as much as those with an HCC code. See Tr. at 62:2-13 (Bassman). From that analysis, Health Connections argues that HHS' calculation is miscalculating the actuarial risk, because it does not account for all enrollees and "underestimates the cost of enroll[ees] without an HCC by 31 percent." Tr. at 62:19-63:11 (Bassman).

HHS rejoined that the risk adjustment program is meant to "deal with systematic risks that [are] predictable." Tr. at 72:9-22 (Powers). HHS also noted that it had received many comments "supportive of the various . . . logical choices" it had made. Tr. at 73:16-18 (Powers). It also argued that "statistical analyses that the agency has applied to its methodology indicate that it is performing just as well if not better than similar kinds of commercially available risk adjustment methodologies." Tr. at 73:21-25 (Powers).

Health Connections next contended that there is no risk of the issuers "gaming" the system. Tr. at 82:6-8 (Bassman). It argued that there is no evidence in the administrative record demonstrating that issuers pressured doctors into prescribing medications not needed so the issuer could obtain an HCC code and a concomitant financial benefit. See Tr. at 82:9-83:6 (Bassman). It also argued that doctors are pressured from "making unnecessary prescriptions," as they could face sanctions from their state. Tr. at 83:9-15 (Bassman).

The Court subsequently asked HHS what the effect would be if it determined HHS' exclusion of data was arbitrary and capricious. See Tr. at 88:14-17 (Court). HHS responded that several issuers would ask the agency for a refund, but that HHS no longer had that money, because "it's been paid out to the recipients under the program." Tr. at 88:20-25 (Powers). HHS argued that this scenario would cause chaos for many issuers, because issuers might think that HHS would "try to take the money back from them." Tr. at 89:1-6 (Powers). See Tr. at 89:9-12

(Powers)("[I]f your honor was to go back retroactively and vacate prior rules . . . that would have some significant and . . . bad effects on this market."). Responding to this colloquy, Health Connections noted that it was within the Court's power to invalidate improper rules promulgated in the past, see Tr. at 97:24-98:2 (Court), and added that, if the Court were to rule on the 2017 risk adjustment rule, such a ruling would be "entirely prospective," Tr. at 97:6 (Bassman).

Health Connections then argued that HHS' rules are biased against the bronze plans. See Tr. at 105:20-23 (Bassman). It argued that bronze plans attract healthier people, but, consequently, issuers that offer the bronze plan are always hit with a risk adjustment charge. See Tr. at 106:6-107:7 (Bassman). Health Connections concludes that, if HHS does not change the statewide premium average calculation, something has to be done to "allow bronze plans to be viable and functioning." Tr. at 107:16-19 (Bassman).

HHS rejoined that the APA requires a more specific attack and that "the bronze plan point is accounted for already to some extent in the formula." Tr. at 109:8-12 (Powers). HHS also argued that "it's not clear what effective rel[ief] the Court could actually offer" given that HHS is already making changes to try and address "certain subpopulations" including those using the bronze plan. Tr. at 109:17-25 (Powers). HHS also contended that it is not clear yet that the risk adjustment formula "renders bronze plans . . . uneconomic." Tr. at 110:1-2 (Powers). It added that there had not been a "widespread problem with . . . bronze plans" as "a result of" agency action, so the risk adjustment program has not had a clear adverse effect on the bronze plans. Tr. at 110:16-22 (Powers).

Health Connections responded that the bronze plan issue would be cured if the Court addressed either the statewide average premium or the estimation bias issue. See Tr. at 112:1-8 (Bassman). It added that, if the Court did not address either of those issues, it would ask the

Court to order HHS to respond to Health Connections' comment about how HHS was going to adjust the formula so bronze plans are not unfairly penalized. See Tr. at 112:9-15 (Bassman).

Finally, Health Connections argued that the Court has jurisdiction, even though HHS argues that the Health Connections' claims are backward-looking so are subject solely to the Court of Federal Claims' jurisdiction, because: (i) they ask for prospective relief on HHS' 2017-18 rule; and (ii) the relief requested for the 2014-16 rules is not monetary. See Tr. at 116:22-117:16 (Powers). Health Connections admits that, if a new rulemaking results from the Court's ruling, Health Connections "may be owed money under it." Tr. at 117:20-22 (Bassman). It added, however, that it is not clear under established case law if a refund is money damages. See Tr. at 118:1-2 (Bassman).

In response, HHS noted that, as to the 2017 and 2018 rules, it is not contesting jurisdiction. See Tr. at 119:1-2 (Powers). HHS argued, however, that Health Connections' case "is fundamentally seeking money damages from the Government" and "the APA does not waive sovereign immunity to do that." Tr. at 120:5-8 (Powers). HHS concluded that, if the Court determines that there is jurisdiction and that Health Connections' claims have merit, the Court should remand the matter to the agency without vacating any rules. See Tr. at 123:1-6 (Powers).

LAW REGARDING RULE 12(b)(1)

"Federal courts are courts of limited jurisdiction; they are empowered to hear only those cases authorized and defined in the Constitution which have been entrusted to them under a jurisdictional grant by Congress." Henry v. Office of Thrift Supervision, 43 F.3d 507, 511 (10th Cir. 1994)(citations omitted). Plaintiffs generally bear the burden of demonstrating a court's jurisdiction to hear his or her claims. See Steel Co. v. Citizens for a Better Env't, 523 U.S. 83, 104 (1998)("[T]he party invoking federal jurisdiction bears the burden of establishing its

existence."). Rule 12(b)(1) of the Federal Rules of Civil Procedure allows a party to challenge subject-matter jurisdiction by motion. See Fed. R. Civ. P. 12(b)(1). The United States Court of Motions to dismiss for lack of subject-matter jurisdiction "generally take one of two forms: (1) a facial attack on the sufficiency of the complaint's allegations as to subject-matter jurisdiction; or (2) a challenge to the actual facts upon which subject matter jurisdiction is based." Ruiz v. McDonnell, 299 F.3d 1173, 1180 (10th Cir. 2002).

> On a facial attack, a plaintiff is afforded safeguards similar to those provided in opposing a rule 12(b)(6) motion: the court must consider the complaint's allegations to be true. See Ruiz v. McDonnell, 299 F.3d at 1180; Williamson v. Tucker, 645 F.2d 404, 412 (5th Cir. 1981). But when the attack is aimed at the jurisdictional facts themselves, a district court may not presume the truthfulness of those allegations. A court has wide discretion to allow affidavits, other documents, and a limited evidentiary hearing to resolve disputed jurisdictional facts under Rule 12(b)(1). In such instances, a court's reference to evidence outside the pleadings does not convert the motion to a Rule 56 motion.

Hill v. Vanderbilt Capital Advisors, LLC, F. Supp. 2d 1228, 1240-41 (D.N.M. 2011)(Browning, J.)(quoting Alto Eldorado Partners v. City of Santa Fe, 2009 WL 1312856, at *8-9 (D.N.M. March 11, 2009)(Browning, J.)). See New Mexicans for Bill Richardson v. Gonzales, 64 F.3d 1495, 1499 (10th Cir. 1995); Holt v. United States, 46 F.3d 1000, 1003 (10th Cir. 1995). Where, however, the court determines that jurisdictional issues raised in a rule 12(b)(1) motion are intertwined with the case's merits, the court should resolve the motion under either rule 12(b)(6) of the Federal Rules of Civil Procedure or rule 56 of the Federal Rules of Civil Procedure. See Franklin Sav. Corp. v. United States, 180 F.3d 1124, 1129 (10th Cir. 1999); Tippett v. United States, 108 F.3d 1194, 1196 (10th Cir. 1997). "When deciding whether jurisdiction is intertwined with the merits of a particular dispute, 'the underlying issue is whether resolution of the jurisdictional question requires resolution of an aspect of the substantive claim.'" Davis ex rel. Davis v. United States, 343 F.3d 1282, 1296 (10th Cir. 2003)(quoting Sizova v. Nat'l Inst. of Standards & Tech., 282 F.3d 1320, 1324 (10th Cir. 2002)).

LAW REGARDING JUDICIAL REVIEW OF AGENCY ACTION

Under the APA,

> [a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States: Provided, that any mandatory or injunctive decree shall specify the Federal officer or officers (by name or by title), and their successors in office, personally responsible for compliance. Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground; or (2) confers authority to grant relief if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.

5 U.S.C. § 702. The APA states that district courts can:

> (1) compel agency action unlawfully withheld or unreasonably delayed; and
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be--
>
> > (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
> >
> > (B) contrary to constitutional right, power, privilege, or immunity;
> >
> > (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
> >
> > (D) without observance of procedure required by law;
> >
> > (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
> >
> > (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

5 U.S.C. § 706.

Under Olenhouse, 42 F.3d at 1560, "[r]eviews of agency action in the district courts [under the APA] must be processed as appeals. In such circumstances the district court should govern itself by referring to the Federal Rules of Appellate Procedure." 42 F.3d at 1580. See Wildearth Guardians v. U.S. Forest Serv., 668 F. Supp. at 1323. "As a group, the devices appellate courts normally use are generally more consistent with the APA's judicial review scheme than the devices that trial courts generally use, which presume nothing about the case's merits and divide burdens of proof and production almost equally between the plaintiff and defendant." Northern New Mexicans Protecting Land and Water Rights v. United States, 2015 WL 8329509, at *9 (D.N.M. 2015)(Browning, J.).

1. Reviewing Agency Factual Determinations.

Under the APA, a reviewing court must accept an agency's factual determinations in informal proceedings unless they are "arbitrary [or] capricious," 5 U.S.C. § 706(2)(A), and its factual determinations in formal proceedings unless they are "unsupported by substantial evidence," 5 U.S.C. § 706(2)(E). The APA's two linguistic formulations amount to a single substantive standard of review. Ass'n of Data Processing Serv. Orgs., Inc. v. Bd. of Govs. of the Fed. Reserve Sys., 745 F.2d 677, 683-84 (D.C. Cir. 1984)(Scalia, J.)(explaining that, as to factual findings, "there is no *substantive* difference between what [the arbitrary or capricious standard] requires and what would be required by the substantial evidence test, since it is impossible to conceive of a 'nonarbitrary' factual judgment supported only by evidence that is not substantial in the APA sense" (emphasis in original)). See also id. at 684 ("[T]his does not consign paragraph (E) of the APA's judicial review section to pointlessness. The distinctive function of paragraph (E) -- what it achieves that paragraph (A) does not -- is to require substantial evidence to be found *within the record of closed-record proceedings* to which it

exclusively applies." (emphasis in original)).

In reviewing agency action under the arbitrary-or-capricious standard, a court considers the administrative record -- or at least those portions of the record that the parties provide -- and not materials outside of the record. See 5 U.S.C. § 706("In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party."); Fed. R. App. P. 16 ("The record on review or enforcement of an agency order consists of . . . the order involved; . . . any findings or report on which it is based; and . . . the pleadings, evidence, and other parts of the proceedings before the agency."); Ass'n of Data Processing Serv. Orgs., Inc. v. Bd. of Govs. of the Fed. Reserve Sys., 745 F.2d at 684 ("[W]hether the administrator was arbitrary must be determined on the basis of what he had before him when he acted."). See also Franklin Sav. Ass'n v. Dir., Office of Thrift Supervision, 934 F.2d 1127, 1137 (10th Cir. 1991)("[W]here Congress has provided for judicial review without setting forth . . . procedures to be followed in conducting that review, the Supreme Court has advised such review shall be confined to the administrative record and, in most cases, no de novo proceedings may be had."). Tenth Circuit precedent indicates, however, that the ordinary evidentiary rules regarding judicial notice apply when a court reviews agency action. See New Mexico ex. rel. Richardson v. Bureau of Land Mgmt., 565 F.3d 683, 702 n.21 (10th Cir. 2009)(citing Fed. R. Evid. 201(b))("We take judicial notice of this document, which is included in the record before us in [another case]."); id. at 702 n.22 ("We conclude that the occurrence of Falcon releases is not subject to reasonable factual dispute and is capable of determination using sources whose accuracy cannot reasonably be questioned, and we take judicial notice thereof."). In contrast, the United States Courts of Appeals for the Ninth and Eleventh Circuits have held that taking judicial notice is inappropriate in APA reviews absent extraordinary circumstances or

inadvertent omission from the administrative record. See Compassion Over Killing v. U.S. Food & Drug Administration, 849 F.3d 849, 852 n.1 (9th Cir. 2017); National Min. Ass'n v. Secretary U.S. Dep't of Labor, 812 F.3d 843, 875 (11th Cir. 2016).

To fulfill its function under the APA, a reviewing court should engage in a "thorough, probing, in-depth review" of the record before it when determining whether an agency's decision survives arbitrary-or-capricious review. Wyoming v. United States, 279 F.3d 1214, 1238 (10th Cir. 2002)(citation omitted). The Tenth Circuit explains:

> In determining whether the agency acted in an arbitrary and capricious manner, we must ensure that the agency decision was based on a consideration of the relevant factors and examine whether there has been a clear error of judgment. We consider an agency decision arbitrary and capricious if the agency relied on factors which Congress had 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.

Colo. Envtl. Coal. v. Dombeck, 185 F.3d 1162, 1167 (10th Cir. 1999). Arbitrary-or-capricious review requires a district court "to engage in a substantive review of the record to determine if the agency considered relevant factors and articulated a reasoned basis for its conclusions," Olenhouse, 42 F.3d at 1580, but it is not to assess the wisdom or merits of the agency's decision, see Colo. Envtl. Coal. v. Dombeck, 185 F.3d at 1172. The agency must articulate the same rationale for its findings and conclusions on appeal upon which it relied in its internal proceedings. See SEC v. Chenery Corp., 318 U.S. 80 (1943). While the court may not supply a reasoned basis for the agency's action that the agency does not give itself, the court should "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc., 419 U.S. 281, 286 (1974)(internal citations omitted).

2. Reviewing Agency Legal Interpretations.

In promulgating and enforcing regulations, agencies must interpret federal statutes, their own regulations, and the Constitution of the United States of America, and Courts reviewing those interpretations apply three different deference standards, depending on the kind of law at issue. First, the federal judiciary accords considerable deference to an agency's interpretation of a statute that Congress has tasked it with enforcing. See United States v. Undetermined Quantities of Bottles of an Article of Veterinary Drug, 22 F.3d 235, 238 (10th Cir. 1994). This is known as Chevron deference, named after the supposedly seminal case, Chevron, U.S.A., Inc. v. Natural Resource Defense Council, Inc., 467 U.S. 837 (1984)("Chevron").[9] Chevron deference is a two-step process[10] that first asks whether the statutory provision in question is clear and, if it is not, then asks whether the agency's interpretation of the unclear statute is reasonable. As the Tenth Circuit has explained,

[9]The case itself is unremarkable, uninstructive, does not explicitly outline the now-familiar two-step process of applying Chevron deference, and does not appear to have been intended to become a "big name" case at all. Its author, the Honorable John Paul Stevens, former Associate Justice of the Supreme Court, insists that the case was never intended to create a regime of deference, and, in fact, Justice Stevens became one of Chevron deference's greatest detractors in subsequent years. See generally Charles Evans Hughes, Justice Stevens and the Chevron Puzzle, 106 Nw. U. L. Rev. 551 (2012).

[10]There is, additionally, a threshold step -- the so-called step zero -- which asks whether Chevron deference applies to the agency decision at all. See Cass R. Sunstein, Chrevron Step Zero, 92 Va. L. Rev. 187 (2006). Step zero asks: (i) whether the agency is Chevron-qualified, meaning whether the agency involved is the agency charged with administering the statute -- for example, the EPA administers a number of statutes, among them the Clean Air Act, Pub. L. No. 88-206, 77 Stat. 392; (ii) whether the decision fits within the category of interpretations afforded the deference -- interpretation of contracts, the Constitution, and the agency's own regulations are not afforded Chevron deference, see, e.g., U.S. West, Inc. v. FCC, 182 F.3d 1224 (10th Cir. 1999)("[A]n unconstitutional interpretation is not entitled to *Chevron* deference."); and (iii) whether Congress intended the agency to "speak with the force of law" in making the decision in question, United States v. Mead Corp., 533 U.S. 218, 229 (2001) -- opinion letters by the agency, for example, do not speak with the force of law and are thus not entitled to Chevron deference, see Christensen v. Harris Cty., 529 U.S. 576 (2000). An affirmative answer to all three inquiries results in the agency's decision passing step zero.

> we must be guided by the directives regarding judicial review of administrative agency interpretations of their organic statutes laid down by the Supreme Court in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 . . . (1984). Those directives require that we first determine whether Congress has directly spoken to the precise question at issue. If the congressional intent is clear, we must give effect to that intent. If the statute is silent or ambiguous on that specific issue, we must determine whether the agency's answer is based on a permissible construction of the statute.

United States v. Undetermined Quantities of Bottles of an Article of Veterinary Drug, 22 F.3d at 238 (citation omitted).

Chevron's second step is all but toothless, because if the agency's decision makes it to step two, it is upheld almost without exception. See Ronald M. Levin, The Anatomy of Chevron: Step Two Reconsidered, 72 Chi.-Kent L. Rev. 1253, 1261 (1997)("[T]he Court has never once struck down an agency's interpretation by relying squarely on the second *Chevron* step." (footnote omitted)); Jason J. Czarnezki, An Empirical Investigation of Judicial Decisionmaking, Statutory Interpretation, and the Chevron Doctrine in Environmental Law, 79 U. Colo. L. Rev. 767, 775 (2008)("Due to the difficulty in defining step two, courts rarely strike down agency action under step two, and the Supreme Court has done so arguably only twice."). Courts essentially never conclude that an agency's interpretation of an unclear statute is unreasonable.

Chevron's first step, in contrast, has bite, but there is substantial disagreement about what it means. In an earlier case, the Court noted the varying approaches that different Supreme Court Justices have taken in applying Chevron deference:

> The Court notices a parallel between the doctrine of constitutional avoidance and the Chevron doctrine. Those Justices, such as Justice Scalia, who are most loyal to the doctrines and the most likely to apply them, are also the most likely to keep the "steps" of the doctrines separate: first, determining whether the statute is ambiguous; and, only then, assessing the merits of various permissible interpretations from the first step. These Justices are also the most likely to find that the statute is unambiguous, thus obviating the need to apply the second step of each doctrine. Those Justices more likely to find ambiguity in statutes are

> more likely to eschew applying the doctrines in the first place, out of their distaste for their second steps -- showing heavy deference to agencies for Chevron doctrine, and upholding facially overbroad statutes, for constitutional avoidance.

Griffin v. Bryant, 30 F. Supp. 3d 1139, 1193 n.23 (D.N.M.2014)(Browning, J.). A number of policy considerations animate Chevron deference, among them: (i) statutory interpretation, i.e., that Congress, by passing extremely open-ended and vague organic statutes, grants discretionary power to the agencies to fill in the statutory gaps; (ii) institutional competency, i.e., that agencies are more competent than the courts at filling out the substantive law in their field; (iii) political accountability, i.e., that agencies, as executive bodies ultimately headed by the President of the United States of America, can be held politically accountable for their interpretations; and (iv) efficiency, i.e., that numerous, subject-matter specialized agencies can more efficiently promulgate the massive amount of interpretation required to maintain the modern regulatory state -- found in the Code of Federal Regulations and other places -- than a unified but Circuit-fragmented federal judiciary can.

Second, when agencies interpret their own regulations -- to, for example, adjudicate whether a regulated party was in compliance with them -- courts accord agencies what is known as Auer or Seminole Rock deference. See Auer v. Robbins, 519 U.S. 452 (1997)("Auer"); Bowles v. Seminole Rock & Sand Co., 325 U.S. 410 (1945). This deference is applied in the same manner as Chevron deference and is substantively identical. There would be little reason to have a separate name for this doctrine, except that its logical underpinnings are much shakier, and its future is, accordingly, more uncertain. Justice Scalia, after years of applying the doctrine followed by years of questioning its soundness, finally denounced Auer deference in 2013 in his dissent in Decker v. Northwest Environmental Defense Center, 568 U.S. 597 (2013). The Court cannot describe the reasons for Justice Scalia's abandonment of the doctrine better than the Justice himself:

For decades, and for no good reason, we have been giving agencies the authority to say what their rules mean, under the harmless-sounding banner of "defer[ring] to an agency's interpretation of its own regulations." *Talk America, Inc. v. Michigan Bell Telephone Co.*, [564] U.S. [50], 131 S. Ct. 2254, 2265, 180 L.Ed.2d 96 (2011) (Scalia, J., concurring). This is generally called *Seminole Rock* or *Auer* deference.

. . . .

The canonical formulation of *Auer* deference is that we will enforce an agency's interpretation of its own rules unless that interpretation is "plainly erroneous or inconsistent with the regulation." But of course whenever the agency's interpretation of the regulation is different from the fairest reading, it is in that sense "inconsistent" with the regulation. Obviously, that is not enough, or there would be nothing for *Auer* to do. In practice, *Auer* deference is *Chevron* deference applied to regulations rather than statutes. The agency's interpretation will be accepted if, though not the fairest reading of the regulation, it is a plausible reading -- within the scope of the ambiguity that the regulation contains.

Our cases have not put forward a persuasive justification for *Auer* deference. The first case to apply it, *Seminole Rock*, offered no justification whatever -- just the *ipse dixit* that "the administrative interpretation . . . becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation." Our later cases provide two principal explanations, neither of which has much to be said for it. First, some cases say that the agency, as the drafter of the rule, will have some special insight into its intent when enacting it. The implied premise of this argument -- that what we are looking for is the agency's intent in adopting the rule -- is false. There is true of regulations what is true of statutes. As Justice Holmes put it: "[w]e do not inquire what the legislature meant; we ask only what the statute means." Whether governing rules are made by the national legislature or an administrative agency, we are bound by what they say, not by the unexpressed intention of those who made them.

The other rationale our cases provide is that the agency possesses special expertise in administering its "'complex and highly technical regulatory program.'" That is true enough, and it leads to the conclusion that agencies and not courts should make regulations. But it has nothing to do with who should interpret regulations -- unless one believes that the purpose of interpretation is to make the regulatory program work in a fashion that the current leadership of the agency deems effective. Making regulatory programs effective is the purpose of rulemaking, in which the agency uses its "special expertise" to formulate the best rule. But the purpose of interpretation is to determine the fair meaning of the rule -- to "say what the law is." Not to make policy, but to determine what policy has been made and promulgated by the agency, to which the public owes obedience. Indeed, since the leadership of agencies (and hence the policy preferences of agencies) changes with Presidential administrations, an agency head can only be sure that the application of his "special expertise" to the issue addressed by a regulation will be given effect if we adhere to predictable principles of textual interpretation rather than defer to the "special expertise" of his successors. If we take agency enactments as written, the Executive has a

stable background against which to write its rules and achieve the policy ends it thinks best.

Another conceivable justification for *Auer* deference, though not one that is to be found in our cases, is this: If it is reasonable to defer to agencies regarding the meaning of statutes that Congress enacted, as we do per *Chevron*, it is a fortiori reasonable to defer to them regarding the meaning of regulations that they themselves crafted. To give an agency less control over the meaning of its own regulations than it has over the meaning of a congressionally enacted statute seems quite odd.

But it is not odd at all. The theory of *Chevron* (take it or leave it) is that when Congress gives an agency authority to administer a statute, including authority to issue interpretive regulations, it implicitly accords the agency a degree of discretion, which the courts must respect, regarding the meaning of the statute. While the implication of an agency power to clarify the statute is reasonable enough, there is surely no congressional implication that the agency can resolve ambiguities in its own regulations. For that would violate a fundamental principle of separation of powers -- that the power to write a law and the power to interpret it cannot rest in the same hands. "When the legislative and executive powers are united in the same person . . . there can be no liberty; because apprehensions may arise, lest the same monarch or senate should enact tyrannical laws, to execute them in a tyrannical manner." Montesquieu, *Spirit of the Laws* bk. XI, at 151-152 (O. Piest ed., T. Nugent transl. 1949). Congress cannot enlarge its own power through *Chevron* -- whatever it leaves vague in the statute will be worked out by someone else. *Chevron* represents a presumption about who, as between the Executive and the Judiciary, that someone else will be. (The Executive, by the way -- the competing political branch -- is the less congenial repository of the power as far as Congress is concerned.) So Congress's incentive is to speak as clearly as possible on the matters it regards as important.

But when an agency interprets its own rules -- that is something else. Then the power to prescribe is augmented by the power to interpret; and the incentive is to speak vaguely and broadly, so as to retain a "flexibility" that will enable "clarification" with retroactive effect. "It is perfectly understandable" for an agency to "issue vague regulations" if doing so will "maximiz[e] agency power." Combining the power to prescribe with the power to interpret is not a new evil: Blackstone condemned the practice of resolving doubts about "the construction of the Roman laws" by "stat[ing] the case to the emperor in writing, and tak[ing] his opinion upon it." 1 Wm. Blackstone, *Commentaries on the Laws of England* 58 (1765). And our Constitution did not mirror the British practice of using the House of Lords as a court of last resort, due in part to the fear that he who has "agency in passing bad laws" might operate in the "same spirit" in their interpretation. The Federalist No. 81, at 543-544 (Alexander Hamilton)(J. Cooke ed. 1961). *Auer* deference encourages agencies to be "vague in framing regulations, with the plan of issuing 'interpretations' to create the intended new law without observance of notice and comment procedures." *Auer* is not a logical corollary to *Chevron* but a dangerous permission slip for the arrogation of power.

> It is true enough that *Auer* deference has the same beneficial pragmatic effect as *Chevron* deference: The country need not endure the uncertainty produced by divergent views of numerous district courts and courts of appeals as to what is the fairest reading of the regulation, until a definitive answer is finally provided, years later, by this Court. The agency's view can be relied upon, unless it is, so to speak, beyond the pale. But the duration of the uncertainty produced by a vague regulation need not be as long as the uncertainty produced by a vague statute. For as soon as an interpretation uncongenial to the agency is pronounced by a district court, the agency can begin the process of amending the regulation to make its meaning entirely clear. The circumstances of this case demonstrate the point. While these cases were being briefed before us, EPA issued a rule designed to respond to the Court of Appeals judgment we are reviewing. It did so (by the standards of such things) relatively quickly: The decision below was handed down in May 2011, and in December 2012 the EPA published an amended rule setting forth in unmistakable terms the position it argues here. And there is another respect in which a lack of *Chevron*-type deference has less severe pragmatic consequences for rules than for statutes. In many cases, when an agency believes that its rule permits conduct that the text arguably forbids, it can simply exercise its discretion not to prosecute. That is not possible, of course, when, as here, a party harmed by the violation has standing to compel enforcement.
>
> In any case, however great may be the efficiency gains derived from *Auer* deference, beneficial effect cannot justify a rule that not only has no principled basis but contravenes one of the great rules of separation of powers: He who writes a law must not adjudge its violation.

Decker v. Nw. Envtl. Def. Ctr., 568 U.S. 597, 616-21 (Scalia, J., dissenting)(alterations in original)(citations omitted). Although the Court shares Justice Scalia's concerns about Auer deference, it is, for the time being, the law of the land, and, as a federal district court, the Court must apply it.

Last, courts afford agencies no deference in interpreting the Constitution. See U.S. West, Inc. v. FCC, 182 F.3d 1224, 1231 (10th Cir. 1999)("[A]n unconstitutional interpretation is not entitled to *Chevron* deference. . . . [D]eference to an agency interpretation is inappropriate not only when it is conclusively unconstitutional, but also when it raises serious constitutional questions." (citing, e.g., Rust v. Sullivan, 500 U.S. 173, 190-91 (1991))). Courts have superior competence in interpreting -- and constitutionally vested authority and responsibility to interpret -- the Constitution's content. The presence of a constitutional claim does not take a

court's review outside of the APA, however -- § 706(2)(B) specifically contemplates adjudication of constitutional issues -- and courts must still respect agency fact-finding and the administrative record when reviewing agency action for constitutional infirmities; they just should not defer to the agency on issues of substantive legal interpretation. See, e.g., Robbins v. U.S. Bureau of Land Mgmt., 438 F.3d 1074, 1085 (10th Cir. 2006)("We review Robbins' [constitutional] due process claim against the [agency] under the framework set forth in the APA.").

3. Waiving Sovereign Immunity.

The APA waives sovereign immunity with respect to non-monetary claims. See 5 U.S.C. § 702. The statute provides:

> An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States:

5 U.S.C. § 702. Claims for money damages seek monetary relief "to substitute for a suffered loss." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d 1290, 1298 (10th Cir. 2009)(emphasis in original). Claims that do not seek monetary relief or that seek "specific remedies that have the effect of compelling monetary relief" are not claims for monetary damages. Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298. To determine whether a claim seeks monetary relief, a court must "look beyond the face of the complaint" and asses the plaintiff's prime object or essential purpose; "'[a] plaintiff's prime objective or essential purpose is monetary unless the non-monetary relief sought has significant prospective effect or considerable value apart from the claim for monetary relief.'" Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (quoting

Burkins v. United States, 112 F.3d 444, 449 (10th Cir. 1997)).

The APA's sovereign immunity waiver for claims "seeking relief other than money damages" does not apply, however, "if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought." 5 U.S.C. § 702. The Tucker Act, 28 U.S.C. §§ 1346, 1491, permits district courts to hear some claims against the United States, but it also states that "district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States." 28 U.S.C. § 1346(a)(2). It follows that the APA does not waive the United States' sovereign immunity as to contract claims even when those claims seek relief other than money damages, such as declaratory or injunctive relief. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1295. Consequently, two questions determine whether the APA waives the United States' sovereign immunity as to a particular claim: "First, does [the] claim seek 'relief other than money damages,' such that the APA's general waiver of sovereign immunity is even implicated? Second, does the Tucker Act expressly or impliedly forbid the relief that Normandy seeks, such that the APA's waiver does not apply?" Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (quoting 5 U.S.C. § 702).

ANALYSIS

The Court concludes that: (i) the APA waives the United States' sovereign immunity for Health Connections' claims; (ii) incorporating statewide average premiums in HHS' risk-adjustment formula is not contrary to law, but it is arbitrary and capricious, because the administrative record indicates that HHS assumed, erroneously, that the ACA requires risk adjustment to be budget neutral, and all of HHS' reasons for using the statewide average premium rely on that budget neutrality assumption; (iii) HHS' methods of predicting healthcare

costs for HCC and non-HCC patients is not arbitrary and capricious; (iv) HHS' risk-adjustment practices regarding partial-year enrollees and prescription-drug data are not arbitrary and capricious; and (v) HHS' risk-adjustment formula does not effectively eliminate bronze-level health-insurance plans. The Court, accordingly, sets aside and vacates HHS' action as to the statewide average premium rules and remands the case to the agency for further proceedings.

I. THE APA WAIVES THE UNITED STATES' SOVEREIGN IMMUNITY FOR HEALTH CONNECTIONS' CLAIMS.

The APA waives sovereign immunity with respect to non-monetary claims. See 5 U.S.C. § 702. The statute provides:

> An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States:

5 U.S.C. § 702. Claims for money damages seek monetary relief "to substitute for a suffered loss." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298 (emphasis in original). Claims that do not seek monetary relief or that seek "specific remedies that have the effect of compelling monetary relief" are not claims for monetary damages. Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298. To determine whether a claim seeks monetary relief, a court must "look beyond the face of the complaint" and asses the plaintiff's prime object or essential purpose; "'[a] plaintiff's prime objective or essential purpose is monetary unless the non-monetary relief sought has significant prospective effect or considerable value apart from the claim for monetary relief.'" Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (quoting Burkins v. United States, 112 F.3d 444, 449 (10th Cir. 1997)).

The APA's sovereign immunity waiver for claims "seeking relief other than money damages" does not apply, however, "if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought." 5 U.S.C. § 702. The Tucker Act, 28 U.S.C. §§ 1346, 1491, permits district courts to hear some claims against the United States, but it also states that "district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States." 28 U.S.C. § 1346(a)(2). It follows that the APA does not waive the United States' sovereign immunity as to contract claims even when those claims seek relief other than money damages, such as declaratory or injunctive relief. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1295. Consequently, two questions determine whether the APA waives the United States' sovereign immunity as to a particular claim: "First, does [the] claim seek 'relief other than money damages,' such that the APA's general waiver of sovereign immunity is even implicated? Second, does the Tucker Act expressly or impliedly forbid the relief that Normandy seeks, such that the APA's waiver does not apply?" Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (quoting 5 U.S.C. § 702).

The Court concludes that Health Connections' claims are not for monetary relief. Health Connections asks the Court to declare HHS' risk adjustment methodology invalid, declare that HHS' risk adjustment methodology must be revised, and enjoin further application of that methodology. See Complaint at 45. Health Connections' claims for declaratory and injunctive relief could cause HHS to pay money to Health Connections, because "[i]f this Court grants the requested relief, HHS will then be directed to conduct a new rulemaking process." Plaintiff's Reply at 29. "If it is determined under that new scheme that HHS owes money back to NMHC . . . HHS can issue that refund or NMHC can sue in the court of Federal Claims." Plaintiff's

Reply at 29. That granting relief to Health Connections "might enable a subsequent claim for monetary relief . . . does not preclude the district court from exercising jurisdiction at this point." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298. Health Connections' challenges to HHS' risk adjustment methodology would, if successful, alter Health Connections' risk adjustment payments for future years. Consequently, Health Connections seeks relief with significant prospective value -- and not monetary relief -- even though providing relief to Health Connections could cause HHS to refund a portion of the risk adjustment payments that Health Connections has already made. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298 (concluding that a plaintiff's claim retained significant prospective value such that its "primary object remains securing equitable relief" even though the claim's success, "over a year after HUD ceased disbursing funds to the company" could cause the agency to make belated payments).

The Court determines that, even if Health Connections' challenge to HHS' risk adjustment methodology seek monetary relief, it does not seek money damages. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296. The Supreme Court has explained that not all judicial remedies requiring monetary payments are characterized as damages. See Bowen v. Mass., 487 U.S. at 893-94. "The fact that a judicial remedy may require one party to pay money to another is not a sufficient reason to characterize the relief as 'money damages.'" Bowen v. Mass., 487 U.S. at 893-94. For example, the Supreme Court has "recognized that relief that orders a town to reimburse parents for educational costs that Congress intended the town to pay is not 'damages.'" Bowen v. Mass., 487 U.S. at 893. In contrast to damages, "'[r]eimbursement merely requires the Town to belatedly pay expenses that it should have paid all along.'" Bowen v. Mass., 487 U.S. at 894 (quoting School Committee of

Burlington v. Department of Education of Mass., 471 U.S. 359, 370-71 (1985)). The Supreme Court also quoted the Honorable Robert Bork, United States Circuit Judge, who explained that "'[d]amages are given to the plaintiff to *substitute* for a suffered loss, whereas specific remedies are not substitute remedies at all, but attempt to give the plaintiff the very thing to which he was entitled.'" Bowen v. Mass., 487 U.S. at 895 (quoting Maryland Dept. of Human Resources v. Department of Health and Human Services, 763 F.2d 1441, 1446 (D.C. Cir. 1985)(Bork, J.)(emphasis in Maryland Dept. of Human Resources v. Department of Health and Human Services)).

Here, Health Connections ultimately wants the Court "to invalidate regulations for past years so that HHS can then fix the regulatory scheme." Plaintiff's Reply at 29. "If it is determined that under that new scheme that HHS owes money back to NMHC, HHS can issue that refund or NMHC can sue in the court of federal claims." Plaintiff's Reply at 29 (emphasis added). These statements indicate that Health Connections is not seeking damages, because "ow[ing] money back" or requesting a "refund" is not a "'*substitute* for a suffered loss.'" Bowen v. Mass., 487 U.S. at 895 (quoting Maryland Dept. of Human Resources v. Department of Health and Human Services, 763 F.2d at 1446 (emphasis in Maryland Dept. of Human Resources v. Department of Health and Human Services)). Rather, Health Connections requests "'the very thing to which [Health Connections is] entitled'" or believes that it is entitled. Bowen v. Mass., 487 U.S. at 895 (quoting Maryland Dept. of Human Resources v. Department of Health and Human Services, 763 F.2d at 1446 (alteration added)). The Court therefore concludes that Health Connections is not requesting damages.

The Court also determines that Health Connections' claim is founded on the ACA and HHS regulations and not on a contract with the federal government, so the Tucker act does not

expressly or implicitly bar that claim. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1299 ("Therefore, in order to determine whether the Tucker Act impliedly forbids the relief sought in this case, we must evaluate whether Normandy's claim is properly understood as one founded on contract or on the federal Constitution, statutes, or regulations."). Specifically, Health Connections' claims relate to HHS' risk adjustment formula's use of state average premiums. See Plaintiff Mem. at 24-25 (citing 2014 Final Rule, 78 Fed. Reg. at 15,430-34); Plaintiff Mem. at 24 (citing 42 U.S.C. § 18063(a)(1)). Because Health Connections' claims arise under HHS regulations and under the ACA, and not under a contract,[11] the Court concludes that the Tucker Act does not forbid the relief sought. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1299. Accordingly, the Court concludes that the APA waives the United States' sovereign immunity as to Health Connections' claims.

II. HHS' USE OF STATEWIDE AVERAGE PREMIUMS IS NOT CONTRARY TO LAW, BUT IS ARBITRARY AND CAPRICIOUS.

Health Connections argues both that HHS' regulations violate the ACA, and that those regulations are arbitrary and capricious. See Plaintiff Mem. at 16. The Court determines that the HHS' risk adjustment regulations are not contrary to law, because the ACA permits risk

[11]In becoming a CO-OP, Health Connections signed a loan agreement with HHS to fund Health Connections' initial formation and operation in New Mexico. See Plaintiff Mem. ¶ 23, at 11 (citing Hickey Declaration at 5 (dated October 5, 2016)(NMHC000867)). This loan agreement is not, however, the source of this litigation. Rather, Health Connections' claims relate to HHS' risk adjustment formula's use of state average premiums. See Plaintiff Mem. at 24-25 (citing 78 Fed. Reg. at 15,430-34); Plaintiff Mem. at 24 (citing 42 U.S.C. § 18063(a)(1)). "When the source of rights asserted is constitutional, statutory, or regulatory in nature, the fact that resolution of the claim requires some reference to contract does not magically transform [the] action . . . into one on the contract and deprive the court of jurisdiction it might otherwise have." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1300 (quotations omitted). Because the source of rights asserted here are statutory and regulatory, the Court concludes that the mere existence of this loan agreement does not deprive the Court of jurisdiction.

adjustment payments to be based on factors other than actuarial risk and because, while the ACA does not require risk adjustment to be budget neutral, it also does not forbid budget neutrality. The Court also determines, however, that HHS' risk adjustment regulations -- specifically their use of the statewide average premium -- are arbitrary and capricious, because HHS' justifications for using the statewide average premium instead of a plan's own premium all assume that the ACA requires risk adjustment to be budget neutral, which is not correct. Nevertheless, HHS could have justified its promulgation of budget neutral regulations if it determined that budget neutrality was a worthy policy goal. HHS never made such a determination in the record, however, and the Court considers only the reasons that the agency actually gave and not the reasons that the agency might have given when determining agency action was arbitrary and capricious.

A. HHS' RISK ADJUSTMENT REGULATIONS ARE NOT CONTRARY TO LAW.

Health Connections makes two contentions regarding the ACA's risk adjustment provisions: (i) those provisions "mandate that risk adjustment assessments be based solely upon actuarial risk," Plaintiff Mem. at 17; and (ii) "there is no statutory requirement that risk adjustment be budget neutral," Plaintiff Mem. at 22. To evaluate those contentions, the Court must determine whether, under Chevron, it must defer to HHS' contrary conclusions about the statute, i.e., that the ACA does not mandate that risk adjustment payments be based solely on actuarial risk and that the ACA requires risk adjustment to be budget neutral. Consequently, the Court must determine whether the ACA's risk adjustment provisions are ambiguous regarding the permissible bases for risk adjustment payments and whether risk adjustment must be budget neutral. See Chevron, 467 U.S. at 842-43. If the ACA is ambiguous on either point, the Court must determine whether HHS' ACA interpretation is reasonable. See Chevron, 467 U.S. at 843

("[T]he question for the court is whether the agency's answer is based on a permissible construction of the statute.").

The ACA does not clearly require risk adjustment payments to be based solely on actuarial risk. That the ACA commands "[t]he Secretary, in consultation with States, [to] establish criteria and methods to be used in carrying out the risk adjustment activities" indicates that the ACA does not oblige HHS to use actuarial risk as the sole actuarial risk criterion. 42 U.S.C. § 18063(b). Telling HHS to establish risk adjustment criteria would make no sense otherwise. The ACA's language stating that health plans and health insurance issuers must make a risk adjustment payment if their enrollees have below-average actuarial risk, see 42 U.S.C. § 18063(a)(1), while health plans and health insurance issuers must receive a risk adjustment payment if their enrollees have above-average actuarial risk, see 42 U.S.C. § 18063(a)(2), does not mean that criteria other than actuarial risk cannot be used when determining the magnitude of those payments. Health Connections insists that the statute is clear that, in calculating the charge, the State or HHS must only consider actuarial risk as a factor, see Plaintiff Mem. at 17; Plaintiff's Reply at 11, but the Court sees no such requirement plainly in the statute's text. The statute does not say anything about how to calculate the charge; it says only "each state shall assess a charge. . . ." 42 U.S.C. § 18063(a)(1). From the text, the charge assessed could be any amount. While a potential -- perhaps even a plausible -- reading of the statutory text might be that the assessment should be proportional to the relative disparity between the average actuarial risk and the insurer's actuarial risk, there is no such explicit or implicit requirement

That the ACA does not clearly require risk adjustment to be based solely on actuarial risk means that HHS determination to the same effect is reasonable, although the Court does not, technically, need to proceed to Chevron step two, because the statute is clear on this point. See

Chevron, 467 U.S. at 842-43 ("First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter."). It also means that the Court is not persuaded by Health Connections' argument that HHS' risk adjustment regulations are contrary to law insofar as they incorporate criteria other than actuarial risk when calculating risk adjustment payments.

The ACA, however, does not unambiguously require the risk adjustment program to be budget neutral. It is an established principle of statutory construction that, when "Congress includes particular language in one section of a statute but omits it in another section of the same Act, it is generally presumed that Congress acts intentionally and purposely in the disparate inclusion or exclusion." Bates v. United States, 523 U.S. 23, 29-30 (1997). This canon of construction applies when a court analyzes whether a statute is ambiguous for Chevron purposes. See New Mexico v. Dep't of Interior, 854 F.3d 1207, 1223 (10th Cir. 2017)("In conducting our *Chevron* step-one analysis, we [e]mploy [] traditional tools of statutory construction. These tools include examination of the statute's text, structure, purpose, history, and relationship to other statutes." (alterations in original)).

The ACA's risk adjustment provisions include no explicit requirements regarding risk adjustment's budgetary implications or the lack thereof. See 42 U.S.C. § 18063. The ACA's reinsurance provisions, however, require reinsurance entities to fund their payments to health insurance issuers who cover high risk individuals with the payments that those reinsurance entities receive from health insurance issuers, i.e., the ACA specifies that outgoing reinsurance payments equal incoming reinsurance payments. See 42 U.S.C. § 18061(b)(1)(B). Risk adjustment and reinsurance serve similar functions, although risk adjustment is permanent while reinsurance is temporary. Compare 2014 Final Rule, 78 Fed. Reg. at 15,411 (dated March 11,

2013)(A.R.000228)("The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees."); id. ("The transitional reinsurance program and the temporary risk corridors program, which begin in 2014, are designed to provide issuers with greater payment stability as insurance market reforms are implemented and Exchanges facilitate increased enrollment."), with id. ("On an ongoing basis, the risk adjustment program is intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees."). That the ACA contains an explicit provision stating that incoming reinsurance payments fund outgoing reinsurance payments and omits any such language regarding risk adjustment payments means that outgoing risk adjustment payments need not equal incoming risk adjustment payments. Because the statute is clear that budget neutrality for the risk adjustment regulations is not required, the Court need not accept HHS' contention that the ACA requires budget neutrality on those regulations. See National Cable & Telecommunications Ass'n v. Brand X Internet Servs., 545 U.S. 967, 985 (2005)(noting that, when a "statute unambiguously requires the court's construction," the court's interpretation trumps the agency's); Chevron, 467 U.S. at 842-43.

Although HHS promulgated its risk adjustment regulations under the erroneous belief that risk adjustment must be budget neutral, it does not follow, however, that those regulations violate the APA. While nothing in the APA requires risk adjustment to be budget neutral, nothing in the APA forbids budget neutrality either. See 42 U.S.C. § 18063. Accordingly, the Court concludes that HHS' risk adjustment regulations are not contrary to law.

B. HHS' RISK ADJUSTMENT REGULATIONS ARE ARBITRARY AND CAPRICIOUS.

To determine whether HHS' risk adjustment regulations survive arbitrary and capricious

review, the Court must determine whether HHS "examine[d] the relevant data and articulate[d] a satisfactory explanation for its action including a rational connection between the facts found and the choice made." Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125. "One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions." Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125. The agency must articulate the same rationale for its findings and conclusions on appeal upon which it relied in its internal proceedings. See SEC v. Chenery Corp., 318 U.S. 80, 87 (1943)("The grounds upon which an administrative order must be judged are those upon which the record discloses that its actions was based.").

HHS published three different documents when first crafting its risk adjustment methodology. First, on September 12, 2011, HHS -- specifically the Center for Consumer Information and Insurance Oversight -- published a white paper titled "Risk Adjustment Implementation Issues." Risk Adjustment Implementation Issues at 1 (dated September 12, 2011)(A.R.004367)("White Paper"). In the White Paper, HHS sets out a basic structure for calculating risk adjustment transfers: "Payments and charges will be calculated by multiplying plan risk relative to the market by a premium amount or 'baseline premium.' Further, they will be calculated in a zero sum, budget-neutral manner." White Paper at 13 (A.R.004379). HHS' only explanation for its declaration that adjustment payments will be calculated budget neutrally is that, "in contrast to some current risk adjustment methodologies, the Affordable Care Act's risk adjustment program is designed to be budget neutral." White Paper at 4 (A.R.004370). In short, HHS assumed that the ACA requires budget neutrality, and HHS does not give an independent policy reason for requiring budget neutrality.

HHS continues by identifying two major issues when developing a methodology to

calculate risk adjustment transfers: (i) "how to establish the baseline premium"; and (ii) "how to balance payments and charges." White Paper at 13-14 (A.R.004379-80). HHS compares two basic approaches to establishing the baseline premium, using an average premium or using a plan's own premium. See White Paper at 14 (A.R.004380). HHS reasons that using an average premium will automatically balance payments and charges, because "the State average is a single dollar amount for all plans, and plan risk scores average to 1.0, [so] the payments and charges are equal in this approach." White Paper at 15 (A.R.004381). HHS determines that using a plan's own premium will not necessarily produce equal payments and charges, so "[s]ince payment and charge transfers will be budget neutral, a method is needed to balance them if payments are greater than charges or vice versa." White Paper at 15 (A.R.004381). Again, HHS gives no policy reason for requiring budget neutrality. See White Paper at 15 (A.R.004381). Finally, HHS also considers balancing risk adjustment payments and charges by increasing charges on a pro-rated basis, decreasing payments on a pro-rated basis, or by doing both. See White Paper at 15 (A.R.004381).

In its 2014 Proposed Rule, HHS decides to use a state's average premium as the baseline premium when calculating risk adjustment charges and payments. See HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,139 (dated December 7, 2012)(A.R.000134)("2014 Proposed Rule"). HHS articulates the rationale for its decision to use a state average premium and not a plan's own premium:

> The approaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero. These examples also demonstrated that the balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan (for example, AV or differences in costs and utilization patterns across rating areas). A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer

estimates).

2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134). According to HHS, "transfers net to zero when the State average premium is used as the basis for calculating transfers," so a balancing adjustment is unnecessary, and "[t]he State average premium provides a straightforward and predictable benchmark for estimating transfers." 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134). Thus, its reasoning is premised on budget neutrality and predictability. The proposed rule does not, however, provide a policy rationale for budget neutrality. HHS' 2014 Final Rule likewise employs a state average premium. See 2014 Final Rule, 78 Fed. Reg. at 15,431 (dated March 11, 2013)(A.R.000248). In that rule, HHS reports that it "agree[s] with commenters that use of a plan's own premium may cause unintended distortions in transfers." 2014 Final Rule, 78 Fed. Reg. at 15,432 (dated March 11, 2013)(A.R.000249). HHS and the commenters' reference to "distortions" is left unexplained. 2014 Final Rule, 78 Fed. Reg. at 15,432 (A.R.000249).

In evaluating whether HHS' interpretation is permissible, the Court must rely upon the rationale the agency articulated in its internal proceedings and not upon post hoc reasoning. See Biodiversity Conservation Alliance v. Jiron, 762 F.3d 1036, 1060 (10th Cir. 2014)("We will not, for example, accept appellate counsel's post-hoc rationalizations for agency action -- we must uphold the agency's action if at all, on the basis articulated by the agency itself."). The rationales HHS relies upon in its internal proceedings are budget neutrality and predictability. See Defendant Mem. at 22-23 (arguing that budget neutrality and predictability are rationales which HHS relies upon). As explained above, HHS assumes budget neutrality as a given, because it believes, erroneously, that the ACA requires it, see 77 Fed. Reg. at 73,139 (A.R.000134)("The approaches that used plans' own premiums resulted in unbalanced payment transfers, **requiring** a balancing adjustment to yield transfers that net to zero." (emphasis

added)), and HHS articulates no independent policy reason for requiring budget neutrality. The ACA does not, however, require the risk adjustment payments to be budget neutral. See supra at 63-64.

That HHS erroneously reads the ACA's risk adjustment provisions to require risk adjustment payments equal risk adjustment charges infects its analysis of the relative merits of using a state's average premium when calculating risk adjustment transfers instead of using a plan's own premium. Because risk adjustment does not need to be budget neutral, HHS' risk adjustment methodology could use a plan's own premium instead of a state's average premium without imposing a balancing adjustment. Accordingly, the problems that HHS identifies with imposing a balancing adjustment -- that a balancing transfer is unpredictable and could produce unintended distortions -- do not justify HHS' aversion to using a plan's own premium to calculate risk adjustment transfers. See 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (asserting that "balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan"); id. ("A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process (that is, plan actuaries would need to factor the uncertainty of the balancing adjustment into their transfer estimates)."). See also Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125 (stating that an agency must articulate a rational connection between the facts it found and the choice it made). Indeed, absent a balancing adjustment, using a plan's own premium without imposing a balancing adjustment is more predictable for health insurance issuers than using a state's average premium; each issuer sets its own premiums, but a state's average premium depends on the decisions of all the health insurance issuers in a particular state. But see 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (concluding that, in contrast to a risk adjustment methodology based on a plan's own

premium and incorporating a balancing adjustment, that "[t]he State average premium provides a straightforward and predictable benchmark for estimating transfers.").

While the ACA does not require risk adjustment to be budget neutral, nothing in the statute forbids budget neutrality and designing risk adjustment to be budget neutral may be a reasonable policy choice. See Minuteman Health, Inc. v. U.S. Dep't of Health and Human Servs., __ F.3d __, 2018 WL 627381, at *20 (D. Mass. 2018)(Saylor, J.)("Although the statute does not require the program to be budget-neutral, it does not prohibit the program from being budget-neutral, either. . . . The question then becomes whether HHS's decision to attempt to operate the risk-adjustment program in a budget-neutral way was unreasonable or arbitrary."). Indeed, there may be excellent policy reasons for making the risk adjustment plan budget neutral. For example, HHS may not have the funding to make up the shortfall between the risk adjustment charges and credits.[12] Budget neutrality may also be a rational policy decision, so that HHS may allocate discretionary funds to other programs that more desperately need that funding. The problem with invoking those policy rationales here, however, is that HHS never articulates any public policy decision to operate risk adjustment in a budget neutral way; HHS' only decision is to comply with a supposed statutory requirement. See 2014 Proposed Rule, 77 Fed. Reg. at 73,139 ("The approaches that used plans' own premiums resulted in unbalanced payment transfers, **requiring** a balancing adjustment to yield transfers that net to zero." (emphasis added)); White Paper at 15 (reasoning that "[b]alancing is needed for all options to establish a baseline premium, except for the State average," because "payments and charges are equal" in that approach). See also Defendant Mem. at 22 ("[B]ecause the risk adjustment

[12]The Court notes that, since Congress passed the ACA, Congress has barred HHS from using its annual appropriations to fund different risk program's shortfalls. See Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, §227; Plaintiff Mem. at 24, n.7. Given that action, it may be rational for HHS to make risk adjustment budget neutral.

program is self-funded and budget-neutral, payments and charges must balance."). That HHS, in designing its risk adjustment methodology, never considered whether budget neutrality was sound public policy means that HHS cannot now appeal to budget neutrality's public policy benefits to justify its decision. See Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc., 419 U.S. at 285-86 (stating that "we may not supply a reasoned basis for the agency's action the agency itself has not given"). That HHS can reasonably conclude that budget neutrality is a worthy public policy goal does not permit the Court, in reviewing HHS' decisionmaking, to act as though HHS actually considered the issue and reached that conclusion.[13]

HHS argues, however, that it articulates two other reasons for adopting its rule. First, it contends that HHS reasons that statewide premiums better calculate actuarial risk than an issuer's own premium. See Defendant Mem. at 20-21 (citing 2014 Final Rule, 78 Fed. Reg. at 15,432 (A.R.000249)). The citation it directs the Court to support its point, however, is HHS' cryptic sentence that "[w]e agree with commenters that use of a plan's own premium may cause unintended distortions in transfers." 2014 Final Rule, 78 Fed. Reg. at 15,432 (A.R.000249).[14] What distortions HHS is describing is unexplained. The sentence's contexts suggest that

[13]In subsequent final rules, HHS does not elaborate further on its budget-neutrality rationale. See 79 Fed. Reg. at 13753-54 (A.R.004542-43); 80 Fed. Reg. at 10,771 (A.R.005703); 81 Fed. Reg. at 12,230 (A.R.007774); 81 Fed. Reg. at 94099-100 (A.R.009636-37). Those final rules also do not provide additional rationales for using the statewide average premium. The Court's holding, thus, applies to the 2014, 2015, 2016, 2017, and 2018 rules.

[14]HHS quotes another portion of the record in this argument, but, at that record portion, the agency does not discuss why it is using the statewide average premium over an issuer's own premium. See Defendant Mem. at 21 (citing 77 Fed. Reg. at 73,140 (A.R.000135)). Instead that record portion defines what a state average premium is and discusses some assumptions that the agency made when deriving the payment transfer formula. See 77 Fed. Reg. at 73,140 (A.R.000135)("The State average premium is the average premium requirement for providing insurance to the applicable market population. . . . Finally, the derivation of the payment transfer also assumed that plans price to cost, that is, that competition among plans for enrollees drives plans' premiums to their premium requirements."). Neither quotation, in context, supports HHS' contention that it reasons in the record that it selects the statewide average premium over an issuer's own premium, because the statewide average premium better calculates actuarial risk.

distortions refer to an imbalance in risk adjustment charge transfers, which implicates budget neutrality and not that statewide average premiums better capture actuarial risk than an issuer's own premium. Alternatively, it could be a reference to HHS' proposed rule's prognostication that "balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan." 77 Fed. Reg. at 73,139. Again, HHS offers, in its briefing, sound policy reasons for using the statewide average premium instead of the issuer's own premium, see, e.g., Defendant Mem. at 21 ("The state average also reduces the effect of inaccurate or outlying pricing decisions by individual plans that could result in the methodology under- or over-compensating for actuarial risk."); the agency does not, however articulate those reasons in the record.

Second, HHS argues that it selects the state average premium over an issuer's own premium "to reduce incentives for plans to avoid high risk enrollees." Defendant Mem. at 21 (citing 78 Fed. Reg. at 15,411 (A.R.000228); White Paper at 36, 50 (A.R.000682, 000696)). The record portions cited, however, do not articulate that policy reason. It is true that the Federal Register cite notes that one of the ACA's policy goal is to "reduce the incentives for issuers to avoid higher-risk enrollees," but it does not explain how a statewide average premium would better effect that goal than an issuer's own premium. 78 Fed. Reg. at 15,411 (A.R.000228). The White Paper cited also does not explain why HHS selects the statewide average premium; rather, it assumes that budget neutrality is a given and analyzes what effect that neutrality has on issuers if HHS decided to use an issuer's own premium. See White Paper at 36, 50 (A.R.000682, A.R.000696). Because the record does not include HHS' proffered rationale, the Court cannot afford it deference. See Bowman Transp., Inc. v. Arkansas-Best Freight System, Inc., 419 U.S. at 285-86. As the Court concludes that HHS has "failed to provide a reasoned explanation for its

action," it sets aside and vacates the agency action as to the statewide average premium rules and "remand[s] the case to the agency for further proceedings." Olenhouse, 42 F.3d at 1575. See 5 U.S.C. § 706(2)(A)("The court shall . . . hold unlawful and set aside agency action, findings and conclusions found arbitrary [and] capricious.").

Although the Court concludes that HHS' 2014-2018 rules vis-à-vis use of the statewide average premium are arbitrary and capricious, it notes that one of Health Connection's arguments against the 2018 rule is meritless. Health Connections argues that the 2018 proposed rule, which still uses the statewide average premium, but reduces the amount by fourteen percent to account for administrative costs, is also arbitrary and capricious, because the 2018 rule does not adequately account for competition and innovation, and ignores the statutory command, which, according to Health Connections, instructs HHS to charge a risk adjustment based only on actuarial risk. See Plaintiff Mem. at 31-32. Health Connections' arguments fail on those grounds, because the statute does not require HHS to consider only actuarial risk when calculating the risk adjustment charge. See 42 U.S.C. § 18063. Moreover, in its 2018 proposed rule, HHS considers whether "inclusion of administrative costs in the Statewide average premium harms efficient plans" and concludes that as "we noted in the 2017 Payment Notice and White Paper . . . low cost plans do not necessarily indicate efficient plans. Should a plan be low cost with low claims costs, it could be an indication of mispricing, as the issuer should be pricing for average risk." 81 Fed. Reg. at 94,099 (dated December 22, 2016)(A.R.009636). Based on this record, the Court concludes that HHS considered Health Connections' efficiency and innovation concerns for the 2018 proposed rule, and, accordingly, HHS did not act arbitrarily or capriciously on those grounds. See Motor Vehicle Mfrs. Ass'n of U.S., Inc., v. State Farm Mut. Auto. Ins. Co., 463 U.S. 29, 43 (1983).

III. HHS' APPROACH TO PREDICTING COSTS FOR HCC AND NON-HCC ELIGIBLE ENROLLEES IS NOT ARBITRARY AND CAPRICIOUS.

Health Connections argues that HHS' risk adjustment formula under-predicts costs for enrollees without HCCs, because the formula does not consider the costs that a non-HCC enrollee incurs when using preventive care services or suffering unexpected health issues. See Plaintiff Mem. at 41. Consequently, Health Connections contends that the flawed formula "penalizes the enrollment of younger and healthier members needed to balance the risk pool and avoid a 'death spiral' of rising medical costs." Plaintiff Mem. at 42 (quoting King v. Burwell, 135 S. Ct. at 2486). HHS' approach is not arbitrary and capricious, because, as the record shows, HHS addressed the issue by considering relevant factors and provided reasoned bases for its decisions.

To begin, when making its rules for 2014-2016, the information before HHS did not clearly demonstrate that its risk adjustment formula was going to have problems predicting cost for non-HCC and HCC enrollees. On the one hand, a Blue Cross and Blue Shield comment warned that overlooking non-HCC enrollees' costs could make HCC enrollees more profitable for insurers, see BCBSA Detailed Comments on the Interim Final Rule with Comment: "Patient Protection and Affordable Care Act; Amendments to the HHS Notice of Benefit and Payment Parameters for 2014" [CMS-9964-IFC] at 5 (undated)(A.R.004330), but on the other hand, a study determined that risk adjusters generally underestimate the costs associated with higher cost individuals, see Ross Winkelman, Society of Actuaries, A Comparative Analysis of Claims-Based Tools for Health Risk Assessment at 24 (dated April 20, 2007)(A.R.001261); Blue Cross and Blue Shield Comments on the Proposed Rule: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" [CMS-9964-P] at 52 (dated December 28, 2012)(A.R.003098). Given the mixed signals HHS received, it was not a clear

error of judgment to finalize its proposed risk adjustment formula.

As for making its 2017 and 2018 rulemaking, HHS responded to criticisms that its risk adjustment formula underestimates costs for healthy enrollees and provided reasoned bases for its decisions. For instance, HHS' 2017 rules incorporated preventative services costs into its risk adjustment formula. See Defendant Reply at 12; 81 Fed. Reg. at 12,218 (dated March 8, 2016) (A.R.007762); Centers for Medicare & Medicaid Services Center for Consumer Information & Insurance Oversight, HHS-Operated Risk Adjustment Methodology Meeting Discussion Paper at 33 (dated March 31, 2016)(A.R.009757). HHS explained that it

> attempted to address the range between enrollees without HHCs and those with HCCs by finalizing the incorporation of preventive services into our simulation of plan liability. While overall this is not a very large effect, it does have a noticeable effect on certain demographic subgroups, resulting in more accurate payments for enrollees without HCCs.

81 Fed. Reg. at 12,218 (dated March 8, 2016)(A.R.007762). HHS also considered modifying its risk adjustment model to more accurately predict costs for healthier enrollees. When proposing its 2018 rules, HHS stated that it was

> evaluating an approach in which we would directly adjust plan liability risk scores outside of the model for [certain] subpopulations. For example, we could potentially make an adjustment to the plan liability risk scores calculated through the HHS risk adjustment models that would adjust for such an underprediction or overprediction in actuarial risk by directly increasing low plan liability risk scores and directly reducing high plan liability risk scores in order to better match the relative risks of these subpopulations.

81 Fed. Reg. at 61,473 (dated September 6, 2016). HHS did not immediately make such adjustments, however, because it believed that "there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well." 81 Fed. Reg. at 61,473. Accordingly, HHS decided to "continu[e] to evaluate the effect of these types of modifications on all aspects of the model's performance before

choosing to implement such an approach, and would not implement these types of modifications if we determined that doing so would have material unintended consequences for the model's performance along other dimensions." 81 Fed. Reg. at 61,473.

HHS reported, in its final rule for 2018, that it believed that modifications to its risk adjustment model could improve its accuracy for low-cost enrollees, but added that it was still considering the tradeoffs associated with such modifications. See 81 Fed. Reg. at 94,083. It also provided a detailed summary of the myriad comments it received regarding adjustments to its risk adjustment model. See 81 Fed. Reg. at 94,083. Given the disparate recommendations contained in those comments, it was neither arbitrary nor capricious for HHS to exercise caution instead of taking precipitous action.

Health Connections argues, nonetheless, that HHS acted arbitrarily and capriciously by not responding to the Foster Memorandum specifically. See Plaintiff Mem. at 36 ("Incredibly, HHS did not respond to Mr. Foster's white paper at all, much less offer any reasoning or data to explain why it was not adopting his detailed proposal."). Health Connections suggests that it is arbitrary to capricious to "ignore[] critical comments to proposed rules," Plaintiff Mem. at 36, but Health Connections' reference to "critical comments" muddies the distinction between comments as to specific proposals and comments as to general issues raised before an agency. For the proposition that an agency ignoring "critical comments to proposed rules" is arbitrary and capricious, Health Connections cites Allied Local & Reg'l Mfrs. Caucus v. U.S. E.P.A., 215 F.3d 61, 79-80 (D.C. Cir. 2000), but that case speaks to the implications of an agency ignoring "significant points raised during the public comment period," 215 F.3d at 80. Cf. NRDC v. EPA, 859 F.2d at 188 ("The fundamental purpose of the response requirement is, of course, to show that the agency has indeed considered all significant points articulated by the public."). The

question for the Court is whether HHS "entirely failed to consider an important aspect of the problem," Colo. Envtl. Coal. V. Dombeck, 185 F.3d at 1167, and/or whether HHS failed to "articulate a reasoned basis for its conclusions," Olenhouse, 42 F.3d at 1580. Regarding its decision to not adopt proposals to address prediction bias by directly adjusting plan liability risk scores -- which appears, to the Court, to be an oblique reference to the Foster Memorandum -- HHS provides a reasoned basis for its decision, explaining:

> We note that while we believe modifications of this type could improve the model's performance along this specific dimension, there is a risk that such modifications could unintentionally worsen model performance along other dimensions on which the model currently performs well. For this reason, we are continuing to evaluate the effect of these types of modifications on all aspects of the model's performance before choosing to implement such an approach, and would not implement these types of modifications if we determined that doing so would have material unintended consequences for the model's performance along other dimensions.

81 Fed. Reg. at 61,473. See Foster Memorandum at 2 ("The adjusted risk scores can be calculated using a simple formula based on a plan's unadjusted risk score from the HHS-HCC model and its actuarial value."). Accordingly, HHS did not act arbitrarily and capriciously here.

IV. HHS' DECISIONS REGARDING PARTIAL YEAR ENROLLEES AND THE USE OF PRESCRIPTION DRUG DATA ARE NOT ARBITRARY AND CAPRICIOUS.

The Court concludes that HHS' decisions regarding partial year enrollees and the use of prescription drug data in its risk adjustment model are not arbitrary and capricious. HHS' risk adjustment model calculates a risk score for every enrollee, which quantifies an enrollee's relative healthiness, and, therefore, the estimated costs of providing healthcare to that enrollee. See Plaintiff Mem. at 40. HHS begins by considering an enrollee's age and sex, but if HHS learns that an enrollee qualifies for an HCC -- such as diabetes or HIV/AIDS -- the enrollee's risk score increases. See Plaintiff Mem. at 40-41. Health Connections argues that HHS does not accurately identify enrollees who have HCCs because of how HHS accounts for partial year

enrollees and because HHS only uses diagnoses -- and not prescription drug data -- when determining whether an enrollee has an HCC. See Plaintiff Mem. at 45. It follows, according to Health Connections, that enrollees' risk scores are inaccurate. See Plaintiff Mem. at 45. A partial-year enrollee is someone who is enrolled in a health insurance plan for part of a year. See Plaintiff Mem. at 45 (citing Hickey Declaration at 22 (NMHC000884)). If an enrollee has an HCC, but is not diagnosed while enrolled in a particular plan, then that plan will not report the HCC. See Plaintiff Mem. at 45 (citing Hickey Declaration at 22-23 (NMHC000884-85)). Using prescription drug data would capture an enrollees HCC status even if that enrollee has not been diagnosed with an HCC. For example, a person may have been diagnosed with diabetes before enrolling in their current health insurance plan. That health plan, therefore, might not have a record of their diabetes diagnosis. The health plan would, however, have records regarding this hypothetical person's insulin prescriptions -- because those prescriptions are filled on a regular basis -- which would indirectly indicate a diabetes diagnosis. See Plaintiff Mem. at 46 (citing Hickey Declaration at 25 (NMHC000887)). In short, Health Connections contends that HHS' decisions regarding how to account for partial year enrollees and its decision not to use prescription drug data to identify enrollees with HCCs are arbitrary and capricious. See Plaintiff Mem. at 49. The Court concludes otherwise.

1. Partial Year Enrollees.

HHS' decision regarding how to account for partial year enrollees is not arbitrary and capricious. HHS rationally considered and addressed concerns regarding partial year enrollment. See 78 Fed. Reg. at 15,421 (dated March 11, 2013)(A.R.000238). HHS notes that "[w]e received several comments that the HHS risk adjustment models do not appropriately account for short-term enrollment. One commenter suggested that risk scores for individuals that were

enrolled for only part of a year would be inaccurate." 78 Fed. Reg. at 15,421 (dated March 11, 2013)(A.R.000238). HHS gave two responses to this comment. It first stated that "[o]ur models were calibrated to account for short-term enrollment in several ways. First, enrollee diagnoses were included from the time of enrollment." 78 Fed. Reg. at 15,421 (dated March 11, 2013)(A.R.000238). This inclusion means that, "if an enrollee joined a plan in April but did not receive her diagnosis until July, she was nevertheless treated as having the condition for the entire period of enrollment," meaning starting in April. Defendant Mem. at 37. HHS next stated that,

> in the statistical estimation strategy for the HHS HCCs, average monthly expenditures were defined as the enrollee's expenditures for the enrollment period divided by the number of enrollment months, annualized expenditures (plan liability) were defined as average monthly expenditures multiplied by 12, and regressions were weighted by months of enrollment divided by 12. We believe that this statistical strategy, alongside the minimum enrollment requirement, ensures that monthly expenditures are correctly estimated for all individuals.

78 Fed. Reg. at 15,421 (dated March 11, 2013)(A.R.000238). Health Connections argues that HHS' first response, "while helpful, does not address the core problem of individuals with very short enrollment periods who never see a doctor while enrolled." Plaintiff Mem. at 48. Health Connections argues that HHS' second response "exacerbates the problem, because many enrollees -- such as woman giving birth -- have their expenses concentrated in a small time period, and thus averaging such expenses over twelve months significantly underestimates the costs of partial year enrollees." Plaintiff Mem. at 48 (citing Hickey Declaration at 23 (NMHC000885)).

Notwithstanding Health Connections' criticisms, by including an enrollee diagnosis from the time of enrollment and averaging monthly expenditures, HHS addressed important aspects of the partial-year enrollee problem, namely how to estimate a partial year enrollee's healthcare

costs. See Colo. Envtl. Coal. v. Dombeck, 185 F.3d at 1167. Further, HHS' statement that "[w]e believe that this statistical strategy, alongside the minimum enrollment requirement, ensures that monthly expenditures are correctly estimated for all individuals" is not "so implausible that it could not be ascribed to a difference in view or the product of agency expertise." Colo. Envtl. Coal. v. Dombeck, 185 F.3d at 1167 (citations omitted). HHS' statistical estimation strategy that attempts to capture an enrollee's healthcare expenses is the product of agency expertise. Colo. Envtl. Coal. v. Dombeck, 185 F.3d at 1167.

Health Connections next argues that HHS later "received a number of comments addressing the problem and offering solutions," but that "it provided no analysis of the issues raised." Plaintiff Mem. at 49 (citing 81 Fed. Reg. at 12,220 (dated March 8, 2016)(A.R.007764)). Instead, HHS responded that "[w]e appreciate commenters' substantive feedback on accounting for partial year enrollment in future recalibrations and will continue to analyze this issue and include our findings in the White Paper for discussion at the March 31, 2016 risk adjustment conference." 81 Fed. Reg. at 12,220 (dated March 8, 2016)(A.R.007764). That HHS essentially stated that it would address new comments at a meeting does not render HHS' behavior arbitrary and capricious. Indeed, "[a]gencies are not required to consider every alternative proposed nor respond to every comment made." Ron Peterson Firearms, LLC v. Jones, 760 F.3d 1147, 1163 (10th Cir. 2014)(internal quotations omitted). More importantly, "[f]ailure to respond is not grounds for APA invalidation unless the points raised in the comments were sufficiently central that agency silence would demonstrate the rulemaking to be arbitrary and capricious." NRDC v. EPA, 859 F.2d at 188. There was, however, no agency silence. After the meeting, "HHS explained that it would recalibrate the model by adding enrollment duration factors." Plaintiff Mem. at 49 (citing 81 Fed. Reg. at 94,072 (dated

December 22, 2016)(A.R.009609)). Given that HHS held a public meeting and changed its model to one more favorable to Health Connections, the Court cannot soundly hold that HHS acted arbitrarily and capriciously.

2. Using Prescription Drug Data.

HHS' decision not to use prescription drug data in its risk adjustment model was not arbitrary and capricious. HHS specifically considered the advantages and disadvantages of using prescription drug data. See RTI International Memorandum at 4 (dated December 15, 2011)(A.R.000838). HHS understood that "the main advantage to drug data are its completeness and timely availability . . . nearly all prescription activity creates an electronic record that is rapidly available to insurance plans." RTI International Memorandum at 2 (A.R.000836). HHS considered, however, that "[c]ounterbalancing the advantages of drug data in risk adjustment models are several problems. Chief among these is the incentives that drug-based payments systems would create." RTI International Memorandum at 4 (A.R.000838). Specifically, "[t]he most salient concern with tying risk adjustment payments to drug usage is the likely distortion of provider decisions toward pharmaceutical therapies." RTI International Memorandum at 4 (A.R.000838). "This distortion would create real costs: not only the costs . . . of the drugs themselves, but also the health outcomes that would be diminished by any deviation from clinical best practices." RTI International Memorandum at 4 (A.R.000838). These costs may include "the risk of doctors steering patients toward drugs rather than behavioral therapies, but also a bias towards certain types of drugs associated with high cost conditions." Defendant Mem. at 40 (citing RTI International Memorandum at 6-7 (A.R.000840-41)).

Further, HHS adequately performed its duty to "consider and respond to significant comments received during the period for public comment." Perez v. Mortgage Bankers Ass'n,

135 S. Ct. 1199, 1204 (2015). HHS' proposed rule for 2014 stated:

> At this time, we have elected not to include prescription drug use as a predictor in each HHS risk adjustment model. While use of particular prescription drugs may be useful for predicting expenditures, we believe that inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing. We seek comments on possible approaches for future versions of the model to include prescription drug information while avoiding adverse incentives.

77 Fed. Reg. at 73,128 (dated December 7, 2012)(A.R.000123). Health Connections contends that HHS did not adequately respond to comments regarding this proposed rule, such as the Pharmaceutical Research and Manufacturers of America Comment (dated December 20, 2012)(A.R.002765-70). See Plaintiff Mem. at 47. That comment states that "prescription medicine utilization can improve the precision of risk scores for certain conditions . . . . [R]esearch has shown that including prescription utilization in . . . risk adjustment models improves the correlation between risk score and actual claim costs." Pharmaceutical Research and Manufacturers of America Comment at 4 (A.R.002768). Essentially, this language argues that the use of prescription drug data would make HHS' risk adjustment model more accurate. See Pharmaceutical Research and Manufacturers of America Comment at 4 (A.R.002768). HHS' 2014 proposed rule had already balanced, however, the possible accuracy that prescription drug data may provide against other concerns, explaining that, "[w]hile use of particular prescription drugs may be useful for predicting expenditures, we believe that inclusion of prescription drug information could create adverse incentives to modify discretionary prescribing." 77 Fed. Reg. at 73,128 (dated December 7, 2012)(A.R.000123). HHS' subsequent responses therefore did not require further detail because HHS' reasoning for its decision was already "clear to the public." NRDC v. EPA, 859 F.2d at 189.

HHS specifically considered the advantages and disadvantages of using prescription drug data. It may be that using prescription drug data would have been a superior public policy

choice; indeed, HHS ultimately changed its mind and decided to use at least some prescription drug data in its risk adjustment model beginning in 2018. See 81 Fed. Reg. at 94,076 (dated December 22, 2016)(A.R.009613). See also Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125 ("Agencies are free to change their existing policies as long as they provide a reasoned explanation for the change."). A suboptimal decision, however, is not necessarily arbitrary and capricious, and the Court will not second-guess HHS' reasonable decision not to incorporate prescription drug data into its risk adjustment model.

V. HHS' RISK ADJUSTMENT FORMULA DOES NOT EFFECTIVELY ELIMINATE BRONZE LEVEL PLANS.

Health Connections argues that HHS' risk adjustment methodology violates the ACA, because it is so burdensome that it effectively eliminates bronze level plans while the ACA took pains to create those plans. See Plaintiff Mem. at 50-51. The ACA states:

> **Levels of coverage defined**
>
> The levels of coverage described in this subsection are as follows:
>
> **(A) Bronze level**
>
> A plan in the bronze level shall provide a level of coverage that is designed to provide benefits that are actuarially equivalent to 60 percent of the full actuarial value of the benefits provided under the plan.

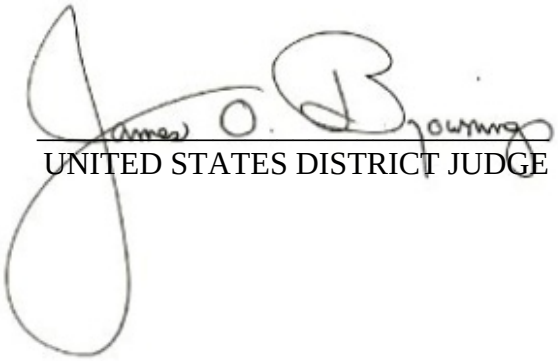
42 U.S.C. § 18022(d)(1)(A). By its plain language, that provision states that a bronze level plan shall have certain features, but it is silent regarding the profitability of those plans. It does not, for example, state that the plan must always be profitable. With its actions, the Court is not convinced that HHS has, as Health Connections insists, "*[d]e [f]acto* [b]anned Bronze Plans." Plaintiff Mem. at 50. For instance, Health Connections argues that many insurers have stopped offering bronze plans, but it does not argue that bronze have vanished entirely. See Plaintiff Mem. at 51. Meanwhile, HHS asserts that "New Mexico health insurers proposed more than 20

different Bronze plans for the 2018 benefit year, including several offered by [Health Connections]." Defendants' Reply at 23. The trend Health Connections identifies raises serious concerns, but those concerns do not mean that HHS has violated the ACA.

Health Connections asks the Court to "remand to the agency . . . [for HHS] to grapple with the question of how the agency can prevent the risk adjustment program from gutting Congress's intent to have viable bronze product offerings," Plaintiff Mem. at 44, or to order HHS to respond to Health Connections' comment about how HHS was going to adjust the formula so bronze plans are not unfairly penalized, see Tr. at 112:9-15 (Bassman). Such relief is neither necessary nor appropriate. HHS has responded to comments that its risk adjustment formula disadvantages bronze level plans. In 2016, HHS addressed proposals for improving its risk adjustment formula's predictive ability and noted that "[a] few commentators . . . suggested that bronze plans are . . . specifically disadvantaged by the existing risk adjustment model." 81 Fed. Reg. at 94,083 (dated December 22, 2016)(A.R.009620). HHS responded that, although some suggestions may improve its risk adjustment formula's predictive ability, it was "still evaluating the tradeoffs that would need to be made in model predictive power among subgroups of enrollees," and it will "continue to explore these modeling approaches." 81 Fed. Reg. at 94,083 (A.R.009620). The Court sees no basis for ordering HHS to provide an additional response to this specific aspect of the discussion.

IT IS ORDERED that: (i) the Plaintiff's Motion for Summary Judgment, filed April 13, 2017 (Doc. 32), is granted in part and denied in part; and (ii) the Defendants' Cross-Motion for Summary Judgment, filed June 1, 2017 (Doc. 34), is granted in part and denied in part. The Court sets aside and vacates the agency action as to using a statewide average premium for the 2014, 2015, 2016, 2017, and 2018 rules and remands the case to the agency for further

proceedings. The Court dismisses the Plaintiff New Mexico Health Connections' remaining claims with prejudice.



UNITED STATES DISTRICT JUDGE

Counsel:

Nancy Ruth Long
Long Komer & Associates, P.A.
Santa Fe, New Mexico

-- and --

Barak A. Bassman
Leah Greenberg Katz
Marc D. Machlin
Sara Richman
Pepper Hamilton, LLP
Philadelphia, Pennsylvania

Attorneys for the Plaintiff

Chad A. Readler
Acting Assistant Attorney General
Joel McElvain
Assistant Branch Director
Arjun Garg
Serena Orloff
James R. Powers
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
Washington, D.C.

Attorneys for the Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS,
a New Mexico Non-Profit Corporation,

Plaintiff,

vs. No. CIV 16-0878 JB/JHR

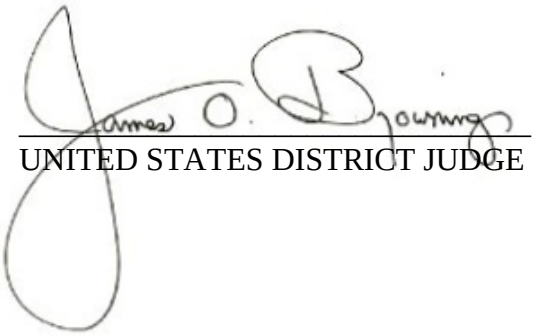
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE AND MEDICAID SERVICES; SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, in her official capacity and ANDREW M. SLAVITT, Acting Administrator for the Centers for Medicare and Medicaid Services, in his official capacity,

Defendants.

FINAL JUDGMENT

THIS MATTER comes before the Court on the Court's Memorandum Opinion and Order, filed February 28, 2018 (Doc. 55)("MOO"). In the MOO, the Court set aside and vacated Defendant United States Department of Health and Human Resources' action as to using a statewide average premium for its 2014, 2015, 2016, 2017, and 2018 rules, and remanded the case to the agency for further proceedings. See MOO at 84. It dismissed all of Plaintiff New Mexico Health Connections' other claims with prejudice. See MOO at 84. Having disposed of all issues, claims, and parties before the Court, the Court now enters Final Judgment and dismisses this case pursuant to rule 58 of the Federal Rules of Civil Procedure.

IT IS ORDERED that: (i) this case is dismissed with prejudice; and (ii) Final Judgment is entered.



UNITED STATES DISTRICT JUDGE

Counsel:

Nancy Ruth Long
Long Komer & Associates, P.A.
Santa Fe, New Mexico

-- and --

Barak A. Bassman
Leah Greenberg Katz
Marc D. Machlin
Sara Richman
Pepper Hamilton, LLP
Philadelphia, Pennsylvania

Attorneys for the Plaintiff

Chad A. Readler
Acting Assistant Attorney General
Joel McElvain
Assistant Branch Director
James R. Powers
Arjun Garg
Serena Orloff
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
Washington, D.C.

Attorneys for the Defendants

IN THE UNITED STATES DISTRICT COURT

FOR THE DISTRICT OF NEW MEXICO

NEW MEXICO HEALTH CONNECTIONS,
a New Mexico Non-Profit Corporation,

Plaintiff,

vs. No. CIV 16-0878 JB\JHR

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; CENTERS FOR MEDICARE AND MEDICAID SERVICES; SYLVIA MATHEWS BURWELL, Secretary of the United States Department of Health and Human Services, in her official capacity and ANDREW M. SLAVITT, Acting Administrator for the Centers for Medicare and Medicaid Services, in his official capacity,

Defendants.

MEMORANDUM OPINION AND ORDER

THIS MATTER comes before the Court on: (i) the Defendants' Motion to Alter or Amend Judgment Pursuant to Federal Rule of Civil Procedure 59(e), filed March 28, 2018 (Doc. 57)("Motion"); (ii) the Plaintiff's Motion to Strike the Declaration of Jeffrey Wu or in the Alternative Grant Plaintiff Leave to Take Discovery, filed April 23, 2018 (Doc. 61)("Motion to Strike"), and Plaintiff's Memorandum of Law in Support of its Motion to Strike the Declaration of Jeffrey Wu or in the Alternative, Grant Plaintiff Leave to Take Discovery, filed April 23, 2018 (Doc. 62)("Strike Mem."); and (iii) the Motion of America's Health Insurance Plans and Blue Cross Blue Shield Association for Leave to File Statement on New Developments in Support of Rule 59(e) Motion as Amici Curiae, filed July 19, 2018 (Doc. 80)("Motion for Leave"). The Court held a hearing on the Motion and the Motion to Strike on June 21, 2018. The primary issues are: (i) whether the Court should reconsider its determination in the Memorandum

Opinion and Order, 312 F. Supp. 3d 1164, filed February 28, 2018 (Doc. 55)("MOO"), that Defendant United States Department of Health and Human Services' ("HHS")[1] risk adjustment formula is arbitrary and capricious, because, HHS contends, it had no obligation to explain its decision to operate the program in a budget-neutral manner, it never stated budget neutrality was compelled by statute, and its decision not to use any budget authority to operate the program was unreviewable; (ii) whether the Court should reconsider its decision to vacate HHS' risk adjustment formula and instead remand without vacatur because, as HHS contends, the Court has equitable discretion to remand without vacatur or to limit the vacatur to New Mexico; (iii) whether the Court may consider the remarks in the Declaration of Jeffrey Wu (executed March 3, 2018), filed March 28, 2018 (Doc. 57-1)("Wu Decl."), because, as Plaintiff New Mexico Health Connections ("Health Connections") contends, it is improper evidence under rule 59 of the Federal Rules of Civil Procedure and the Administrative Procedure Act; and (iv) whether the Court should grant America's Health Insurance Plans ("AHIP") and Blue Cross Blue Shield Association ("Blue Cross") leave to file a joint statement as amici curiae, because, as Health Connections contends, the request is untimely, irrelevant, and moot.

While the Court carefully reconsiders its MOO, the Court stands by both its determination that HHS' risk adjustment formula is arbitrary and capricious, and that vacating the formula and remanding to HHS for further consideration is the appropriate remedy. The Court also concludes that it is appropriate to consider recent developments and the consequences of its decision in this case and, thus, may consider the remarks in the Wu Decl. and the statement

[1]HHS is not the only Defendant in this case, but Plaintiff New Mexico Health Connections challenges the agency's actions, so the Court will, for simplicity's sake, refer to HHS only.

that AHIP and Blue Cross wish to file as amici curiae. Accordingly, the Court denies the Motion and the Motion to Strike, and grants the Motion for Leave.

FACTUAL BACKGROUND

Congress enacted The Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010)(codified at 42 U.S.C. §§ 300gg-1 to -19, 18001-18022)("ACA") "to expand coverage in the individual health insurance market." King v. Burwell, 135 S. Ct. 2480, 2485 (2015)(Roberts, C.J.). To affect that goal, the ACA: (i) bars insurers from considering pre-existing medical conditions when deciding whether to sell insurance and when determining prices; (ii) requires individuals to make an individual shared responsibility payment to the Internal Revenue Service unless they maintain health-insurance coverage; and (iii) gives certain individuals tax credits to make health insurance more affordable for them. See King v. Burwell, 135 S. Ct. at 2485; 26 U.S.C. § 5000A (describing the individual shared responsibility payment requirement).

The ACA expands healthcare access, but it also increases health-insurance-industry risk. That the ACA requires insurers to cover all individuals, healthy or otherwise, means an insurer could end up providing coverage to a particularly sickly group of customers. See 42 U.S.C. § 300gg-1(a) ("[E]ach health insurance issuer that offers health insurance coverage in the individual or group market in a State must accept every employer and individual in the State that applies for such coverage."). The ACA prohibits those same insurers from responding to the increased cost of providing healthcare coverage to sicker individuals by charging those individuals higher prices. See 42 U.S.C. § 300gg(a) (prohibiting price discrimination based on factors other than geography, age, tobacco use, and whether coverage extends to an individual or to a family). Taken together, those two ACA requirements "threaten to impose massive new

costs on insurers, who are required to accept unhealthy individuals but prohibited from charging them rates necessary to pay for their coverage." Nat'l Fed'n of Indep. Bus. v. Sebelius, 567 U.S. 519, 548 (2012).

The ACA contemplates three kinds of programs -- two temporary and one permanent -- to ameliorate that problem. See 42 U.S.C. §§ 18061-63. First, under transitional reinsurance programs, which operated only from 2014 to 2016, insurers make payments to "an applicable reinsurance entity," typically HHS, and reinsurance entities use those funds to provide "reinsurance payments" to insurers "that cover high risk individuals in the individual market." 42 U.S.C. § 18061(b)(1). According to HHS, "The reinsurance program will reduce the uncertainty of insurance risk in the individual market by partially offsetting issuers' risk associated with high-cost enrollees." HHS Notice of Benefit and Payment Parameters for 2014, 78 Fed. Reg. 15,410, 15,411 (dated March 11, 2013)(A.R.000228)("2014 Final Rule"). "Each State is eligible to establish a reinsurance program," but "HHS will establish a reinsurance program for each State that does not elect to establish its own reinsurance program." 45 C.F.R. § 153.210(a), (c).

Second, under the temporary risk corridor program, which also operated only from 2014 to 2016, sufficiently profitable insurers must make payments to HHS while HHS must make payments to sufficiently unprofitable insurers. See 42 U.S.C. § 18062. Those payments, HHS predicts, "will protect against uncertainty in rate setting for qualified health plans by limiting the extent of issuers' financial losses and gains." 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R.000228).

Third, under permanent risk adjustment programs, "each State shall assess a charge" on insurers "if the actuarial risk of [their] enrollees . . . for a year is less than the average actuarial

risk of all enrollees in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1). Likewise, "each State shall provide a payment" to insurers "if the actuarial risk of [their] enrollees . . . is greater than the average actuarial risk of all enrollees in all plans and coverage in such State for such year." 42 U.S.C. § 18063(a)(2). Risk adjustment programs are "intended to provide increased payments to health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees." 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R.000228).

While the ACA refers to "States" assessing charges and providing payments in risk adjustment programs, 42 U.S.C. § 18063(a), it also tells HHS to "issue regulations setting standards for meeting" the ACA's requirements "with respect to . . . the establishment of the reinsurance and risk adjustment programs." 42 U.S.C. § 18041(a). When a state establishes a risk adjustment program, it must use "the Federal standards" or "a State law or regulation that the [HHS] Secretary determines implements the standards within the State." 42 U.S.C. § 18041(b). If a state does not establish a risk adjustment program or if a state establishes a risk adjustment program but does not take "the actions the [HHS] Secretary determines necessary to implement" federal risk adjustment standards, then "the [HHS] Secretary shall take such actions as are necessary to implement" those standards. 42 U.S.C. § 18041(c).

HHS regulations implementing that open-ended mandate in 42 U.S.C. § 18041(c) declare that the agency will operate risk adjustment programs for "[a]ny State that does not elect to operate an Exchange, or that HHS has not approved to operate an Exchange," 45 C.F.R. § 153.310(a)(2); for "[a]ny State that elects to operate an Exchange but does not elect to administer risk adjustment," 45 C.F.R. § 153.310(a)(3); and for, "[b]eginning in 2015, any State that is approved to operate an Exchange and elects to operate risk adjustment but has not been

approved by HHS to operate risk adjustment," 45 C.F.R. § 153.310(a)(4). Only Massachusetts, however, elected to operate its own risk adjustment program, see HHS Notice of Benefit and Payment Parameters for 2016, 80 Fed. Reg. 10,750, 10,759 (dated February 27, 2015)(A.R.005691)("2016 Final Rule"), and that program did not last long, see HHS Notice of Benefit and Payment Parameters for 2017, 81 Fed. Reg. 12,204, 12,230 (dated March 8, 2016)(A.R.007774)("2017 Final Rule")("We are not recertifying the alternate State methodology for use in Massachusetts for 2017 risk adjustment. Massachusetts and HHS will begin the transition that will allow HHS to operate risk adjustment in Massachusetts in 2017."). The bottom line is that HHS now operates New Mexico's -- and forty-nine other states' -- risk adjustment program. See 2017 Final Rule, 81 Fed. Reg. at 12,230 (A.R.007774)("HHS will operate risk adjustment in all States for the 2017 benefit year.").

Each year, HHS publishes the methodology it uses to calculate the risk adjustment payments that insurers make to HHS or receive from HHS. See 45 C.F.R. § 153.320(c) ("HHS will specify in the annual HHS notice of benefit and payment parameters for the applicable year the Federally certified risk adjustment methodology that will apply in States that do not operate a risk adjustment program."). That annual publication must describe: (i) how HHS calculates individual risk scores, see 45 C.F.R. § 153.320(b)(1), which are "relative measure[s] of predicted health care costs" for particular individuals, 45 C.F.R. § 153.20; (ii) how HHS determines a plan's average actuarial risk from individual risk scores, see 45 C.F.R. §§ 153.20, .320(b)(2); and (iii) how HHS uses a plan's average actuarial risk to determine the plan's risk adjustment payments and charges, see 45 CFR §§ 153.20, .320(b)(3).

HHS' risk adjustment methodology[2] "predict[s] plan liability for an enrollee based on that person's age, sex, and diagnoses (risk factors), producing a[n individual] risk score." 2014 Final Rule, 78 Fed. Reg. at 15,419 (A.R.000236). HHS calculates a health plan's average risk score by averaging its enrollees' individual risk scores; each individual risk score is weighted by the number of months that the relevant individual was enrolled in the health plan. See 2014 Final Rule, 78 Fed. Reg. at 15,432(A.R.000249). HHS multiplies the "State average premium" by several plan-cost factors -- "relative measures that compare how [a] plan[] differ[s] from the market average with respect to cost factors" -- including the plan average risk score to produce its first plan-premium estimate. 2014 Final Rule, 78 Fed. Reg. at 15,431 (A.R.000248). See 2014 Final Rule, 78 Fed. Reg. at 15,430-31 (A.R.000247-48)(describing the plan-cost factors: plan average risk score, actuarial value, permissible rating variation, geographic cost differences, and induced demand). "Multiplying the plan average risk score by the State average premium shows how a plan's premium would differ from the State average premium based on the risk selection experienced by the plan." 2014 Final Rule, 78 Fed. Reg. at 15,430 (A.R.000247). HHS then produces a second plan-premium estimate by multiplying the state average premium by plan-cost factors other than the plan average risk score. See 2014 Final Rule, 78 Fed. Reg. at 15,430 (A.R.000247). HHS' payment transfer formula takes the first plan-premium estimate and subtracts the second, which "provides a per member per month (PMPM) transfer amount for a

[2]The Court refers to HHS' published risk adjustment methodology in general terms even though HHS has five different published risk adjustment methodologies at issue, one for each year from 2014 to 2018, because, while those methodologies differ in detail, they have the same basic structure. See, e.g., 2017 Final Rule, 81 Fed. Reg. at 12,230 (A.R.007774)("Although we did not propose to change the payment transfer formula from what was finalized in the 2014 Payment Notice . . . we believe it is useful to republish the formula in its entirety, since, as noted above, we are recalibrating the HHS risk adjustment model."). Where the differences between HHS' five payment methodologies are important, the Court will be more specific.

plan." 2014 Final Rule, 78 Fed. Reg. at 15,431 (A.R.000248). Finally, HHS multiplies a plan's per member, per month transfer amount by its number of "billable member months . . . to calculate the plan's total risk adjustment payment." 2014 Final Rule, 78 Fed. Reg. at 15,431 (A.R.000248).

Health Connections is a Consumer Operated and Oriented Plan ("CO-OP")[3] insurer that has operated in New Mexico since 2014, and thus falls under the programs established under the ACA. See Declaration of Martin Hickey, MD ¶ 27, at 5 (dated October 5, 2016)(NMHC000867)("Hickey Decl."). Health Connections signed a loan agreement with HHS to fund Health Connections' initial formation and its New Mexico operations. See Hickey Decl. ¶ 27, at 5 (NMHC000867). Health Connections began enrolling members in October 2013, and providing coverage in January 2014. See Hickey Decl. ¶ 27, at 5 (NMHC000867). Health Connections has grown from 14,000 members in 2014, to 44,500 members in 2016. See Hickey Decl. ¶ 33, at 6 (NMHC000868).

Health Connections offers -- and has offered since its inception -- the lowest or second-lowest cost health insurance plan in New Mexico. See Hickey Decl. ¶ 31, at 6 (NMHC000868). It has offered such affordable plans even while serving unhealthy enrollees -- such as many who suffer from Hepatitis C, since New Mexico has the highest prevalence of it in the nation. See Patient Protection and Affordable Care Act Comments to HHS Notice of Benefit and Payment Parameters for 2018 at 19-20 (dated October 6, 2016)(NMHC0000853-54)("2018 Comments").

[3]ACA established the CO-OP program to provide loans and grants to new nonprofit health-insurance issuers, which fosters competition in the individual health-insurance market. See 42 U.S.C. § 18042. See also Memorandum of Law in Support of New Mexico Health Connections' Motion for Summary Judgment ¶ 19, at 10, filed April 13, 2017 (Doc. 33)("Plaintiff Mem.")("Congress created the CO-OP program to enhance competition."). To receive these loans or grants, however, insurers must offer their health-insurance plans on the Exchanges. See 45 C.F.R. § 156.515(c). See also Plaintiff Mem. ¶ 21, at 10.

"At a meeting of the National Association of Insurance Commissioners, the Superintendent of Insurance of New Mexico stated" that Health Connections' entry into the health-insurance marketplace increased competition and saved New Mexicans "over half a billion dollars over the last three years." Hickey Decl. ¶ 36, at 7 (NMHC000869).

While many health-insurance companies aim for a profit margin between 2% and 5% of their premiums, see Hickey Decl. ¶ 19, at 4 (NMHC000866), for 2014, many small health-insurance companies were required to pay over 10% of their premiums as risk adjustment charges, see Letter from CHOICES to Centers for Medicare & Medicaid Services, United States Department of Health and Human Services (dated April 22, 2016)(NMHC001018). For that year, HHS assessed Health Connections a $6,666,798.00 risk adjustment charge, which is equal to 21.5% of Health Connections' 2014 premiums. See Hickey Decl. ¶ 17, at 3 (NMHC000865). For 2015, HHS assessed Health Connections a $14,569,495.74 risk adjustment charge, which is equal to 14.7% of Health Connections' 2015 premiums. See Hickey Decl. ¶ 18, at 4 (NMHC000866).

Risk adjustment charges have, thus, forced several CO-OP program participants to close their doors. See 2018 Comments at 3 (NMHC000837); U.S. House of Representatives Committee on Energy and Commerce, Implementing Obamacare: A Review of CMS' Management of the Failed CO-OP Program at 19-22 (dated September 13, 2016)(NMHC000910-13); CHOICES, Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans at 11-13 (NMHC001000-02); Connecticut Insurance Department, Insurance Department Places HealthyCT Under Order of Supervision (dated September 26, 2016)(NMHC001351-52). Several state insurance commissioners have expressed concern about the risk adjustment program. For

example, Maryland's Insurance Commissioner testified to Congress:

> Over the past few years, new innovative health insurance plans have been created that are providing enhanced competition and patient care. And it is working. For year-end 2014, CareFirst had a 91% market share of the individual market in Maryland. Today, it is 57%, due in part to a more competitive marketplace. These carriers have the potential to continue but their ability to do so is severely jeopardized by the adverse and perhaps fatal financial impact caused by the technical shortcoming of the current risk adjustment and risk corridor programs. . . .
>
> The risk adjustment formula is of concern to state regulators because it has proven to place newer carriers at a distinct disadvantage. For example, the risk adjustment formula quantifies an enrollee's health status based on age, sex and diagnoses recorded during the course of the year. New carriers have very limited information on the health status or previous claims history of the applicants. Therefore, the carrier's population may appear healthier than it actually is if some diagnoses are not captured which may result in improper risk adjustment payments.

See Written Testimony for: Mr. Al Redmer, Jr., Commissioner, Maryland Insurance Administration (NMHC001331). The New York Superintendent of Financial Services had similar concerns:

> DFS [(New York State Department of Financial Services)] is concerned that the risk adjustment program has created inappropriately disparate impacts among health insurance issuers in New York and unintended consequences.
>
> Specifically, it is DFS's understanding that, based on the data accumulated by [Centers for Medicare & Medicaid Services ("CMS")] for the upcoming report on June 30, 2016, new and smaller issuers generally are considered to have had relatively healthy members than their larger and more established competitors. CMS's anticipated determination appears to be unduly impacted by the dates of diagnoses or recording of diagnoses of members' medical conditions rather than actual relative health of the members. This disparity may be because the new and smaller health insurers have not been in operation long enough to have amassed the long term data and records management systems that have helped to allow the large, established health insurers to convince CMS that their members are relatively unhealthy and, concomitantly, will allow them to receive large payments from the risk adjustment program.

Letter from Maria T. Vullo, Superintendent of Financial Services of the State of New York, to Sylvia M. Burwell, Sec'y of HHS, and Andrew Slavitt, Acting Adm'r for CMS at 1-2 (dated June 28, 2016)(NMHC001335-36).

PROCEDURAL BACKGROUND

Health Connections filed its initial complaint on July 29, 2016, see Complaint for Declaratory and Injunctive Relief at 1, filed July 29, 2016 (Doc. 1), and it filed an amended complaint approximately six months later, see Amended Complaint for Declaratory and Injunctive Relief at 1, filed January 12, 2017 (Doc. 21)("Complaint"). The Complaint invokes the judicial review provisions that the Administrative Procedure Act, Pub. L. No. 79-404, 60 Stat. 237 (1946)("APA") contains. See Complaint ¶ 193, at 55 (citing 5 U.S.C. § 706). See also 5 U.S.C. § 706(2) (requiring a reviewing court to "hold unlawful and set aside agency action, findings, and conclusions" that are "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law"). Both Health Connections and HHS moved the Court for summary judgment and filed memoranda in support of those motions. See Plaintiff's Motion for Summary Judgment, filed April 13, 2017 (Doc. 32); Defendants' Cross-Motion for Summary Judgment, filed June 1, 2017 (Doc. 34); Memorandum of Law in Support of New Mexico Health Connections' Motion for Summary Judgment, filed April 13, 2017 (Doc. 33)("MSJ"); Defendants' Memorandum in Support of its Cross-Motion for Summary Judgment and Opposition to Plaintiff's Motion for Summary Judgment, filed June 1, 2017 (Doc. 35)("Cross MSJ"). Because the Complaint seeks judicial review of agency action, however, the MSJ and Cross MSJ are properly characterized as appellate briefs.

> Reviews of agency action in the district courts must be processed *as appeals.* In such circumstances the district court should govern itself by referring to the Federal Rules of Appellate Procedure. Motions to affirm and motions for

> summary judgment are conceptually incompatible with the very nature and purpose of an appeal.

Olenhouse v. Commodity Credit Corp., 42 F.3d 1560, 1580 (10th Cir. 1994)(emphasis in original). See Fed. R. App. P. 28 (providing rules for appellate briefs).

In the MSJ, Health Connections argues -- among other things[4] -- that HHS' decision to base risk adjustment payments on statewide average premiums and not on each insurer's own average premium is both contrary to law, and arbitrary and capricious. See MSJ at 16. It is contrary to law, according to Health Connections, because "use of the statewide average premium is an unlawful departure from Congress's mandate that risk adjustment assessments be based solely upon actuarial risk." MSJ at 17. HHS' use of statewide average premiums is arbitrary and capricious, according to Health Connections, because "HHS never coherently confronted the requirements of the ACA, and never offered any justification for developing a methodology driven by factors unrelated to actuarial risk." MSJ at 22.

In the briefing leading up to the Court's MOO, no third-party filed a motion for leave to file an amicus brief or filed an amicus brief. Indeed, in the United States District Court for the District of Massachusetts, when the Honorable F. Dennis Saylor IV decided Minuteman Health, Inc. v. United States Department of Health and Human Services, 291 F. Supp. 3d 174 (D. Mass. 2018), on January 30, 2018,[5] no one filed a motion for leave to file an amicus brief or filed an amicus brief.

---

[4]In its MOO, the Court summarized and analyzed Health Connections' MSJ arguments. See MOO at 14-22, 312 F. Supp. 3d at 1177-82 (setting out those arguments); MOO at 59-82, 312 F. Supp. 3d at 1207-18 (analyzing those arguments). The Court now presents only the details that relate to the Motion and the Motion to Strike.

[5]Judge Saylor presided over a similar challenge to HHS' risk adjustment program under the APA that a different nonprofit health-insurance provider brought, holding that HHS "acted

within the bounds of its authority" and thus granting HHS' motion for summary judgment. 291 F. Supp. 3d at 179. Minuteman Health, Inc., the insurance provider challenging HHS' regulations in the case, also challenged the agency's decision to use the statewide average premium in its formula for being contrary to law, and arbitrary and capricious. See 291 F. Supp. 3d at 198. Judge Saylor determined that the statute does not prohibit nor require HHS' decision to use the statewide average premium in the risk adjustment formula, and thus the decision was not contrary to law. See 291 F. Supp. 3d at 199. Judge Saylor then determined if this decision was "reasonable (under *Chevron*) and not arbitrary and capricious (under the APA)." 291 F. Supp. 3d at 199. In determining reasonableness, Judge Saylor noted that the administrative record shows "HHS's decision to use the statewide average premium was the result of excessive debate." 291 F. Supp. 3d at 199. Judge Saylor stated:

> Ultimately, HHS chose to use the statewide average premium, subject to certain cost-factor adjustments. It did so because it concluded that such an approach would result in balanced transfers, was a "straightforward and predictable benchmark," and would best compensate plans for liability differences due to risk selection, as opposed to other cost factors. Those articulated reasons have a clearly rational connection to HHS's choice. Thus, the record demonstrates that the proposal to use a plan's own premium was actively considered and rejected on rational grounds.

291 F. Supp. 3d at 201 (quoting 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134)).

Judge Saylor then tackled the question "whether HHS's decision to attempt to operate the risk-adjustment program in a budget-neutral way was unreasonable or arbitrary," concluding, "[i]t was not." 291 F. Supp. 3d at 201. Judge Saylor considered HHS' goal in operating the program -- "to spread risk of insuring unhealthy enrollees among all insurers and eliminate incentives for plans to engage in risk selection" -- and the modeling in the White Paper, infra, showing "that use of a plan's own premium without balancing ran the risk of a shortfall, where there was no money to shore up plans that took on less-healthy patients." 291 F. Supp. 3d at 201 (citing Standards Related to Reinsurance, Risk Corridors and Risk Adjustment, 77 Fed. Reg. 17,220, 17,230 (dated March 23, 2012)(A.R.000068); 2014 Final Rule, 78 Fed. Reg. at 15,411 (A.R.000228); White Paper, infra, at 35 (A.R.000681)). Judge Saylor noted that, according to HHS' modeling, "reducing payments or increasing charges would disproportionately penalize high-and low-risk plans . . . and splitting the shortfall would still fail to cover the payments due to plans with less-healthy members, and therefore still encourage plans to risk-select." 291 F. Supp. 3d at 202 (citing White Paper, infra, at 36-38 (A.R.000682-84)). In response to Minuteman Health's argument that "general appropriations could be used to fund any shortfall," Judge Saylor wrote:

> [A] showing that there are other ways a budget-neutral program *might* have been achieved is not a showing that what HHS actually *did* was unreasonable or arbitrary. The risk-adjustment statute may be reasonably read as intending to level the playing field by spreading the risk among insurers, not by having the government subsidize the costs of insuring less-healthy people . . . .

1. The MOO.

In its MOO, the Court determines that HHS' decision to use statewide average premiums is not contrary to law, but it is arbitrary and capricious. See MOO at 59-60, 312 F. Supp. 3d at 1205. The Court concludes that HHS' decision is not contrary to law, because the ACA does not require HHS to base its risk adjustment methodology solely on actuarial risk. See MOO at 61, 312 F. Supp. 3d at 1206.

> That the ACA commands "[t]he Secretary, in consultation with States, [to] establish criteria and methods to be used in carrying out the risk adjustment activities" indicates that the ACA does not oblige HHS to use actuarial risk as the sole actuarial risk criterion. 42 U.S.C. § 18063(b). Telling HHS to establish risk adjustment criteria would make no sense otherwise. The ACA's language stating

---

291 F. Supp. 3d at 202 (emphasis in original). Judge Saylor also noted that, because Congress intended the states to run the risk adjustment program, "absent an appropriation, Congress expected the states to run budget-neutral risk-adjustment programs, and for HHS to set its federal regulations to allow it to certify such programs." 291 F. Supp. 3d at 202 (citing 45 C.F.R. § 153.310). Further, Judge Saylor decided that "[i]t was not unreasonable or arbitrary for HHS to attempt to design the program to pay for itself." 291 F. Supp. 3d at 202. Finally, Judge Saylor did not find merit in Minuteman Health's claim that HHS inadequately explained its decision to run the program in a budget-neutral manner, because "[t]here is no evidence that there was any significant comment on the topic that HHS was required to address in 2014," and, "in the 2011 white paper, HHS considered the effects of non-budget neutral methodologies and rationally chose to operate a budget-neutral program." 291 F. Supp. 3d at 202.

Minuteman Health also challenged HHS' transfer formula on three other points: (i) for "systemically underestimat[ing] the costs of insuring members who are not diagnosed with a condition associated with an HCC [(hierarchical condition category)]"; (ii) for "miss[ing] enrollees who are eligible for HHC classification" by failing to use prescription-drug data, until 2018, and failing to account for partial year enrollees who were undiagnosed, until 2017; and (iii) for making "lower-cost bronze plans economically unviable." 291 F. Supp. 3d at 197. Judge Saylor rejected these three challenges as well, finding these decisions and resulting "regulations were not arbitrary and capricious," and granting HHS' motion for summary judgment. 291 F. Supp. 3d at 214.

With regards to comments brought requiring HHS to address budget neutrality, this Court agrees with Judge Saylor that there was "no significant comment on the topic that HHS was required to address in 2014." 291 F. Supp. 3d at 202. The Court notes, however, that, as Judge Saylor wrote, "in the 2011 white paper, HHS considered the effects of non-budget neutral methodologies." 291 F. Supp. 3d at 202. HHS' raising the issue on its own, as discussed infra Section I.A., is why the Court concludes that issue exhaustion does not waive the challenge on this point and why the Court concludes that HHS inadequately explained its decision.

> that health plans and health insurance issuers must make a risk adjustment payment if their enrollees have below-average actuarial risk, see 42 U.S.C. § 18063(a)(1), while health plans and health insurance issuers must receive a risk adjustment payment if their enrollees have above-average actuarial risk, see 42 U.S.C. § 18063(a)(2), does not mean that criteria other than actuarial risk cannot be used when determining the magnitude of those payments. . . . The statute does not say anything about how to calculate the charge; it says only "each state shall assess a charge. . . ." 42 U.S.C. § 18063(a)(1). From the text, the charge assessed could be any amount.

MOO at 61-62, 312 F. Supp. 3d at 1206 (alterations in original).

The Court also concludes, however, that HHS' decision was arbitrary and capricious, because the agency did not give adequate reasons for its decision to use statewide average premiums and not each insurer's own average premium when calculating risk adjustment payments. See MOO at 64, 312 F. Supp. 3d at 1208. Under HHS' reading of the ACA, its risk adjustment methodology must be budget neutral, i.e., the risk adjustment payments that HHS receives from insurers with healthier-than-average customers must be equal to the risk adjustment payments that HHS makes to insurers with sicker-than-average customers. See MOO at 25, 312 F. Supp. 3d at 1184 (citing Cross MSJ at 22-23). The Court declines to adopt that reading of the ACA -- notwithstanding the deference it owes to an administrative agency that reasonably interprets an ambiguous statute that is within the agency's remit -- because the ACA's provisions regarding risk adjustment are unambiguous insofar as they do not require budget neutrality. See MOO at 60-61, 312 F. Supp. 3d at 1206 (citing Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc., 467 U.S. 837, 842-43 (1984)("Chevron")). See also Transcript of Motion Proceedings at 49:12-13 (taken January 22, 2018)(Powers), filed February 1, 2018 (Doc. 49)(conceding that "the statute does not require budget neutrality"). The Court then explains that HHS' erroneous reading of the ACA infects the agency's analysis of the available alternatives, because HHS considered only alternatives that were budget neutral. See MOO at

67-68, 312 F. Supp. 3d at 1209-10. Finally, the Court acknowledges that the ACA does not forbid HHS to design its risk adjustment methodology to be budget neutral and that "there may be excellent policy reasons for making the risk adjustment plan budget neutral," but those facts do not alter the Court's analysis:

> The problem with invoking those policy rationales here, however, is that HHS never articulates any public policy decision to operate risk adjustment in a budget neutral way; HHS' only decision is to comply with a supposed statutory requirement. That HHS, in designing its risk adjustment methodology, never considered whether budget neutrality was sound public policy means that HHS cannot now appeal to budget neutrality's public policy benefits to justify its decision. That HHS can reasonably conclude that budget neutrality is a worthy public policy goal does not permit the Court, in reviewing HHS' decisionmaking, to act as though HHS actually considered the issue and reached that conclusion.

MOO at 68-69, 312 F. Supp. 3d at 1210 (citations omitted). The Court, accordingly, sets aside and vacates "the agency action as to the statewide average premium rules," and remands the case for further proceedings. MOO at 71, 312 F. Supp. 3d at 1211-12.

There was very little published as to the Court's ruling. See, e.g., Marie C. Baca, Favorable NM Health Connections Ruling Has National Implications, LAS CRUCES SUN NEWS (March 2, 2018, 1:07 PM), https://www.lcsun-news.com/story/news/local/new-mexico/2018/03/02/favorable-nm-health-connections-ruling-has-national-implications/390119002/; John Kennedy, HHS Must Reconsider Formula for ACA Payments, LAW360 (March 1, 2018, 9:02 PM), https://www.law360.com/articles/1017456/hhs-must-reconsider-formula-for-aca-payments; Shelby Livingston, New Mexico Co-op Scores Partial Victory in ACA Risk-Adjustment Case, MOD. HEALTHCARE (March 2, 2018), http://www.modernhealthcare.com/article/20180302/NEWS/180309960; Paige Minemyer, FIERCEHEALTHCARE (March 2, 2018, 10:47 AM), https://www.fiercehealthcare.com/payer/new-mexico-health-connections-risk-adjustment-hhs-affordable-care-act; Federal District Court Vacates Part of CMS's ACA Risk

Adjustment Methodology, COVINGTON & BURLING LLP (March 6, 2018), https://www.cov.com/en/news-and-insights/insights/2018/03/federal-district-court-vacates-part-of-cmss-aca-risk-adjustment-methodology; Judge: HHS Mistakenly Envisioned ACA Risk-Adjustment Program as Budget Neutral, LEXIS LEGAL NEWS (March 2, 2018, 2:46 PM), https://www.lexislegalnews.com/articles/24727/judge-hhs-mistakenly-envisioned-aca-risk-adjustment-program-as-budget-neutral; U.S. District Court Rules in Favor of New Mexico Health Connections in Risk Adjustment Case, GRANT COUNTY BEAT (March 1, 2018), http://www.grantcountybeat.com/news/non-local-news-releases/42569-u-s-district-court-rules-in-favor-of-new-mexico-health-connections-in-risk-adjustment-case. No third party attempted to file an amicus brief or filed an amicus brief.

2. The Motion.

HHS argues that the Court should reconsider its determination that HHS' decision to use statewide average premiums in its risk adjustment transfer formula "is arbitrary and capricious because HHS did not explain its reasons for designing the program in a budget-neutral manner." Motion at 1. HHS gives three reasons why, in its view, reconsideration is appropriate. First, HHS argues that, "under black-letter principles of administrative law, HHS was not required to explain -- and NMHC was largely foreclosed from challenging -- HHS's budget-neutral approach to the risk adjustment program, because at no point during the 2014-2017 rulemakings did NMHC or any other commenter challenge or question that approach." Motion at 2. See Motion at 11 ("Furthermore, when NMHC did finally raise the budget neutrality issue to the agency during the 2018 rulemaking (after it filed this lawsuit), it largely argued only that budget neutrality is not statutorily mandated, not that it is irrational."). HHS asserts that, when commenters finally objected to the budget-neutral approach during the 2018 rulemaking, it

adequately addressed the objections by explaining that "the absence of additional funding for the HHS-operated risk adjustment program" requires budget neutrality. Motion at 2 (internal quotations and emphasis omitted)(quoting HHS Notice of Benefit and Payment Parameters for 2018, 81 Fed. Reg. 94, 058, 94, 101 (dated Dec. 22, 2016)(A.R.009638)("2018 Final Rule")).

Second, HHS asserts that, even though the ACA does not explicitly require risk adjustment to be budget neutral, HHS' budgetary restraints mean that, as a practical matter, budget neutrality is the agency's only option. See Motion at 2-3. HHS avers that risk adjustment charges are the only funding source from which the agency can make risk adjustment payments, because Congress has not made a risk-adjustment-specific appropriation or permitted HHS to use its program management appropriation to fund risk adjustment. See Motion at 15-16, 15 n.4.[6] See also Motion at 14-15 ("[T]he ACA neither authorized nor appropriated additional funding for risk adjustment payments beyond the amount of charges paid in, nor authorized HHS to obligate itself for risk adjustment payments in excess of charges collected."). It follows, according to HHS, that "the Court clearly erred in holding that HHS's budget-neutral

[6]HHS articulates several reasons why its program management appropriation is not available to fund risk adjustment:

> First, as discussed above, [the risk adjustment program] is designed to be implemented by the states. The lump sum is an appropriation to CMS, which has no authority to transfer such funds to state governments. Second, as the underlying budget requests reflect, the Program Management lump sum is for *program management expenses*, such as administrative costs for various CMS programs such as Medicaid, Medicare, the Children's Health Insurance Program, and the ACA's insurance market reforms -- not for the program payments themselves, which would vastly exceed the amount of the lump sum. Third, the lump sum appropriation for each year was enacted *after* the applicable Benefit Rule authorizing payments for that year. Thus, the later-enacted lump sum could not have authorized HHS to deviate from the budget-neutral design of the ACA in those Benefit Rules.

Motion at 16 (emphasis in original)(citations and footnotes omitted).

approach . . . was a discretionary policy choice subject to notice and comment rulemaking as opposed to a straightforward application of binding appropriations law." Motion at 18 (citation omitted). Third, HHS contends that, "[e]ven if HHS had the authority to design the risk adjustment program in a non-budget neutral manner, its decision not to exercise that authority would be committed to agency discretion as a matter of law and thus exempted from judicial review." Motion at 19.

HHS then argues that -- if the Court stands by its determination that HHS acted arbitrarily and capriciously -- the Court should reconsider the remedy it imposed. See Motion at 3-4. HHS faults the Court for "assuming that vacatur was mandatory and declining to weigh the equities before entering such an extraordinarily disruptive remedy." Motion at 3. According to HHS, "The Tenth Circuit has made clear that a court has the discretion to remand without vacatur based on equitable considerations, and courts have consistently held that when an agency's only error is inadequate explanation, the proper course is to remand for additional explanation without vacating the agency's action." Motion at 3-4. See Motion at 21 ("The Tenth Circuit recently confirmed that a court may decline to vacate agency action even if it finds that action arbitrary and capricious." (citing WildEarth Guardians v. U.S. Bureau of Land Mgmt., 870 F.3d 1222, 1239-40 (10th Cir. 2017))); Motion at 22 ("[R]emand without vacatur is appropriate when the only defect in an agency's decision is inadequate explanation." (citing Dist. Hosp. Partners, L.P. v. Burwell, 786 F.3d 46, 60 (D.C. Cir. 2015)(Henderson, J.); Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs, 781 F.3d 1271, 1289-91 (11th Cir. 2015); Cent. & S. W. Servs., Inc. v. U.S. EPA, 220 F.3d 683, 692 (5th Cir. 2000))). HHS asserts that "vacatur creates significant uncertainty, financial hardship, and undue burden for hundreds of health insurance issuers and millions of enrollees nationwide." Motion at 4. In the alternative, HHS suggests that, "if the

Court declines to remand without vacatur, it should limit the relief it orders to the operation of the risk adjustment program in New Mexico, so that its relief does not sweep more broadly than that needed to address NMHC's claims." Motion at 4.

3. The Wu Decl.

HHS filed the Wu Decl. as an attachment to the Motion. See Wu Decl. ¶ 1, at 1. Wu is the Associate Deputy Director for Policy Coordination at the Center for Consumer Information and Insurance Oversight, an HHS component. See Wu Decl. ¶ 2, at 1. Wu describes the risk adjustment program as a permanent program under ACA meant "to mitigate the potential impact of adverse selection, stabilize the price of health insurance in the individual and small group markets, and ensure that premiums are not based on the health status of enrollees." Wu Decl. ¶ 6, at 2. He states that the risk adjustment program, like the temporary reinsurance and risk corridors programs, "are each funded entirely from amounts that insurance entities pay into them. Congress did not enact separate appropriations for these provisions." Wu Decl. ¶ 7, at 2. According to Wu, the Court's vacatur of the 2014-2018 rules will impose administrative burdens on health insurance companies and create uncertainty for them. See Wu Decl. ¶¶ 6-22, at 2-6.

4. The Response.

Health Connections' response explains why, in its view, the Court should not grant the Motion. See Plaintiff's Memorandum of Law in Opposition to Defendants' Motion to Alter or Amend Judgment Pursuant to Rule 59(e) at 1, filed April 23, 2018 (Doc. 63)("Response"). Health Connections begins by responding to HHS' argument that Health Connections waived its challenge to "HHS's use of the statewide average premium in the risk adjustment transfer formula as opposed to an issuer's own premium." Response at 5. Health Connections contends

that HHS' focus on whether it or other commenters challenged HHS' budget-neutral approach to risk adjustment is misplaced:

> HHS's argument is premised on an artificial distinction between the agency action challenged -- the use of the statewide average premium instead of an issuer's own premium -- and the agency's justification for that action. However, the action engaged in by the agency, challenged by NMHC, and addressed by this Court was the decision to use the statewide average premium instead of a plan's own premium. The agency's justification for its choice -- budget neutrality -- is not in and of itself an agency action subject to separate challenge under the APA.

Response at 6. According to Health Connections, HHS "confuses the agency action being challenged with the proffered justification for the action." Response at 7. Health Connections asserts: "There can be no dispute that NMHC and other commenters challenged the agency's decision to use the statewide average premium instead of an issuer's own premium in both the 2017 and 2018 rulemaking periods." Response at 7 (listing examples). Health Connections also asserts that the fact "that commenters may not have squarely addressed the issue during the 2014-2016 rulemakings is immaterial[,] because the agency considered the issues on its own initiative." Response at 8. See Response at 8 ("If an agency considered the issue *sua sponte*, the Court will not invoke the waiver rule because the agency had the opportunity to consider the issue and apply its expertise." (citations omitted)). Health Connections further asserts that "parties are not required to challenge 'key assumptions' used to justify the agency's rule" or obvious problems underlying their claim. Response at 8 (quoting Nat. Res. Def. Council v. EPA, 755 F.3d 1010, 1023 (D.C. Cir. 2014)). Finally, Health Connections argues that "the Court may excuse waiver in 'exceptional circumstances.'" Response at 8 (quoting Portland Gen. Elec. Co. v. Bonneville Power Admin., 501 F.3d 1009, 1024 (9th Cir. 2007)).

Health Connections then addresses HHS' argument that budgetary constraints prevent it from adopting a risk adjustment formula that is not budget neutral. See Response at 9-10.

Health Connections argues that HHS can use its program management appropriation to fund the risk adjustment program if HHS adopts a budget-negative formula. See Response at 14-15. Health Connections contends that HHS' assertion that the agency's program management appropriation cannot fund the risk adjustment program is "entitled to no deference," because it is a post-hoc litigation position that "contradicts the [Government Accountability Office ("GAO")], which is the actual expert agency in the field of government appropriations, whose views are entitled to deference." Response at 14-15 (citing Motion at 16). Health Connections adds that its argument regarding HHS' program management appropriation is not a challenge to HHS' "decision not to allocate funds" for risk adjustment; instead, that argument regarding fund availability is part of a challenge to "the agency's action in adopting a formula using the statewide average premium instead of each issuer's own premium." Response at 16.

Finally, Health Connections contends that the Court should vacate HHS' risk adjustment formula and remand for further consideration, because that is "the standard remedy when a Court finds regulatory action to violate the APA." Response at 16 (citing Se. Alaska Conservation Council v. U.S. Army Corps of Eng'rs, 486 F.3d 638, 654 (9th Cir. 2007), rev'd on other grounds, 557 U.S. 261 (2009); St. Lawrence Seaway Pilots Ass'n v. U.S. Coast Guard, 85 F. Supp. 3d 197, 208 (D.D.C. 2015)(Chutkan, J.)). Health Connections continues by arguing that equitable considerations do not indicate that vacatur is an inappropriate remedy in this case:

> The bulk of Mr. Wu's argument [on HHS' behalf] is that vacatur upsets settled expectations and reliance interests in the previously issued risk adjustment regulations. But this harm is self-inflicted: the Court has not prohibited HHS from continuing the same risk adjustment formula, but only required it to justify its policy choices in compliance with the APA. Mr. Wu nowhere explains why HHS has not simply commenced a new rulemaking to address the errors found by the Court. The only conclusion is either that the agency does not consider risk adjustment important enough to act upon, in which case the cry of disruption rings hollow, or the agency cannot address the Court's critique, in which case the

remedy is wholly appropriate to address a serious deficiency.

> In addition, the reliance interests are overstated. The administrative record contains substantial evidence that carriers are unable to predict risk adjustment transfers and thus cannot rely upon them. . . . NMHC's 2018 comments pointed out that every carrier in New Mexico built into its 2017 premium the assumption that it would make a risk adjustment payment -- a mathematical impossibility under the risk adjustment formula which always has a balance of payments in and out within a state. These rate-setting assumptions can only be explained by the carriers' inability to predict how the formula will work and a desire to have a cushion if the outcome were adverse.

Response at 19-20 (citing Hickey Decl. ¶¶ 52-55, at 11-12 (NMHC000873-74)). Health Connections concludes by commenting: "[T]here is no reason to limit the vacatur to New Mexico. The regulations apply nationwide. Courts regularly vacate and enjoin enforcement of nationwide regulations even when challenged by an individual plaintiff." Response at 24 (citing Earth Island Inst. v. Ruthenbeck, 459 F.3d 954, 966 (9th Cir. 2006), rev'd on other grounds, 555 U.S. 488, 500 (2009)).

5. The Reply.

HHS filed a reply. See Defendants' Reply in Support of Their Motion to Alter or Amend the Judgment, filed May 17, 2018 (Doc. 68)("Reply"). In the Reply, HHS renews its argument that Health Connections "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," and that it adequately responded when the budget-neutral approach was challenged during the 2018 rulemaking. Reply at 2. HHS avers that no exception to the exhaustion requirement applies in this case. See Reply at 3-4.

HHS also renews its argument that, "because of black-letter constraints on the authority of agency officials to obligate federal funds absent or in advance of an appropriation," the agency had to "devise a risk adjustment program that could be funded with amounts the agency

then knew would be available to make risk adjustment payments," i.e., risk adjustment charges. Reply at 5. HHS contends that, at least in its risk adjustment rule for 2018, it "explained that its budget-neutral approach to the risk adjustment program is necessitated by a lack of funding." Reply at 6. HHS also contends that the Wu Decl. confirms that "the absence of additional funding for the risk adjustment program" requires the agency to "balance payments and charges across plans." Reply at 6 (internal quotations omitted)(quoting Wu Decl. ¶ 9, at 3).

HHS then recites the reasons why, in the agency's view, it could not have used its program management appropriation to design risk adjustment in a way that was not budget neutral:

> [HHS] 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.

Reply at 8 (quoting Motion at 16). It also notes that the GAO decision Health Connections cites to "addressed a different program and an entirely different legal question"; it did not analyze "whether HHS itself could *create* a payment formula requiring expenditures exceeding amounts available in existing appropriations." Reply at 8-9 (emphasis in original)(citing Dep't of Health & Human Services-Risk Corridors Program, B-325630, 2014 WL 4825237 (Comp. Gen. Sept. 30, 2014)("GAO Report")). HHS then underscores its belief that, even if it could have used its program management appropriation to make the risk adjustment rules, its decision not to allocate funds from the appropriation is within agency discretion and outside the purview of the Court's review under the APA. See Reply at 9-10 (citing Motion at 19-21).

Finally, HHS argues that its "only error is a failure to adequately explain the rationale underlying a decision," so the Court should have followed "the presumptive approach," i.e., to

"remand *without* vacatur." Reply at 10-11 (emphasis in original)(citing Motion at 22-24). HHS also asserts that "the Court did not weigh the equities or otherwise demonstrate that it was exercising that discretion here" in deciding whether to vacate. Reply at 11. It postulates that vacatur is not equitable here, because many issuers "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," and, even if the "methodology is not perfectly predicable, this does not militate in favor of depriving issuers of important payments they would otherwise receive." Reply at 11-12 (citing 2018 Final Rule, 81 Fed. Reg. at 94,085; Wu Decl. ¶¶ 13-22, at 4-6).

6. The Motion to Strike.

In addition to contesting the Motion's substance, Health Connections argues that the Wu Decl. is "improper extra-record evidence outside of the Court's purview in an Administrative Procedures Act case." Motion to Strike at 1. The APA, Health Connections asserts, limits judicial review to "the administrative record already in existence, not some new record made initially in the reviewing court." Strike Mem. at 5 (internal quotation marks omitted)(quoting Bar MK Ranches v. Yuetter, 994 F.2d 735, 739 (10th Cir. 1993)). Health Connections also argues that the Wu Decl. is "inappropriate under Rule 59 [of the Federal Rules of Civil Procedure] because it improperly expands upon and repackages facts and arguments that were previously available and asserted." Motion to Strike at 1. Health Connections argues: "That HHS opted not to expound upon its arguments against vacatur" at the summary judgment stage "does not grant it license to revive its arguments in more detail with newly submitted evidence at the Rule 59 stage." Strike Mem. at 4 (citing Williams v. HSBC Bank USA, N.A., No. 15-9372, 2016 U.S. Dist. LEXIS 99858, *3 (D. Kan. July 29, 2016)(Robinson, J.), aff'd, 681 F. App'x 693

(10th Cir. 2017)(unpublished)). Accordingly, Health Connections asks the Court to strike the Wu Decl. See Motion to Strike at 1. Alternatively, Health Connections asks the Court for "leave to conduct discovery into the allegations contained in the Wu Declaration." Motion to Strike at 1. Health Connections argues that the Court should "conduct any new fact-finding on the question of remedy" with "a full record." Strike Mem. at 3. A full record, Health Connections avers, requires that it have "the opportunity to conduct discovery into Mr. Wu's statements and examine him under oath so that NMHC has a full and fair opportunity to present opposing arguments." Strike Mem. at 6.

7. The Motion to Strike Response.

HHS responds to Health Connections' Motion to Strike. See Defendants' Opposition to Plaintiff's Motion to Strike or for Discovery, filed May 7, 2018 (Doc. 64)("Motion to Strike Response"). HHS asserts that it provided the Wu Decl. "solely to inform the Court's exercise of its equitable discretion in setting a remedy if the Court concludes that the agency erred in its explanation of its use of a budget neutral approach." Motion to Strike Response at 2. HHS contends that the APA's "bar on extra-record evidence concerns judicial review of the merits of agency action, not the evidence a court may consider in determining how to exercise its equitable discretion in fashioning a remedy." Motion to Strike Response at 2. In fact, HHS contends, the Court should consider "the facts as they exist at the time of the judicial order" when fashioning its remedy. Motion to Strike Response at 6. HHS adds that "permit[ing] post-judgment discovery with regard to Mr. Wu's declaration" would be inappropriate, because "NMHC cites no legal authority for why it should be granted such post-judgment discovery, and it has said nothing about what facts it hopes to discover or what role they would play in the Court's evaluation of the remedial issues to which Mr. Wu's declaration was directed." Motion to Strike

Response at 2. HHS also notes that the "Court has repeatedly held that motions to strike are disfavored and will only be granted where the motion concerns a pleading or a document prohibited by the Court's local rules." Motion to Strike Response at 3. The Wu. Decl., HHS avers, "falls into neither category, and the motion to strike should be denied." Motion to Strike Response at 3.

8. The Motion to Strike Reply.

Health Connections replies to the Motion to Strike Response. See Plaintiff's Reply Brief in Further Support of Its Motion to Strike the Declaration of Jeffrey Wu or in the Alternative, Grant Plaintiff Leave to Take Discovery, filed May 21, 2018 (Doc. 69)("Motion to Strike Reply"). First, Health Connections asserts that it is not moving to strike under rule 12(f) but, rather, under the Court's "inherent power to control [its] docket[]." Motion to Strike Reply at 2 (internal quotation marks omitted)(quoting Anthony v. BTR Auto. Sealing Sys., Inc., 339 F.3d 506, 516 (6th Cir. 2003)). According to Health Connections, courts regularly grant "motions to strike extra-record material in [APA] cases." Motion to Strike Reply at 4. Health Connections asserts that "HHS notably fails to articulate any substantive basis for the Court to consider the Wu Declaration as part of its Rule 59 analysis." Motion to Strike Reply at 5. Health Connections contends that, notwithstanding HHS' "claims that . . . the Wu Declaration can be considered by the Court because it addresses the remedy and not the merits of the risk adjustment challenge," the Wu Decl. "contains a number of statements purporting to support HHS' theories on budget neutrality -- an issue that is squarely on the merits of both the underlying case and the Rule 59 motion." Motion to Strike Reply at 7. Health Connections adds that, "if the Court decides to consider HHS's new evidence outside of [the administrative] record, it should also consider additional new evidence submitted by NMHC in its [Response] that provides a more

fulsome context and rebuts the Wu Declaration." Motion to Strike Reply at 7 n.3. Finally, Health Connections argues that, should the Court consider the Wu Decl., the Court should allow Health Connections to conduct discovery as "to investigate and challenge one-sided, cherry-picked testimony that is being proffered without the opportunity to cross-examine Mr. Wu." Motion to Strike Reply at 9.

9. The First Notice of Supplemental Authority.

After the parties completed their briefing regarding the Motion and the Motion to Strike, Health Connections brought a recently decided case to the Court's attention. See Notice of Supplemental Authority at 1, filed June 15, 2018 (Doc. 74)("Notice"). According to Health Connections, in Moda Health Plan, Inc. v. United States, 892 F.3d 1311 (Fed. Cir. 2018)(Prost, C.J.)("Moda"), "HHS argued, like here, that the lack of a specific appropriation necessitated budget neutrality for the risk corridors program," but the United States Court of Appeals for the Federal Circuit rejected that argument, "explaining 'it has long been the law that the government may incur a debt independent of an appropriation.'" Notice at 1 (quoting Moda, 892 F.3d at 1321). Health Connections states: "The Federal Circuit also rejected HHS's arguments (which mirror those made in this case) that the Anti-Deficiency Act and the structure of Medicare Part D's risk stabilization programs supported its budget neutral operation of the risk corridors program." Notice at 1-2. Health Connections concludes by distinguishing the Federal Circuit's conclusion "that certain appropriations riders mandated budget neutrality for the *risk corridors* program," because "these riders were silent as to risk adjustment." Notice at 2 (emphasis in the original).

10. The Notice Response.

HHS filed a response to the Notice. See Defendants' Response to Plaintiff's Notice of Supplemental Authority, filed June 20, 2018 (Doc. 75)("Notice Response"). HHS argues that Moda recognizes that Congress -- and not an administrative agency -- can create a legally enforceable obligation without providing an associated appropriation. See Notice Response at 1. HHS explains that "the *Moda* decision relied on 42 U.S.C. § 18062(b), which the court read to establish a set formula of mandatory payments that was not limited by the amount of payments into the program," but the risk adjustment statute "does not dictate a formula for mandatory payments." Notice Response at 2 (citing 42 U.S.C. § 18063(b)). It follows, according to HHS, that "the *Moda* decision concluded that Congress, in certain circumstances, can create an enforceable payment obligation absent an appropriation," but "nothing in *Moda* supports Plaintiff's suggestion that *HHS* could have done so via regulation." Notice at 2 (emphasis in original)(citing Moda, 892 F.3d at 1320-22).

11. The Hearing.

The Court held a hearing on June 21, 2018. See Transcript of Motion Proceedings at 1 (taken June 21, 2018), filed July 3, 2018 (Doc. 77)("Tr."). At the hearing, HHS began by asserting that it is entitled to reconsideration of the judgment in the MOO under rule 59, because the judgment was "based on misapprehensions of the parties' positions and the controlling law, and that they result in manifest injustice." Tr. at 5:8-14 (Powers). HHS then repeated its argument that Health Connections "was foreclosed from challenging the budget neutrality determination for the 2014 to 2017 rules," because "there were no comments to the agency in those rules challenging the decision to structure the program in a budget neutral fashion." Tr. at 6:23-7:3 (Powers). According to HHS, "there needs to be some sort of raising of the issue before

the agency out of the simple fairness to the agency to allow them to apply their expertise in the first instance, and to explain themselves further or to change their decision as the case may be." Tr. at 7:11-16 (Powers). HHS conceded, however, that this issue exhaustion requirement is satisfied as long as someone -- and not necessarily "the particular party before the court" -- raises the issue before the agency. Tr. at 7:7-11 (Powers).

The Court then asked for Health Connections' perspective regarding HHS' argument on the issue exhaustion requirement. See Tr. at 9:22-10:2 (Court). Health Connections contended that "the comment rule exists to give the agency an opportunity to address an issue, and exercise its expertise and its reasoned decision making and rule making." Tr. at 10:5-8 (Bassman). Health Connections asserted that this rationale means that, "when an agency actually addresses an issue, and does it itself without needing a comment or product, there is no exhaustion requirement from commenters." Tr. at 10:9-12 (Bassman). See Tr. at 10:22-23 ("There is no requirement for a commenter to ask an agency to engage in analysis it already did."). Health Connections then averred that "the agency action being challenged [is] the decision the agency made in setting the original formula to use the statewide average premium instead of each issuer's own premium," and "[t]hat was a decision that the agency made itself and analyzed." Tr. at 10:13-19 (Bassman). Health Connections contended that there is no issue exhaustion issue, because HHS recognized and addressed the statewide average premium decision, so there was no need for commenters to challenge it from 2014-2016, and that, in 2017 and 2018, commenters had "directly challenged" the decision. Tr. at 15:12-15 (Bassman).

In reply, HHS clarified that "we don't contend there has been waiver with respect to challenging statewide average premium itself." Tr. at 16:8-10 (Powers).

> The argument we're making is that there is waiver as to challenging the

> budget neutrality determination. Now, we recognize that [Health Connections] contends that it is challenging the statewide average premium. But the Court's decision relied on the fact that there was a failure to explain the budget neutrality determination. And we believe that . . . is necessarily a determination that that decision, that antecedent decision, was arbitrary and capricious, because if the budget neutrality determination was simply a parameter of the program, we believe the agency was entitled to treat that as one of the kind of factors that it would consider in deciding how to proceed. And that would be a sufficient basis to support the use of the statewide average premium.

Tr. at 16:11-25 (Powers). HHS then contended that "the sua sponte exception" does not apply, because "[i]t concerns when the agency has actually addressed the particular challenge that's raised," which HHS asserted "is that the program could have been nonbudget neutral because it could have been backfilled with lump sum appropriations or with resort to the Judgment Fund." Tr. at 17:19-22 (Powers). HHS contended that it "did not address those points, so it has not sua sponte addressed" the issue. Tr. at 17:22-24 (Powers). HHS then averred that when it did address the budget neutrality issue, with the 2018 rule, it did so "sufficiently," in "an application of binding appropriations principles," because the rule "says that, '[i]n the absence of additional appropriations the program will be operated in a budget neutral fashion.'" Tr. at 20:4-9 (quoting 2018 Final Rule, 81 Fed. Reg. at 94,101).

Health Connections rejoined:

> [I]n coming up with the original 2014 rule, Your Honor's opinion does an extremely thorough analysis of what the agency said then. And what the agency said then was that it was under the belief that the Risk Adjustment Statute mandated budget neutrality, and that that was Congress' intent in the text of the statute. That was the explanation they gave. There was not an absence of explanation for why they took the position they did. It's laid out in the 2011 white paper. Defendants don't seem to be willing to defend anymore what the agency actually said in its contemporaneous reasoning. But that's the reason that was given.
>
> This is not a case where the agency failed to explain itself. The agency wrote a very thick white paper explaining itself, and then detailed rule making in 2014.

Tr. at 23:3-20 (Bassman). Health Connections then noted that the justification to which HHS points for budget neutrality in the 2018 rule does not seem to be sufficient, because it raises the question whether "the agent [is] adopting a new position and rationale," Tr. at 25:3 (Bassman), because "the prior position was the statute mandated it," Tr. at 25:12-13 (Court). Health Connections stated: "If it were changing its rationale, then under the Supreme Court's opinion in Encino Motorcars[, LLC v. Navarro, 136 S. Ct. 2117 (2016)], it was required to acknowledge that there was [a] change in position and give a reasoned explanation for the change in position." Tr. at 25:6-10 (Bassman). Health Connections continued by addressing HHS' argument that, "to have a nonbudget neutral formula, even though the statute doesn't require a budget neutral formula, there needs to be some separate, new Congressional appropriations bill that says: Thou shalt spend X dollars on risk adjustment." Tr. at 26:20-24 (Bassman). Health Connections pointed to Moda as authority showing that the absence of a line-item appropriation for risk adjustment does not require risk adjustment to be budget neutral. See Tr. at 28:18-23 (Bassman)("[T]he DOJ argued to the Federal Circuit[that] the Risk Corridor Program had to be budget neutral from the get-go because there was no separate specific line item appropriations bill for it. And the Federal Circuit said that was hogwash."). Health Connections then asserted that the CMS' lump sum appropriation was available to fund risk adjustment payments. See Tr. at 28:24-29:24 (Bassman).

HHS responded that budget neutrality is "mandated by the absence of the authority or appropriations that would have permitted the agency to operate the program in a different fashion," not that it was "commanded by Congress." Tr. at 32:6-10 (Powers). HHS then attempted to distinguish Moda:

[In t]he Moda decision by the Federal Circuit, the Court held or concluded that

> the Risk Corridor statute sets forth a payment formula that, you know, is mandatory and does create an obligation.
>
> Now, as the plaintiff has raised, the DOJ has disagreed with that conclusion as well. But even if you take that conclusion on its face and move from there, that is something where Congress has loosened the purse strings, so to speak, rather than the agency. And under the appropriations clause of the Constitution and the Antideficiency Act, administrative agencies, executive officials, are limited in their capacity to obligate the government or to authorize spending in advance of statutory authorization to do so. And so the fact that the Moda Court held that there could have been an obligation by product of statute is irrelevant to the question here of whether or not the agency itself could have created such an obligation of its own, you know, exercise of discretion. And I think that that really shows the distinguishing characteristics there, the dispositive distinguishing characteristics to Moda, and why that is largely irrelevant to the Court's consideration here of the issues.

Tr. at 32:15-33:13 (Powers). HHS also argued that CMS' lump sum appropriation was not available to fund risk adjustment payments, because "those lump sum appropriations are for things like salaries, for administrative expenses of the agency." Tr. at 43:6-8 (Powers). Alternatively, HHS asserted that, "even if they were available, and the Court were to conclude they're available, the agency's discretion to tap those funds for any particular program is not reviewable under the APA." Tr. at 43:11-15 (Powers). See Tr. at 55:22-25 (Powers)("[W]hen it comes to the allocation of a lump sum appropriation, the agency is not obligated to explain its decision making in regard to how it will allocate that.").

The Court then turned from the merits to the remedies issue. See Tr. at 57:1-10 (Court). The Court began by stating that its understanding is that "vacatur is the general rule" when a court concludes that a regulation is arbitrary and capricious, Tr. at 57:6 (Court), and HHS agreed that the Court's understanding is correct, see Tr. at 57:11-16 (Powers). The Court then asked HHS why -- in its view -- the general rule does not apply to this case. See Tr. at 57:17-21 (Court). HHS replied:

> I think it comes from a weighing of the equities, of evaluating the error identified by the Court, which is a failure to explain the budget neutrality determination, and weighing the disruption that will be caused by vacatur, in light of the potential that that error can be rectified on remand.
>
> And so I think that, you know, when one weighs those equities in that manner, the clear, you know, equitable outcome would be remand without vacatur, here the only area, as I said, is a failure to explain. And there is little doubt, in our view, that the agency can adequately resolve this and adequately explain the decision to treat the program in a budget neutral fashion.

Tr. at 57:22-58:11 (Powers). The Court asked HHS for "the strongest case that you would say that I got . . . this relief issue wrong." Tr. at 59:20-22 (Court). HHS indicated that WildEarth Guardians v. United States Bureau of Land Management, 870 F.3d 1222 (10th Cir. 2017), supports its view "that when an error has been identified . . . equitable considerations may inform the Court's decision about whether or not to simply remand without vacating the challenged agency action." Tr. at 62:18-22 (Powers). As to the equities, HHS averred that, "absent a change to the Court's order or further administrative proceedings," it would not be able to collect charges or to make payments under the 2017 rule, as it planned to do in August through October. Tr. at 65:16-19 (Powers). HHS noted that the Court's order affects "the whole nation" and not just New Mexico. Tr. at 66:8-9 (Powers).

The Court then noted that its order "doesn't really impact the government," yet it appears that "nobody else seems to be too interested in this case." Tr. at 68:8-11 (Court). The order, in the Court's mind, "really impacts . . . the recipients of these risk adjustment payments; that's who would want this to be a remand rather than a vacatur." Tr. at 68:11-14 (Court). The Court then asked: "Why have I not seen, for example, Blue Cross and other large insurance companies that are the typical recipients of these payments coming in and telling me, [']Look, you've just

got to change this part of the relief, because it's just going to be so inequitable to us.[']" Tr. at 68:19-24 (Court).

In response, HHS reiterated that "it's important to evaluate in reflection of the particular error identified," Tr. at 69:7-9 (Powers), although it agreed that the Court will also have to "consider the equities of the parties that are the recipients or payers of the funds," Tr. at 69:12-15 (Court, Powers). HHS argued that issuers "are expecting to receive hundreds of millions of dollars or at least millions of dollars in payment to help cover the exorbitant cost of covering higher than average actual risk folks [and] are going to be harmed by delays in receiving these funds, which they have anticipated receiving." Tr. at 71:2-8 (Powers). Vacatur of the rules for previous years in which charges and payments have been completed, HHS asserted, also "create[s] some uncertainty about the status of payments and charges already issued for those years." Tr. at 72:5-9 (Powers). Remanding without vacatur would, as HHS stated, "help the Department, because it would mean that there was no question that the rules had ever ceased to be effective, but rather that the agency then would undertake administrative process that would be consistent with the Court's opinion." Tr. at 72:13-17 (Powers). HHS also argued that its error -- lack of explanation on the budget neutrality decision -- could be fixed with just a remand. See Tr. at 76:1-5 (Powers).

The Court questioned why, if the error is "such a minor defect that . . . it's not worth any sort of remedy," HHS has not corrected it. Tr. at 77:4-7 (Court). HHS responded: "[B]ecause we have been pursuing this relief here." Tr. at 77: 8-9 (Powers). Health Connections argued against HHS' classification of this case as "a failure to explain case. This is a case where the explanation given was found to be arbitrary and capricious." Tr. at 81:18-20 (Bassman). Health Connections asserted that vacatur is proper here, because HHS provided an explanation for

budget neutrality and that explanation was insufficient under the APA. See Tr. at 82:4-13 (Bassman). Further, that "the Blue Crosses of the world" have not appeared as amici curiae, Health Connections averred, calls into doubt HHS' assertion that vacatur will cause a "great disruption." Tr. at 82:14-83:3 (Bassman). Heath Connections also averred that the big insurance companies receiving the payments do not really care that payments are halted, because they are "very well capitalized." Tr. at 85:1-16 (Bassman). Health Connections then noted that HHS has not identified any insurance company that is "actually upset that . . . risk adjustment is right now on hold." Tr. at 83:10-12 (Bassman). Health Connections also argued the equities weigh in favor of vacatur, because HHS has not acted in the four months since the Court's MOO -- when it would have been easy to issue a notice of proposed rulemaking and review comments, especially in light of the fact that HHS has already "thought through these issues really well, [and] got their answers at the ready." Tr. at 83:13-84:10 (Bassman). See Tr. at 84:7-8 (Bassman)("The disruption is either a self-inflicted wound or an admission of a serious deficiency.").

HHS then moved to argue its alternative request that, because Health Connections "point[s] to the particular situation involving this state, . . . we've also requested that Your Honor narrow the relief to New Mexico to only accord full relief to the plaintiff." Tr. at 70:6-10 (Powers). It asserted that "the Court in exercising its equitable discretion also has discretion to fashion narrower relief than a full vacatur," Tr. at 90:16-18 (Powers), and should do so here so to avoid "having an effect on plans across the county that have nothing to do with the New Mexico marketplace" while still granting Health Connections' relief, Tr. at 90:25-91:2 (Powers). HHS argued that a limited vacatur is consistent with the APA, because "the APA does not disturb courts' equitable discretion to deny equitable relief on any ground." Tr. at 93:6-8 (Powers).

Health Connections noted that HHS' rules are "not New Mexico-specific," Tr. at 94:1 (Bassman), but allowed "that for our particular injuries as one plaintiff, an order about New Mexico, as opposed to an order about the United States, would leave us equally whole and in the same position," Tr. at 94:5-9 (Bassman). Neither party could, however, point to a time where HHS has made a similar argument or any case in which a court has granted a limited vacatur. See Tr. at 91:14-92:18 (Court, Powers); Tr. at 94:14-21 (Court, Bassman).

As to the Motion to Strike, Health Connections argued that the Wu Decl. is "improper under Rule 59, because this is not newly discovered evidence that was not previously available" and, thus, HHS should have presented this evidence in the motion-for-summary-judgment briefing. Tr. at 96: 9-15 (Bassman). Health Connections also requested that, should the Court consider the Wu Decl., it should also consider the "additional affidavits and other materials" it attached to its Response. Tr. at 96:18-24 (Bassman). HHS conceded that it would be fair for the Court to consider the Wu Decl. only on the equity issues, but argued that the declaration is properly considered under rule 59 for the reasons stated in its Motion. See Tr. at 13-23 (Court, Powers). Health Connections then asked the Court for the opportunity to cross-examine Mr. Wu should the Court "engage in fact finding and find based on Mr. Wu's declaration that the defendants have proven some sort of remedy equity facts that entitle them to a change in relief." Tr. at 107:22-108:2 (Bassman). HHS then reiterated its position that "[t]here is no need for discovery." Tr. at 109:18-19 (Powers).

12. Suspension of Risk Adjustment Transfers.

On July 7, 2018, sixteen days after the Court's June 21, 2018, hearing, CMS suspended risk adjustment transfers for the 2017 benefits year, "[i]n light of the current status of litigation" in the United States District Court for the District of New Mexico. Center for Consumer

Information & Insurance Oversight, Department of Health and Human Services, Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year at 2, available at https://downloads.cms.gov/cciio/Summary-Report-Risk-Adjustment-2017.pdf (dated July 9, 2018), filed July 19, 2018 (Doc. 78-2)("2017 Risk Adjustment Summary Report").[7] The New York Times, however, reported that "[t]he Trump administration said Saturday that it was suspending a program that pays billions of dollars to insurers to stabilize health insurance markets under the" ACA. Robert Pear, Health Insurers Warn of Market Turmoil as Trump Suspends Billions in Payments, N.Y. TIMES (July 7, 2018), https://www.nytimes.com/2018/07/07/us/politics/trump-risk-adjustment-payments-obamacare.html. "Trump administration officials said they decided to suspend payments under the program because of a ruling in February in Federal District Court in New Mexico. Pear, supra.

"Billions of dollars in risk-adjustment payments and collections are now on hold," and AHIP stated that the Court's "decision will have serious consequences for millions of consumers." Zachary Tracer et al., Trump Health Officials Toss Obamacare Insurers Another Curveball, BLOOMBERG (July 7, 2018), https://www.bloomberg.com/news/articles/2018-07-07/cms-puts-on-hold-payments-to-insurers-that-cover-sicker-patients. CMS Administrator Seema Verma told the Wall Street Journal: "We are disappointed by the court's recent ruling." Stephanie Armour & Anna Wilde Matthews, Trump Administration Halts Payments Expected by Health Insurers, WALL STREET J. (July 7, 2018, 5:46 PM), https://www.wsj.com/articles/trump-

[7]The Court takes judicial notice of the 2017 Risk Adjustment Summary Report's contents, because they "can be accurately and readily determined from sources whose accuracy cannot reasonably be questioned," Fed. R. Evid. 201(b), i.e., a federal agency's website, see New Mexico ex rel. Richardson v. Bureau of Land Mgmt., 565 F.3d 683, 702 n.22 (10th Cir. 2009)(Lucero, J.)(taking judicial notice of facts set out on "[t]he websites of two federal agencies").

administration-halts-payments-expected-by-health-insurers-1530992052 (internal quotation marks omitted). The Wall Street Journal notes that the risk adjustment program "plays a major role in the ACA markets" as, in 2016, the "transfers were valued at 11% of total premium dollars in the individual market." Armour & Matthews, supra. It also quoted AHIP as being "very discouraged by the new market disruption" and Blue Cross as stating that "this action will significantly increase 2019 premiums for millions of individuals and small business owners." Armour & Matthews, supra (internal quotation marks omitted). Deep Banerjee, analyst with S&P Global Ratings, stated that, because many insurers had already input estimates of the 2017 payouts into their books, the abrupt suspension of the risk adjustment payments "would be a big hit to their financial position." Armour & Matthews, supra (internal quotation marks omitted)(quoting Deep Banerjee). Tom Snook, actuary with Milliman Inc., notes that rising uncertainty in the market may provide cause for insurers to "argue that they need a bigger profit margin built into their 2019 rates." Armour & Matthews, supra. The New York Times mirrored much of what the Washington Post wrote, and also pointed to HHS officials saying: "[T]hey were caught between two conflicting court rulings," with the New Mexico Court voiding the current formula, and the Massachusetts court upholding it. Pear, supra.

Dr. Martin Hickey, the CEO of Health Connections when it filed the lawsuit, however, welcomes a revised methodology and states "it's always been unpredictable. We need a new formula that has less of a negative impact and encourages more entrance and competition in the marketplace." Marie C. Baca, NM Lawsuit Central to "Obamacare" Change, ALBUQUERQUE J. (July 9, 2018, 10:30 PM), https://www.abqjournal.com/1194625/nm-lawsuit-central-to-obamacare-change.html. Dr. Hickey also says the decision "will allow more companies to get into the insurance market. That will increase competition, and competition will help keep prices

down." Pear, supra. The Albuquerque Journal notes that risk adjustment payments "were one of several factors that led to the demise of many of the" twenty CO-OPs, of the twenty-four which the ACA created, that are now defunct. Baca, supra. On July 9, 2018, the Albuquerque Journal also reached out to "two of New Mexico's large insurance organizations," who replied that "they were still weighing the consequences of the CMS announcement." Baca, supra. One of these organizations is BlueCross BlueShield of New Mexico, which wrote that it is "currently assessing the implications and any potential impacts as a result of this development." Baca, supra. Presbyterian Health Plan, another large insurance company in New Mexico, wrote "we do not believe it will impact our operations extensively." Baca, supra.

In response to HHS' decision to halt the program, Nicholas Bagley, a professor of law at the University of Michigan Law School, notes that

> the government had several options . . . . [I]t could have adopted a rule that addressed the judge's concerns. Second, it could have sought a stay of the judge's order while it prepared an appeal. Finally, the government might have narrowly interpreted the order to apply only to New Mexico Health connections, or any New Mexico insurer, and acted accordingly . . . .[8]

Joseph Ditzler, New Mexico Lawsuit Puts "Obamacare" Provision on Chopping Block, SANTA FE NEW MEXICAN (July 14, 2018), http://www.santafenewmexican.com/news/health_and_science/new-mexico-lawsuit-puts-obamacare-provision-on-chopping-block/article_edb2979d-edc7-594e-9e36-72b1a55d81e8.html. "The administration had options at its disposal that would cause less confusion and uncertainty for insurers than halting the program entirely."

[8]Professor Bagley suggests that HHS should have ignored the Court's vacatur order and limit the effects of the Court's MOO just to New Mexico. See Ditzler, supra. The Court appreciates that HHS did not do what Professor Bagley suggests. Instead, HHS did what the United States and any party should do when it loses, in an orderly society, and filed a motion to reconsider the remedy and limit the remedy, not just ignore the order and give it a dishonest reading.

Ditzler, supra. As the Albuquerque Journal notes, HHS "could have just issued a new 'interim' rule," especially because it "already [has] such language handy." Catherine Rampell, Repealing Obamacare Didn't Work, So Republicans Try Sabotage, ALBUQUERQUE J. (July 13, 2018, 12:02 AM), https://www.abqjournal.com/1195956/repealing-obamacare-didnt-work-so-republicans-try-sabotage.html. "It is unclear why the administration didn't choose one of its less disruptive options, especially since previous court filings suggested it wanted to keep the program running. As of Monday morning, administration officials had not responded to my questions about their reasoning or timing." Rampell, supra. Professor Bagley also writes that the Court's MOO "wasn't compelling, to put it mildly" and that "the court's decision is weak."[9] Nicholas Bagley, Taking a Dive on Risk Adjustment, INCIDENTAL ECONOMIST (July 9, 2018, 9:43 AM), https://theincidentaleconomist.com/ wordpress/taking-a-dive-on-risk-adjustment/. He says:

> The point of risk adjustment isn't to subsidize insurers with especially unhealthy populations. The point is to adjust risk among insurers. That's why risk adjustment has to be "budget neutral." It's totally senseless to compel CMS to explain something that was obvious to the agency and to every stakeholder in the process.[10] As I see it, the judge's decision typifies the kind of mistake that

[9]When Professor Bagley calls the Court's analysis in its MOO "weak," he underscores what is wrong with much of legal scholarship, and, indeed, scholarship in general in modern law schools and universities. The academic world should offer something more than an editorial in the newspaper. Scholarship is useful, and to be given respect and deference, when it does the hard work of statistical research or analysis the courts or parties may not be able to do, such as James Q. Wilson used to do. See, e.g., George L. Kelling & James Q. Wilson, Broken Windows: The Police and Neighborhood Safety, ATLANTIC (March 1982), https://www.theatlantic.com/ magazine/archive/1982/03/broken-windows/304465/?single_ age=true.

[10]Professor Bagley makes one observation with which the Court agrees and finds helpful. Professor Bagley argues that HHS should not have had to discuss the need of budget neutrality, because that need is so patently obvious. He does not argue that HHS explained the rationale for its budget neutral rule. The Court draws some comfort from his reading of the record, because the Court agrees that HHS did not explain its rationale of its rule.

The Court disagrees with Professor Bagley, however, in that budget neutrality is so obvious that HHS did not have to address it. First, HHS itself does not make the argument that "risk adjustment has to be 'budget neutral'" because of its goal "to adjust risk among insurers,"

> generalist judges make in reviewing complex rules that they only dimly understand.[11]

Bagley, supra. Professor Bagley notes the possibility "that the New Mexico court meant to impose a nationwide injunction, even though it never said so," but counters that "the Justice

---

Bagley, supra; rather, HHS argues the statute "designed" the program to be budget neutral and that budget neutrality was mandated by the lack of congressional appropriations, Motion at 12. Second, HHS therefore does not argue that the need for operating the risk adjustment program in a budget-neutral manner was so obvious that it did not need to explain its decision to do so -- HHS' argument is that it did not need to explain this decision because no commenter raised this issue. See Motion at 9-10. Third, even if the need for budget neutrality were obvious, HHS would still need to explain this decision for there is no obviousness exception to an agency's explanation of a rule. See 5 U.S.C. § 553(c) ("[T]he agency shall incorporate in the rules adopted a concise general statement of their basis and purpose."); Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto. Ins., 463 U.S. at 43 ("[T]he agency must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" (quoting Burlington Truck Lines v. United States, 371 U.S. at 168)). While courts have upheld rules that failed to include a statement of basis and purpose as required under 5 U.S.C. § 553(c) "where the agency's aims are obvious and unmistakable," this requires the reviewing court to be able to discern the basis and purpose from "the surrounding regulatory context." United States v. Exxon Corp., 561 F. Supp 816, 828 (D.D.C. 1983)(Flannery, J.). There is no such ability for the Court to determine HHS' basis and purpose from the regulatory context; the Court can only speculate as to what HHS' basis and purpose could be. Finally, it is clear that operating the program in a budget-neutral manner was not an obvious choice, because commenters noted that it "leads to inadequate compensation for enrollees' risk." 2018 Final Rule, 81 Fed. Reg. 94,101 (A.R.009638).

[11]While Professor Bagley criticizes the rulings of generalists such as federal trial judges, he does not offer any alternatives. He does not suggest whether law professors, a specialist court, or a district judge in another part of the country would be better able to review and understand complex rules. The history of specialist courts, such as the United States Court of Appeals for the Federal Circuit, has not been uniformly good in this country, and the specialty courts have been criticized. See, e.g., Laura G. Pedraza-Fariña, Understanding the Federal Circuit: An Expert Community Approach, 30 Berkeley Tech. L.J. 89, 92-93 (2015); Tamar M. Meekins, "Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense System, 40 Suffolk U. L. Rev. 1, 4 (2006). Moreover, it is unclear what the specialty court here would be -- just one on the ACA or something broader. If some believe that federal judges in the District of Columbia or the Southern District of New York should be the only ones to decide certain issues, that is terribly elitist. For better or worse, the Congress and the nation entrusts these issues to federal trial judges throughout the country, and, absent some other alternative, the Court cannot be fearful of exercising jurisdiction, where no one disputes it.

Department believes that district courts lack the power to enter that kind of nationwide injunction." Bagley, supra. With these considerations in mind, Bagley writes that he is shocked that HHS suspended the program and considers this an act of "sabotage." Bagley, supra.

13. The 2017 Risk Adjustment Summary Report.

Besides noting the suspension of the risk adjustment program for the 2017 benefit year, the 2017 Risk Adjustment Summary Report describes the program as "working as intended by more evenly spreading the financial risk borne by issuers that enrolled higher-risk individuals, thereby protecting issuers against adverse selection within a market within a state and supporting them in offering products that serve all type of consumers." 2017 Risk Adjustment Summary Report at 2. It notes that the "absolute value of risk adjustment transfers as a percent of premiums decreased to 10 percent of premiums in the individual non-catastrophic risk pool and decreased to 5 percent of premiums in the small group risk pool." 2017 Risk Adjustment Summary Report at 2. CMS states that the program's transfers total about $10.4 billion: $5.2 billion in risk adjustment charges and $5.2 billion in risk adjustment payments. See 2017 Risk Adjustment Summary Report at 8. In addition to that total, the report "set[s] forth the 2017 benefit year risk adjustment transfer amounts by issuer." 2017 Risk Adjustment Summary Report at 11. See 2017 Risk Adjustment Summary Report at 11-28 (listing issuer-specific information). In New Mexico, for example, Blue Cross' Licensee Health Care Service Corporation[12] is due a payment of about $7.7 million in the small group risk pool, whereas

[12]Health Care Service Corporation runs Blue Cross' insurance plans in New Mexico as its licensee. See Company Information, BLUECROSS BLUESHIELD OF NEW MEXICO, https://www.bcbsnm.com/company-info (last visited Oct. 9, 2018)("Blue Cross and Blue Shield of New Mexico, a division of Health Care Service Corporation, a Mutual Legal Reserve Company, an independent licensee of the Blue Cross and Blue Shield Association."); Who We Are: Overview, HEALTH CARE SERVICE CORPORATION, http://www.hcsc.com/who-we-are (last

Health Connections is assessed a charge of roughly $4.7 million in the same pool. See 2017 Risk Adjustment Summary Report at 20. In the individual non-catastrophic risk pool, Blue Cross' Health Care Service Corporation is due about $3.7 million and Molina Healthcare is due about $5.1 million, whereas Health Connections is charged $724,274.47 and not-for-profit CHRISTUS Health[13] is charged about $7.4 million. See 2017 Risk Adjustment Summary Report at 20. Presbyterian Healthcare Services, another large insurance provider in New Mexico, is assessed charges: $738,102.52 in the individual non-catastrophic risk pool, and about $4.4 million in the small group risk pool. See 2017 Risk Adjustment Summary Report at 20.

14. The First HHS Notice.

On July 19, 2018, HHS notified the Court that it "has begun the process of promulgating a new Interim Final Rule." Notice at 1, filed July 19, 2018 (Doc. 78)("First HHS Notice"). HHS states that it is "unable to provide further information at this time about the content of this rule as inter-agency review is still ongoing." HHS Notice at 1. HHS adds that it "will promptly advise the Court about further developments with respect to the rule and what effect, if any, the final rule will have on the pending motion for reconsideration," but the agency is "unable to provide an estimated timeframe for these events at present." HHS Notice at 1-2.

---

visited Oct. 9, 2018)("Health Care Service Corporation, a Mutual Legal Reserve Company (HCSC), and an Independent Licensee of the Blue Cross and Blue Shield Association, is the largest customer-owned health insurer in the United States and fourth largest overall, operating through our Blue Cross and Blue Shield® Plans in Illinois, Montana, New Mexico, Oklahoma, and Texas.").

[13]CHRISTUS Health is relatively small, New Mexico, Texas, Arkansas, and Louisiana in the United States. See About Us, CHRISTUS HEALTH, https://www.christushealth.org/about (last visited Oct. 9, 2018). It is a "not-for-profit system made up of more than 600 centers, including long-term care facilities, community hospitals, walk-in clinics and health ministries." About Us, supra.

15. The Motion for Leave.

On July 19, 2018 -- four weeks after the Court asked why there were no amici curiae statements after HHS suggested that vacatur would disrupt risk adjustment collections and payments, and about a week and a half after HHS' suspension of the payments and collections -- two health insurance industry groups, AHIP and Blue Cross, sought leave to file a statement as amici curiae. See Motion for Leave at 1. AHIP is "the national trade association representing health plans," and Blue Cross is "the national association of Blue Cross Blue Shield health plans." Amici Motion at 1. AHIP and Blue Cross argue that the Court should permit them to file an amici statement, because "their perspective will provide the Court with a deeper and more comprehensive understanding of the issues involved in -- and the urgency of an immediate resolution of -- the pending" Motion. Amici Motion at 1. AHIP and Blue Cross add that they both "represent health plans that both pay and receive risk adjustment transfers." Amici Motion at 1-2.

AHIP and Blue Cross attach to the Motion for Leave the statement that they want the Court to consider. See Statement of *Amici Curiae* America's Health Insurance Plans and Blue Cross Blue Shield Association on New Developments in Support of Rule 59(e) Motion at 1, filed July 19, 2018 (Doc. 80-1)("Amici Statement"). The Amici Statement point to CMS "surpris[ing] all carriers by" halting collections and payments under the risk adjustment program, calling for a "new urgency to resolution -- and grant (at least as to remedy) -- of" the Motion. Amici Statement at 1. AHIP and Blue Cross assert that this decision "has serious and time-sensitive ramifications for the functioning of the market for individual and small group health plans," because the "decision deprives many AHIP and BCBSA members of substantial risk adjustment payments that the Affordable Care Act guarantees and that they have relied on in making critical

plan offering and pricing decisions." Amici Statement at 2. They assert that the decision also harms those issuers who pay the risk adjustment transfers, because the decision "jeopardizes the future market participation of plans that receive risk adjustment payments, and the resulting change in risk-profile adversely affects the plans that remain and the calculation of their rates." Amici Statement at 2. Further, AHIP and Blue Cross argue that "the freeze creates profound uncertainty for future health plan pricing," which "could result in increased premiums for many health plans and reduced coverage options." Amici Statement at 2.

AHIP and Blue Cross also note that the nature of the risk adjustment program means that issuers must consider transfers under the program when setting their premiums and that deadlines for issuers -- such as those for changing their individual market submissions or electing to participate in the individual market Exchanges -- are fast approaching. See Amici Statement at 2-3. Finally, AHIP and Blue Cross state:

> [I]t is unclear how health plans are to treat risk adjustment payments or transfers in the calculation of their medical loss ratio (MLR) . . . . Accurate and complete calculation of MLRs is essential in determining whether a plan has met certain legally mandated requirements and if the plan has any corresponding financial obligations (*e.g.*, whether or not direct rebates must be paid to consumers).

Amici Statement at 3-4. AHIP and Blue Cross thus "respectively urge the Court to resolve Defendants' Motion -- and grant the relief requested -- as soon as possible." Amici Statement at 4.

16. The Second HHS Notice.

On July 25, 2018, HHS notified the Court that it "issued a new Final Rule concerning the risk adjustment methodology for the 2017 benefit year, which will be effective upon its publication in the Federal Register." Notice at 1, filed July 25, 2018 (Doc. 81)("Second HHS Notice")(citing Centers for Medicare & Medicaid Services, CMS-9920-F, Adoption of the

Methodology for the HHS-operated Permanent Risk Adjustment Program under the Patient Protection and Affordable Care Act for the 2017 Benefit Year, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/CMS -9920-F-7-24-18-final.pdf, filed July 25, 2018 (Doc. 81-1)("New 2017 Rule")). HHS states that the New 2017 Rule "adopts the risk adjustment methodology previously promulgated by the agency for the 2017 benefit year," but responds to the MOO "by providing additional explanation of the agency's use of statewide average premium in the risk adjustment payment transfer formula, as well as the risk adjustment program's budget neutral design." Second HHS Notice at 1 (citing New 2017 Rule at 6-12).

With the New 2017 Rule, HHS "will now proceed with carrying out the risk adjustment program for the 2017 year, including collecting charges and making payments for the 2017 benefit year." Second HHS Notice at 2. HHS asserts the New 2017 Rule "further demonstrate[s] that the earlier 2017 benefit year rule at issue in this litigation was not arbitrary and capricious," and urges the Court to grant its Motion. Second HHS Notice at 2. Finally, HHS notes that it "intend[s] to issue a Notice of Proposed Rulemaking to propose and solicit comment on the risk adjustment methodology that will apply to the 2018 benefit year," and will provide more information "when appropriate." Second HHS Notice at 2 (citation omitted).

17. The Motion for Leave Opposition.

On August 1, 2018, Health Connections responded to the Motion for Leave, arguing why the Court should not grant AHIP and Blue Cross leave to file their Amici Statement. See New Mexico Health Connections' Opposition to America's Health Insurance Plans and Blue Cross Blue Shield Association's Motion for Leave to File Statement as Amici Curiae at 1, filed August 1, 2018 (Doc. 82)("Motion for Leave Opposition"). Health Connections notes that appearance as

amici curiae is "a matter of privilege, not of right," so "the Court has broad discretion to deny" the Motion for Leave. Motion for Leave Opposition at 2 (citing Lopez v. Santa Fe Police Dep't, No. CIV 09-1214 JH/LFG, 2010 BL 17160, at *1 (D.N.M. Jan. 25, 2010)(Garcia, M.J.); WildEarth Guardians v. Lane, No. CIV 12-118 LFG/KBM, 2012 U.S. LEXIS 189661, at *4 (D.N.M. June 20, 2012)(Garcia, M.J.)). This discretion is especially true in district courts, Health Connections asserts, in which "*amicus* requests are subject to greater scrutiny." Motion for Leave Opposition at 3.

Health Connections argues that the Motion for Leave is untimely, because it is filed in support of the Motion over three months after the Motion was filed, and the Federal Rules of Appellate Procedure require amicus briefs be filed within seven days of the filing of the principal brief it is supporting. See Motion for Leave Opposition at 4 (citing Fed. R. App. P. 29(a)(6)). Health Connections also asserts that the proposed Amici Statement provides no useful information that will help the Court, because "the entire premise of the *amicus* statement was to apprise the Court of the now-ended Risk Adjustment Suspension." Motion for Leave Opposition at 5. Health Connections further argues against the granting of the Motion for Leave, because "there is no indication that the parties to the law suit . . . will not adequately present all relevant legal arguments, [so] there is no persuasive reason to grant" the Motion for Leave. Motion for Leave Opposition at 5 (internal quotation marks omitted)(quoting Am. Coll. of Obstetricians & Gynecologists, PA Section v. Thornburgh, 699 F.2d 644, 645 (3rd Cir. 1983)). Finally, Health Connections argues that the Amici Statement "is just another attempt to preserve [Blue Cross'] market dominance and to protect the risk adjustment program that has been so effective in thwarting their competitors' efforts to establish a foothold in the market and provide options to consumers." Motion for Leave Opposition at 7-8. Health Connections asserts that the ACA

created the individual and small group markets "to foster competition, [but] HHS's risk adjustment program is doing the opposite. Rather than supporting new entrants and providing consumers with more options, the risk adjustment program as implemented has been preserving the dominance of Blue Cross Blue Shield plans." Motion for Leave Opposition at 6-7.

18. The Second HHS Notice Response.

Health Connections responded to the Second HHS Notice on August 1, 2018, to note that the New 2017 Rule moots the Motion as to the "reconsideration of the Court's findings on the 2017 rule." Plaintiff New Mexico Health Connections' Response to HHS's Notice at 1, filed August 1, 2018 (Doc. 83)("Second HHS Notice Response"). Health Connections also asserts that HHS' "cry of disruption was a purely self-inflicted wound," because it is clearly able to promulgate new rules. Second HHS Notice Response at 2. Finally, Health Connections argues the New 2017 Rule is improper under the APA, because HHS "delay[ed] taking action for months and then used an alleged timing emergency of its own creation to avoid going through notice and comment," and that the New 2017 Rule "underscores just how specious HHS's pending Rule 59 motion is." Second HHS Notice Response at 2.

19. The Third HHS Notice.

On August 8, 2018, HHS notified the Court that it "issued a new Notice of Proposed Rulemaking ('NPRM') concerning the risk adjustment methodology for the 2018 benefit year." Notice at 1, filed August 8, 2018 (Doc. 84)("Third HHS Notice")(citing Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program for the 2018 Benefit Year Proposed Rule, 83 Fed. Reg. 39,644, 39,644 (dated August 10, 2018)("2018 NPRM")). HHS notes that the 2018 NPRM "responds to the Court's prior decision by providing additional explanation of the agency's use of statewide average premium in the risk adjustment payment

transfer formula, as well as the risk adjustment program's budget neutral design, and seeks comment on these issues." Third HHS Notice at 1-2 (citing 2018 NPRM, 83 Fed. Reg. at 39,645-48). HHS also notifies the Court that the New 2017 Rule has "been published in the Federal Register" and requests that the Court grant its Motion "in full," because issuance of the New 2017 Rule and the 2018 NPRM "does not moot the motion with respect to the 2014-2016 rules." Third HHS Notice at 2 (citing Adoption of the Methodology for the HHS-Operated Permanent Risk Adjustment Program Under the Patient Protection and Affordable Care Act for the 2017 Benefit Year, 83 Fed. Reg. 36,456, 36,456 (dated July 30, 2018)).

20. The Third HHS Notice Response.

Health Connections responded to the Third HHS Notice on August 13, 2018. See Plaintiff New Mexico Health Connections' Response to HHS's Notice at 1, filed August 13, 2018 (Doc. 85)("Third HHS Notice Response"). Health Connections asserts that, with the 2018 NPRM and New 2017 Rule, HHS' Motion "is now entirely moot as to 2017 and 2018." Third HHS Notice Response at 1. Health Connections further asserts that "[t]he issuance of both new regulations also betrays the hollowness of HHS's cry that this Court's remedy of vacatur will inevitably cause market disruption." Third HHS Notice Response at 2.

21. The Second Notice of Supplemental Authority.

Health Connections brings another case to the Court's attention: Mont. Health Co-op v. United States, No. 18-143C, 2018 U.S. Claims LEXIS 1066 (Fed. Cl. Sept. 4, 2018)(Kaplan, J.)("Montana Health"). See Notice of Supplemental Authority at 1, filed November 6, 2018 (Doc. 88)("Second Notice"). Health Connections notes that, as in Moda, the United States Court of Federal Claims in Montana Health "expressly rejected the appropriations-based arguments HHS advances in its pending" Motion. Second Notice at 1. Health Connections states: "In

Montana Health, the Government argued that the lack of a specific appropriation discharged its obligation to make cost-sharing reduction payments to the Plaintiff, a health insurer. The Court rejected this theory, explaining that 'Congress's failure to appropriate funds to make those payments did not vitiate [the Government's statutory] obligation.'" Second Notice at 1 (alteration in original)(quoting Montana Health, 2018 U.S. Claims LEXIS 1066, at *1). Health Connections further notes that the Court of Federal Claims "pointed to the United States Supreme Court's clear precedent that 'a bare failure to appropriate funds to meet a statutory obligation could not vitiate that obligation.'" Second Notice at 2 (quoting Montana Health, 2018 U.S. Claims LEXIS 1066, at *19-20). Finally, Health Connections says Montana Health "rejected the Government's argument (which mirrors that made in this case) that the structure of the Medicare Part D statute supported its claims." Second Notice at 2 (quoting Montana Health, 2018 U.S. Claims LEXIS 1066, at *14-15).

22. The Second Notice Response.

HHS responded to the Second Notice. See Defendants' Response to Plaintiff's Notice of Supplemental Authority at 1, filed November 13, 2018 (Doc. 89)("Second Notice Response"). HHS argues that Montana Health is "a decision largely irrelevant to the appropriations law arguments advanced in" the Motion. Second Notice Response at 1. HHS notes that Health Connections quotes parts of the decision that "are clear that the court's reasoning relied on the existence of a *statutory* obligation to make payments." Second Notice Response at 1-2 (emphasis in original)(citing Second Notice at 1-2). HHS asserts that this "reasoning has no bearing on this case because there is no dispute that the statute creating the risk adjustment program does not dictate a formula for mandatory payments." Second Notice Response at 2 (citing 42 U.S.C. § 18063(b)). Thus, HHS argues, Montana Health does not discuss "whether

agency officials can make or authorize a legally-enforceable obligation in the absence of an appropriation." Second Notice Response at 2 (emphasis in original).

LAW REGARDING MOTIONS TO RECONSIDER

Except where the Federal Rules of Civil Procedure specify, motions to reconsider in civil cases fall into three categories. First, there are motions to reconsider "filed within [twenty-eight][14] days of the entry of judgment," which are "treated as a motion to alter or amend the judgment under rule 59(e)." Pedroza v. Lomas Auto Mall, Inc., 258 F.R.D. 453, 462 (D.N.M. 2009)(Browning, J.). Second, there are motions to reconsider "filed more than [twenty-eight] days after judgment," which are "considered a motion for relief from judgment under rule 60(b)." Pedroza v. Lomas Auto Mall, Inc., 258 F.R.D. at 462. Finally, there are motions to reconsider "any order that is not final," which are treated as "a general motion directed at the Court's inherent power to reopen any interlocutory matter in its discretion." Pedroza v. Lomas Auto Mall, Inc., 258 F.R.D. at 462. See Price v. Philpot, 420 F.3d 1158, 1167 & n.9 (10th Cir. 2005); Computerized Thermal Imaging, Inc. v. Bloomberg, L.P., 312 F.3d 1292, 1296 n.3 (10th Cir. 2002).

Courts may treat motions for reconsideration as a rule 59(e) motion when the movant

[14]Former rule 59 provided for a ten-day period after entry of judgment to file motions to reconsider. In 2009, the rule was amended, extending the filing period to twenty-eight days:

> Experience has proved that in many cases it is not possible to prepare a satisfactory post-judgment motion in 10 days, even under the former rule that excluded intermediate Saturdays, Sundays, and legal holidays. These time periods are particularly sensitive because Appellate Rule 4 integrates the time to appeal with a timely motion under these rules. Rather than introduce the prospect of uncertainty in appeal time by amending Rule 6(b) to permit additional time, the former 10-day periods are expanded to 28 days.

Federal Rules of Civil Procedure, Rule 59, Legal Information Institute, https://www.law.cornell.edu/rules/frcp/rule_59 (Committee Notes on Rules -- 2009 Amendment).

files within twenty-eight days of a court's entry of judgment. See Price v. Philpot, 420 F.3d at 1167 n.9. If the movant files outside that time period, courts should treat the motion as seeking relief from judgment under rule 60(b). See Price v. Philpot, 420 F.3d at 1167 n.9. "[A] motion for reconsideration of the district court's judgment, filed within [rule 59's filing deadline], postpones the notice of appeal's effect until the motion is resolved." Jones v. United States, 355 F. App'x 117, 122 (10th Cir. 2009)(unpublished).[15] The time limit in rule 59(e) is now twenty-eight days from the entry of a judgment. See Fed. R. Civ. P. 59(e).

A court cannot enlarge the time for filing a rule 59(e) motion. See Brock v. Citizens Bank of Clovis, 841 F.2d 344, 348 (10th Cir. 1988)(holding that district courts lack jurisdiction over untimely rule 59(e) motions); Plant Oil Powered Diesel Fuel Sys., Inc. v. ExxonMobil Corp., No. 11-0103, 2012 WL 869000, at *2 (D.N.M. March 8, 2012)(Browning, J.)("The Court may not extend the time period for timely filing motions under Rule 59(e) . . . ."). "A motion under rule 59 that is filed more than 28 days after entry of judgment may be treated as a Rule 60(b) motion for relief from judgment." 12 James Wm. Moore et al., Moore's Federal Practice § 59.11[4][b], at 59-32 (Matthew Bender 3d ed.)(citations omitted). Nevertheless, a court will not generally treat an untimely rule 59(e) motion as a rule 60(b) motion when the party is seeking "'reconsideration of matters properly encompassed in a decision on the merits'

[15]Jones v. United States is an unpublished Tenth Circuit opinion, but the Court can rely on an unpublished Tenth Circuit opinion to the extent its reasoned analysis is persuasive in the case before it. See 10th Cir. R. 32.1(A), 28 U.S.C. ("Unpublished decisions are not precedential, but may be cited for their persuasive value."). The Tenth Circuit has stated: "In this circuit, unpublished orders are not binding precedent, . . . and . . . citation to unpublished opinions is not favored. However, if an unpublished opinion . . . has persuasive value with respect to a material issue in a case and would assist the court in its disposition, we allow a citation to that decision." United States v. Austin, 426 F.3d 1266, 1274 (10th Cir. 2005)(citations omitted). The Court concludes that Jones v. United States, Village of Logan v. United States Department of Interior, and Hospice of New Mexico, LLC v. Sebelius have persuasive value with respect to a material issue, and will assist the Court in its disposition of this Memorandum Opinion and Order.

contemplated by Rule 59(e)." Jennings v. Rivers, 394 F.3d 850, 854 (10th Cir. 2005)(quoting Osterneck v. Ernst & Whinney, 489 U.S. 169, 174 (1989)).

Whether a motion for reconsideration should be considered a motion under rule 59 or rule 60 is not only a question of timing, but also "depends on the reasons expressed by the movant." Commonwealth Prop. Advocates, LLC v. Mortg. Elec. Registration Sys., Inc., 680 F.3d 1194, 1200 (10th Cir. 2011). Where the motion "involves 'reconsideration of matters properly encompassed in a decision on the merits,'" a court considers the motion under rule 59(e). Phelps v. Hamilton, 122 F.3d 1309, 1323-24 (10th Cir. 1997)(quoting Martinez v. Sullivan, 874 F.2d 751, 753 (10th Cir. 1989)). In other words, if the reconsideration motion seeks to alter the district court's substantive ruling, then it should be considered a rule 59 motion and be subject to rule 59's constraints. See Phelps v. Hamilton, 122 F.3d at 1324. In contrast, under rule 60,

> [o]n motion and just terms, the court may relieve a party or its legal representatives from a final judgment, order, or proceeding for the following reasons:
>
> (1) mistake, inadvertence, surprise, or excusable neglect;
>
> (2) newly discovered evidence that, with reasonable diligence, could not have been discovered in time to move for a new trial under Rule 59(b);
>
> (3) fraud (whether previously called intrinsic or extrinsic), misrepresentation, or misconduct by an opposing party;
>
> (4) the judgment is void;
>
> (5) the judgment has been satisfied, released or discharged; it is based on an earlier judgment that has been reversed or vacated; or applying it prospectively is no longer equitable; or
>
> (6) any other reason that justifies relief.

Fed. R. Civ. P. 60(b). Neither a rule 59 nor a rule 60 motion for reconsideration is an appropriate vehicle

> to reargue an issue previously addressed by the court when the motion merely advances new arguments, or supporting facts which were available at the time of the original motion. . . . Grounds warranting a motion to reconsider include (1) an intervening change in the controlling law, (2) new evidence previously unavailable, and (3) the need to correct clear error or prevent manifest injustice.

Servants of the Paraclete v. Does, 204 F.3d 1005, 1012 (10th Cir. 2000).[16] "[A] motion for reconsideration is appropriate where the court has misapprehended the facts, a party's position, or the controlling law." Servants of the Paraclete v. Does, 204 F.3d at 1012. A district court has considerable discretion in ruling on a motion to reconsider. See Phelps v. Hamilton, 122 F.3d at 1324.

The United States Court of Appeals for the Tenth Circuit reviews a district court's ruling on a motion to alter or amend "under an abuse of discretion standard." Phelps v. Hamilton, 122

[16]A loose conflation in terminology in Servants of the Paraclete v. Does, which refers to rule 59(e) motions -- "motion[s] to alter or amend a judgment," Fed. R. Civ. P. 59(e) (emphasis added) -- as "motion[s] to reconsider," 204 F.3d at 1012, has created some confusion as to the proper standard for a district court to apply when reconsidering an "interlocutory or interim" order, i.e., an order that a district court issues while the case is ongoing, as distinguished from a final judgment. The Honorable Paul J. Kelly, Jr., now-Senior United States Circuit Judge for the Tenth Circuit, who authored Servants of the Paraclete v. Does, refers to rule 59(e) motions as "motion[s] to reconsider" several times throughout the opinion. 204 F.3d at 1012. He uses the term "motion to reconsider" as an umbrella term that can encompass three distinct motions: (i) motions to reconsider an interlocutory order, which no set standard governs, save that the district court must decide them "before the entry of . . . judgment," Fed. R. Civ. P. 54(b); (ii) motions to reconsider a judgment made within 28 days of the entry of judgment, which the Servants of the Paraclete v. Does standard governs; and (iii) motions to reconsider a judgment made more than 28 days after the entry of judgment, which rule 60(b) governs. There is arguably a fourth standard for motions to reconsider filed more than a year after the entry of judgment, as three of the rule 60(b) grounds for relief expire at that point.

Much confusion could be avoided by using the term "motion to reconsider" exclusively to refer to the first category, "motion to amend or alter the judgment" exclusively to refer to the second category, and "motion for relief from judgment" exclusively to refer to the third category (and arguable fourth category). These are the terms that the Federal Rules of Civil Procedure -- and other Courts of Appeals -- use to describe (ii) and (iii). The Court agrees with Judge Kelly -- and all he likely meant by using motion to reconsider as an umbrella term is -- that, if a party submits a motion captioned as a "motion to reconsider" after an entry of final judgment, the court should evaluate it under rule 59(e) or 60(b), as appropriate, rather than rejecting it as untimely or inappropriate.

F.3d at 1324. Under that standard, "a trial court's decision will not be disturbed unless the appellate court has a definite and firm conviction that the lower court made a clear error of judgment or exceeded the bounds of permissible choice in the circumstances." 122 F.3d at 1324. "The purpose [of a rule 59(e)] motion is to correct manifest errors of law or to present newly discovered evidence." Monge v. RG Petro-Mach. (Group) Co., 701 F.3d 598, 611 (10th Cir. 2012)(alteration in original)(internal citations omitted)(quoting Webber v. Mefford, 43 F.3d 1340, 1345 (10th Cir. 1994)). "Where the motion requests a substantive change in the district court's judgment or otherwise questions its substantive correctness, the motion is a Rule 59 motion, regardless of its label." Yost v. Stout, 607 F.3d 1239, 1243 (10th Cir. 2010).

The Court has recently written on the issue of parties filing rule 59(e) motions which repeats arguments that they already made:

> Under rule 59(e)'s framework, the Court is not restricted to rule 50(b)'s remedies and may alter the judgment when there is: "(1) an intervening change in the controlling law, (2) new evidence previously unavailable, [or] (3) the need to correct clear error or prevent manifest injustice." Servants of Paraclete v. Does, 204 F.3d at 1012. The Tenth Circuit has noted that motions to alter, amend, or reconsider should not rehash old arguments, or advance new arguments or facts that could have been raised earlier. See United States v. Amado, 841 F.3d [867, 871 (10th Cir. 2016)]("A proper motion to reconsider does not simply state facts previously available or make arguments previously made."); Servants of Paraclete v. Does, 204 F.3d at 1012 ("Thus, a motion for reconsideration is appropriate where the court has misapprehended the facts, a party's position, or the controlling law. It is not appropriate to revisit issues already addressed or advance arguments that could have been raised in prior briefing."). As the Court has already noted, the Defendants' Motion raises the same arguments that the Defendants previously argued during their Motion to Alter. The Court, however, also concludes that Servants of Paraclete v. Does, does not force the Court to deny a motion to amend or alter, simply because it raises identical issues; rather, it affords the Court the option to deny that motion for reasons of judicial efficiency. A court need not review a motion to alter or amend with the same rigor if the motion raises issues already considered, because it would waste time by forcing a judge to rewrite an opinion already rendered. If, on the other hand, a party raises an identical issue on a motion to alter, and, upon the district judge's reflection, perhaps after passions have cooled, he or she concludes that he or she erred

> previously, Servants of Paraclete v. Does does not chain that district judge to an erroneous legal conclusion. 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.

Nelson v. City of Albuquerque, 283 F. Supp. 3d 1048, 1099 (D.N.M. 2017)(Browning, J.). In Nelson v. City of Albuquerque, the Court looked to the Servants of Paraclete v. Does factors and decided to grant the motion to alter the previous judgment based on "clear error," despite the other two factors not favoring granting the motion. 283 F. Supp. 3d at 1099 & n.35. Cf. Lopez v. Delta Int'l Machinery Corp., 312 F. Supp. 3d 1115, 1153-62 (D.N.M. 2018)(Browning, J.)(denying a rule 59(e) motion because the plaintiff did not show the Court erred in its judgment); United States v. 2002 Pontiac Bonneville SE, No. CIV 12-0580 JB/LFG, 2015 WL 8331144, at *6 (D.N.M. Dec. 7, 2015)(Browning, J.)(denying a rule 59(e) motion because the plaintiff did not make a showing of: "(i) a change in the controlling law; (ii) new evidence; (iii) clear legal error; [or] (iv) manifest injustice." (citations omitted)).

LAW REGARDING JUDICIAL REVIEW OF AGENCY ACTION

Under the APA,

> [a] person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States: *Provided*, that any mandatory or injunctive decree shall specify the Federal officer or officers (by name or by title), and their successors in office, personally responsible for compliance. Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground; or (2) confers authority to grant relief if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.

5 U.S.C. § 702 (emphasis in original). The APA states that district courts can:

> (1) compel agency action unlawfully withheld or unreasonably delayed; and
>
> (2) hold unlawful and set aside agency action, findings, and conclusions found to be --
>
> > (A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law;
> >
> > (B) contrary to constitutional right, power, privilege, or immunity;
> >
> > (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right;
> >
> > (D) without observance of procedure required by law;
> >
> > (E) unsupported by substantial evidence in a case subject to sections 556 and 557 of this title or otherwise reviewed on the record of an agency hearing provided by statute; or
> >
> > (F) unwarranted by the facts to the extent that the facts are subject to trial de novo by the reviewing court.

5 U.S.C. § 706.

Under Olenhouse v. Commodity Credit Corp., "[r]eviews of agency action in the district courts [under the APA] must be processed *as appeals*. In such circumstances the district court should govern itself by referring to the Federal Rules of Appellate Procedure." 42 F.3d 1560, 1580 (10th Cir. 1994)(emphasis in original). See WildEarth Guardians v. U.S. Forest Serv., 668 F. Supp. 2d 1314, 1323 (D.N.M. 2009)(Browning, J.). "As a group, the devices appellate courts normally use are generally more consistent with the APA's judicial review scheme than the devices that trial courts generally use, which presume nothing about the case's merits and divide burdens of proof and production almost equally between the plaintiff and defendant." N. New Mexicans Protecting Land & Water Rights v. United States, No. CIV 15-0559, 2015 WL 8329509, at *9 (D.N.M. 2015)(Browning, J.).

1. Reviewing Agency Factual Determinations.

Under the APA, a reviewing court must accept an agency's factual determinations in informal proceedings unless they are "arbitrary [or] capricious," 5 U.S.C. § 706(2)(A), and its factual determinations in formal proceedings unless they are "unsupported by substantial evidence," 5 U.S.C. § 706(2)(E). The APA's two linguistic formulations amount to a single substantive standard of review. Ass'n of Data Processing Serv. Orgs., Inc. v. Bd. of Govs. of Fed. Reserve Sys., 745 F.2d 677, 683-84 (D.C. Cir. 1984)(Scalia, J.)(explaining that, as to factual findings, "there is no *substantive* difference between what [the arbitrary or capricious standard] requires and what would be required by the substantial evidence test, since it is impossible to conceive of a 'nonarbitrary' factual judgment supported only by evidence that is not substantial in the APA sense" (emphasis in original)); See Ass'n of Data Processing Serv. Orgs., Inc. v. Bd. of Govs. of Fed. Reserve Sys., 745 F.2d at 684 ("[T]his does not consign paragraph (E) of the APA's judicial review section to pointlessness. The distinctive function of paragraph (E) -- what it achieves that paragraph (A) does not -- is to require substantial evidence to be found *within the record of closed-record proceedings* to which it exclusively applies." (emphasis in original)). See also Jarita Mesa Livestock Grazing Ass'n v. U.S. Forest Serv., 140 F. Supp. 3d at 1167-68 (discussing this fact).

In reviewing agency action under the arbitrary-or-capricious standard, a court considers the administrative record -- or at least those portions of the record that the parties provide -- and not materials outside of the record. See 5 U.S.C. § 706 ("In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party . . . ."); Fed. R. App. P. 16(a) ("The record on review or enforcement of an agency order consists of . . . the order involved; . . . any findings or report on which it is based; and . . . the

pleadings, evidence, and other parts of the proceedings before the agency."); Ass'n of Data Processing Serv. Orgs., Inc. v. Bd. of Govs. of the Fed. Reserve Sys., 745 F.2d at 684 ("[W]hether the administrator was arbitrary must be determined on the basis of what he had before him when he acted . . . ."). See also Franklin Sav. Ass'n v. Dir., Office of Thrift Supervision, 934 F.2d 1127, 1137 (10th Cir. 1991)("[W]here Congress has provided for judicial review without setting forth . . . procedures to be followed in conducting that review, the Supreme Court has advised such review shall be confined to the administrative record and, in most instances, no de novo proceedings may be had." (footnote omitted)). Tenth Circuit precedent indicates, however, that the ordinary evidentiary rules regarding judicial notice apply when a court reviews agency action. See New Mexico ex. rel. Richardson v. Bureau of Land Mgmt., 565 F.3d at 702 n.21 (10th Cir. 2009)("We take judicial notice of this document, which is included in the record before us in [another case]." (citing Fed. R. Evid. 201(b))); New Mexico ex. rel. Richardson v. Bureau of Land Mgmt., 565 F.3d at 702 n.22 ("We conclude that the occurrence of Falcon releases is not subject to reasonable factual dispute and is capable of determination using sources whose accuracy cannot reasonably be questioned, and we take judicial notice thereof."). In contrast, the United States Courts of Appeals for the Ninth and Eleventh Circuits have held that taking judicial notice is inappropriate in APA reviews absent extraordinary circumstances or inadvertent omission from the administrative record. See Compassion Over Killing v. U.S. Food & Drug Admin., 849 F.3d 849, 852 n.1 (9th Cir. 2017); Nat'l Mining Ass'n v. Sec'y U.S. Dep't of Labor, 812 F.3d 843, 875 (11th Cir. 2016).

To fulfill its function under the APA, a reviewing court should engage in a "thorough, probing, in-depth review" of the record before it when determining whether an agency's decision survives arbitrary-or-capricious review. Wyoming v. United States, 279 F.3d 1214, 1238 (10th

Cir. 2002)(citation and internal quotation marks omitted). The Tenth Circuit explains:

> "[I]n determining whether the agency acted in an 'arbitrary and capricious manner,' we must ensure that the agency 'decision was based on a consideration of the relevant factors' and examine 'whether there has been a clear error of judgment.'" We consider an agency decision arbitrary and capricious if "the agency . . . relied on factors which Congress had 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."

Colo. Envtl. Coal. v. Dombeck, 185 F.3d 1162, 1167 (10th Cir. 1999)(quoting Friends of the Bow v. Thompson, 124 F.3d 1210, 1215 (10th Cir. 1997)). Arbitrary-or-capricious review requires a district court "to engage in a substantive review of the record to determine if the agency considered relevant factors and articulated a reasoned basis for its conclusions," Olenhouse, 42 F.3d at 1580, but it is not to assess the wisdom or merits of the agency's decision, see Colo. Envtl. Coal. v. Dombeck, 185 F.3d at 1172. The agency must articulate the same rationale for its findings and conclusions on appeal upon which it relied in its internal proceedings. See SEC v. Chenery Corp., 318 U.S. 80, 92-95 (1943). While the court may not supply a reasoned basis for the agency's action that the agency does not give itself, the court should "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned." Bowman Transp., Inc. v. Arkansas-Best Freight Sys., Inc., 419 U.S. 281, 286 (1974)(citation omitted).

2. Reviewing Agency Legal Interpretations.

In promulgating and enforcing regulations, agencies must interpret federal statutes, their own regulations, and the Constitution of the United States of America, and Courts reviewing those interpretations apply three different deference standards, depending on the kind of law at issue. First, the federal judiciary accords considerable deference to an agency's interpretation of

a statute that Congress has tasked it with enforcing. See United States v. Undetermined Quantities of Bottles of an Article of Veterinary Drug, 22 F.3d 235, 238 (10th Cir. 1994). This is known as Chevron deference, named after the supposedly seminal case, Chevron, U.S.A., Inc. v. Natural Resource Defense Council, Inc., 467 U.S. 837 (1984)("Chevron").[17] Chevron deference is a two-step process[18] that first asks whether the statutory provision in question is clear and, if it is not, then asks whether the agency's interpretation of the unclear statute is reasonable. As the Tenth Circuit has explained,

> we must be guided by the directives regarding judicial review of administrative agency interpretations of their organic statutes laid down by the Supreme Court in *Chevron, U.S.A., Inc. v. Natural Resources Defense Council, Inc.*, 467 U.S. 837 . . . (1984). Those directives require that we first determine whether Congress has directly spoken to the precise question at issue. If the congressional intent is clear, we must give effect to that intent. If the statute is silent or ambiguous on that specific issue, we must determine whether the agency's answer is based on a permissible construction of the statute.

---

[17]The case itself is unremarkable, uninstructive, does not explicitly outline the now-familiar two-step process of applying Chevron deference, and does not appear to have been intended to become a "big name" case at all. Its author, the Honorable John Paul Stevens, former Associate Justice of the Supreme Court, insists that the case was never intended to create a regime of deference, and, in fact, Justice Stevens became one of Chevron deference's greatest detractors in subsequent years. See generally Charles Evans Hughes, Justice Stevens and the Chevron Puzzle, 106 Nw. U. L. Rev. 551 (2012).

[18]There is, additionally, a threshold step -- the so-called step zero -- which asks whether Chevron deference applies to the agency decision at all. See Cass R. Sunstein, Chrevron Step Zero, 92 Va. L. Rev. 187 (2006). Step zero asks: (i) whether the agency is Chevron-qualified, meaning whether the agency involved is the agency charged with administering the statute -- for example, the EPA administers a number of statutes, among them the Clean Air Act, Pub. L. No. 88-206, 77 Stat. 392; (ii) whether the decision fits within the category of interpretations afforded the deference -- interpretation of contracts, the Constitution, and the agency's own regulations are not afforded Chevron deference, see, e.g., U.S. West, Inc. v. FCC, 182 F.3d 1224 (10th Cir. 1999)("[A]n unconstitutional interpretation is not entitled to *Chevron* deference."); and (iii) whether Congress intended the agency to "speak with the force of law" in making the decision in question, United States v. Mead Corp., 533 U.S. 218, 229 (2001) -- opinion letters by the agency, for example, do not speak with the force of law and are thus not entitled to Chevron deference, see Christensen v. Harris Cty., 529 U.S. 576 (2000). An affirmative answer to all three inquiries results in the agency's decision passing step zero.

United States v. Undetermined Quantities of Bottles of an Article of Veterinary Drug, 22 F.3d at 238 (citing Chevron, 467 U.S. at 842-43).

Chevron's second step is all but toothless, because if the agency's decision makes it to step two, it is upheld almost without exception. See Ronald M. Levin, The Anatomy of Chevron: Step Two Reconsidered, 72 Chi.-Kent L. Rev. 1253, 1261 (1997)("[T]he Court has never once struck down an agency's interpretation by relying squarely on the second *Chevron* step."); Jason J. Czarnezki, An Empirical Investigation of Judicial Decisionmaking, Statutory Interpretation, and the Chevron Doctrine in Environmental Law, 79 U. Colo. L. Rev. 767, 775 (2008)("Due to the difficulty in defining step two, courts rarely strike down agency action under step two, and the Supreme Court has done so arguably only twice."). Courts essentially never conclude that an agency's interpretation of an unclear statute is unreasonable.

Chevron's first step, in contrast, has bite, but there is substantial disagreement about what it means. In an earlier case, the Court noted the varying approaches that different Supreme Court Justices have taken in applying Chevron deference:

> The Court notices a parallel between the doctrine of constitutional avoidance and the Chevron doctrine. Those Justices, such as Justice Scalia, who are most loyal to the doctrines and the most likely to apply them, are also the most likely to keep the "steps" of the doctrines separate: first, determining whether the statute is ambiguous; and, only then, assessing the merits of various permissible interpretations from the first step. These Justices are also the most likely to find that the statute is unambiguous, thus obviating the need to apply the second step of each doctrine. Those Justices more likely to find ambiguity in statutes are more likely to eschew applying the doctrines in the first place, out of their distaste for their second steps -- showing heavy deference to agencies for Chevron doctrine, and upholding facially overbroad statutes, for constitutional avoidance.

Griffin v. Bryant, 30 F. Supp. 3d 1139, 1192 n.23 (D.N.M. 2014)(Browning, J.). A number of policy considerations animate Chevron deference, among them: (i) statutory interpretation, i.e., that Congress, by passing extremely open-ended and vague organic statutes, grants discretionary

power to the agencies to fill in the statutory gaps; (ii) institutional competency, i.e., that agencies are more competent than the courts at filling out the substantive law in their field; (iii) political accountability, i.e., that agencies, as executive bodies ultimately headed by the President of the United States of America, can be held politically accountable for their interpretations; and (iv) efficiency, i.e., that numerous, subject-matter specialized agencies can more efficiently promulgate the massive amount of interpretation required to maintain the modern regulatory state -- found in the Code of Federal Regulations and other places -- than a unified but Circuit-fragmented federal judiciary can.

Second, when agencies interpret their own regulations -- to, for example, adjudicate whether a regulated party was in compliance with them -- courts accord agencies what is known as Auer or Seminole Rock deference. See Auer v. Robbins, 519 U.S. 452 (1997)("Auer"); Bowles v. Seminole Rock & Sand Co., 325 U.S. 410 (1945)("Seminole Rock"). This deference is applied in the same manner as Chevron deference and is substantively identical. There would be little reason to have a separate name for this doctrine, except that its logical underpinnings are much shakier, and its future is, accordingly, more uncertain. Justice Scalia, after years of applying the doctrine followed by years of questioning its soundness, finally denounced Auer deference in 2013 in his dissent in Decker v. Northwest Environmental Defense Center, 568 U.S. 597 (2013). The Court cannot describe the reasons for Justice Scalia's abandonment of the doctrine better than the Justice himself:

> For decades, and for no good reason, we have been giving agencies the authority to say what their rules mean, under the harmless-sounding banner of "defer[ring] to an agency's interpretation of its own regulations." This is generally called *Seminole Rock* or *Auer* deference.
>
> . . . .

The canonical formulation of *Auer* deference is that we will enforce an agency's interpretation of its own rules unless that interpretation is "plainly erroneous or inconsistent with the regulation." But of course whenever the agency's interpretation of the regulation is different from the fairest reading, it is in that sense "inconsistent" with the regulation. Obviously, that is not enough, or there would be nothing for *Auer* to do. In practice, *Auer* deference is *Chevron* deference applied to regulations rather than statutes. The agency's interpretation will be accepted if, though not the fairest reading of the regulation, it is a plausible reading -- within the scope of the ambiguity that the regulation contains.

Our cases have not put forward a persuasive justification for *Auer* deference. The first case to apply it, *Seminole Rock*, offered no justification whatever -- just the *ipse dixit* that "the administrative interpretation . . . becomes of controlling weight unless it is plainly erroneous or inconsistent with the regulation." Our later cases provide two principal explanations, neither of which has much to be said for it. First, some cases say that the agency, as the drafter of the rule, will have some special insight into its intent when enacting it. The implied premise of this argument -- that what we are looking for is the agency's *intent* in adopting the rule -- is false. There is true of regulations what is true of statutes. As Justice Holmes put it: "[w]e do not inquire what the legislature meant; we ask only what the statute means." Whether governing rules are made by the national legislature or an administrative agency, we are bound *by what they say*, not by the unexpressed intention of those who made them.

The other rationale our cases provide is that the agency possesses special expertise in administering its "'complex and highly technical regulatory program.'" That is true enough, and it leads to the conclusion that agencies and not courts should make regulations. But it has nothing to do with who should interpret regulations -- unless one believes that the purpose of interpretation is to make the regulatory program work in a fashion that the current leadership of the agency deems effective. Making regulatory programs effective is the purpose of *rulemaking*, in which the agency uses its "special expertise" to formulate the best rule. But the purpose of interpretation is to determine the fair meaning of the rule -- to "say what the law is." Not to make policy, but to determine what policy has been made and promulgated by the agency, to which the public owes obedience. Indeed, since the leadership of agencies (and hence the policy preferences of agencies) changes with Presidential administrations, an agency head can only be sure that the application of his "special expertise" to the issue addressed by a regulation *will be given effect* if we adhere to predictable principles of textual interpretation rather than defer to the "special expertise" of his successors. If we take agency enactments as written, the Executive has a stable background against which to write its rules and achieve the policy ends it thinks best.

Another conceivable justification for *Auer* deference, though not one that

is to be found in our cases, is this: If it is reasonable to defer to agencies regarding the meaning of statutes that *Congress* enacted, as we do per *Chevron*, it is *a fortiori* reasonable to defer to them regarding the meaning of *regulations that they themselves crafted*. To give an agency less control over the meaning of its own regulations than it has over the meaning of a congressionally enacted statute seems quite odd.

But it is not odd at all. The theory of *Chevron* (take it or leave it) is that when Congress gives an agency authority to administer a statute, including authority to issue interpretive regulations, it implicitly accords the agency a degree of discretion, which the courts must respect, regarding the meaning of the statute. While the implication of an agency power to clarify the statute is reasonable enough, there is surely no congressional implication that the agency can resolve ambiguities in its own regulations. For that would violate a fundamental principle of separation of powers -- that the power to write a law and the power to interpret it cannot rest in the same hands. "When the legislative and executive powers are united in the same person . . . there can be no liberty; because apprehensions may arise, lest the same monarch or senate should enact tyrannical laws, to execute them in a tyrannical manner." Congress cannot enlarge its *own* power through *Chevron* -- whatever it leaves vague in the statute will be worked out *by someone else*. *Chevron* represents a presumption about who, as between the Executive and the Judiciary, that someone else will be. (The Executive, by the way -- the competing political branch -- is the less congenial repository of the power as far as Congress is concerned.) So Congress's incentive is to speak as clearly as possible on the matters it regards as important.

But when an agency interprets its own rules -- that is something else. Then the power to prescribe is augmented by the power to interpret; and the incentive is to speak vaguely and broadly, so as to retain a "flexibility" that will enable "clarification" with retroactive effect. "It is perfectly understandable" for an agency to "issue vague regulations" if doing so will "maximiz[e] agency power." Combining the power to prescribe with the power to interpret is not a new evil: Blackstone condemned the practice of resolving doubts about "the construction of the Roman laws" by "stat[ing] the case to the emperor in writing, and tak[ing] his opinion upon it." And our Constitution did not mirror the British practice of using the House of Lords as a court of last resort, due in part to the fear that he who has "agency in passing bad laws" might operate in the "same spirit" in their interpretation. *Auer* deference encourages agencies to be "vague in framing regulations, with the plan of issuing 'interpretations' to create the intended new law without observance of notice and comment procedures." *Auer* is not a logical corollary to *Chevron* but a dangerous permission slip for the arrogation of power.

It is true enough that *Auer* deference has the same beneficial pragmatic effect as *Chevron* deference: The country need not endure the uncertainty

> produced by divergent views of numerous district courts and courts of appeals as to what is the fairest reading of the regulation, until a definitive answer is finally provided, years later, by this Court. The agency's view can be relied upon, unless it is, so to speak, beyond the pale. But the duration of the uncertainty produced by a vague regulation need not be as long as the uncertainty produced by a vague statute. For as soon as an interpretation uncongenial to the agency is pronounced by a district court, the agency can begin the process of amending the regulation to make its meaning entirely clear. The circumstances of this case demonstrate the point. While these cases were being briefed before us, EPA issued a rule designed to respond to the Court of Appeals judgment we are reviewing. It did so (by the standards of such things) relatively quickly: The decision below was handed down in May 2011, and in December 2012 the EPA published an amended rule setting forth in unmistakable terms the position it argues here. And there is another respect in which a lack of *Chevron*-type deference has less severe pragmatic consequences for rules than for statutes. In many cases, when an agency believes that its rule permits conduct that the text arguably forbids, it can simply exercise its discretion not to prosecute. That is not possible, of course, when, as here, a party harmed by the violation has standing to compel enforcement.
>
> In any case, however great may be the efficiency gains derived from *Auer* deference, beneficial effect cannot justify a rule that not only has no principled basis but contravenes one of the great rules of separation of powers: He who writes a law must not adjudge its violation.

Decker v. Nw. Envtl. Def. Ctr., 568 U.S. at 616-21 (Scalia, J., dissenting)(alterations and emphasis in original)(citations omitted). Although the Court shares Justice Scalia's concerns about Auer deference, it is, for the time being, the law of the land, and, as a federal district court, the Court must apply it.

Last, courts afford agencies no deference in interpreting the Constitution. See U.S. West, Inc. v. FCC, 182 F.3d 1224, 1231 (10th Cir. 1999)("[A]n unconstitutional interpretation is not entitled to *Chevron* deference. . . . [D]eference to an agency interpretation is inappropriate not only when it is conclusively unconstitutional, but also when it raises serious constitutional questions." (citing, e.g., Rust v. Sullivan, 500 U.S. 173, 190-91 (1991))). Courts have superior competence in interpreting -- and constitutionally vested authority and responsibility to

interpret -- the Constitution's content. The presence of a constitutional claim does not take a court's review outside of the APA, however -- § 706(2)(B) specifically contemplates adjudication of constitutional issues -- and courts must still respect agency fact-finding and the administrative record when reviewing agency action for constitutional infirmities; they just should not defer to the agency on issues of substantive legal interpretation. See, e.g., Robbins v. U.S. Bureau of Land Mgmt., 438 F.3d 1074, 1085 (10th Cir. 2006)("We review Robbins' [constitutional] due process claim against the [agency] under the framework set forth in the APA.").

3. Waiving Sovereign Immunity.

The APA waives sovereign immunity with respect to non-monetary claims. See 5 U.S.C. § 702. The statute provides:

> An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States . . . .

5 U.S.C. § 702. Claims for money damages seek monetary relief "to *substitute* for a suffered loss." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d 1290, 1298 (10th Cir. 2009)(emphasis in original). Claims that do not seek monetary relief or that seek "specific remedies that have the effect of compelling monetary relief" are not claims for monetary damages. Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1298. To determine whether a claim seeks monetary relief, a court must "look beyond the face of the complaint" and assess the plaintiff's prime objective or essential purpose; "[a] plaintiff's prime objective or essential purpose is monetary unless the non-monetary relief sought

has significant prospective effect or considerable value apart from the claim for monetary relief." Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (internal quotation marks omitted)(quoting Burkins v. United States, 112 F.3d 444, 449 (10th Cir. 1997)).

The APA's sovereign immunity waiver for claims "seeking relief other than money damages" does not apply, however, "if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought." 5 U.S.C. § 702. The Tucker Act, 28 U.S.C. §§ 1346, 1491, permits district courts to hear some claims against the United States, but it also states that "district courts shall not have jurisdiction of any civil action or claim against the United States founded upon any express or implied contract with the United States." 28 U.S.C. § 1346(a)(2). It follows that the APA does not waive the United States' sovereign immunity as to contract claims even when those claims seek relief other than money damages, such as declaratory or injunctive relief. See Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1295. Consequently, two questions determine whether the APA waives the United States' sovereign immunity as to a particular claim: "First, does [the] claim seek 'relief other than money damages,' such that the APA's general waiver of sovereign immunity is even implicated? Second, does the Tucker Act expressly or impliedly forbid the relief that [the plaintiff] seeks, such that the APA's waiver does not apply?" Normandy Apartments, Ltd. v. U.S. Dep't of Hous. & Urban Dev., 554 F.3d at 1296 (quoting 5 U.S.C. § 702).

LAW REGARDING ISSUE EXHAUSTION

As a general matter, parties need "to raise their issues before the agency during the administrative process in order to preserve those issues for judicial review." Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin., 429 F.3d 1136, 1148 (D.C. Cir. 2005). There are, essentially, two lines of cases articulating this issue exhaustion requirement.

The first line of cases applies when courts review administrative adjudications, and the second applies when courts review administrative rulemaking.

1. Administrative Adjudication.

Vis-à-vis administrative adjudication, "requirements of administrative issue exhaustion are largely creatures of statute" or regulations, but courts "have imposed an issue-exhaustion requirement even in the absence of a statute or regulation." Sims v. Apfel, 530 U.S. 103, 107-08 (2000)(citing Marine Mammal Conservancy, Inc. v. Dep't of Agric., 134 F.3d 409, 412 (D.C. Cir. 1998)). "The basis for a judicially imposed issue-exhaustion requirement is an analogy to the rule that appellate courts will not consider arguments not raised before trial courts." Sims v. Apfel, 530 U.S. at 108-09. The Supreme Court explained why fairness to administrative-adjudication litigants requires such an analogy:

> Ordinarily an appellate court does not give consideration to issues not raised below. For our procedural scheme contemplates that parties shall come to issue in the trial forum vested with authority to determine questions of fact. This is essential in order that parties may have the opportunity to offer all the evidence they believe relevant to the issues which the trial tribunal is alone competent to decide; it is equally essential in order that litigants may not be surprised on appeal by final decision there of issues upon which they have had no opportunity to introduce evidence. And the basic reasons which support this general principle applicable to trial courts make it equally desirable that parties should have an opportunity to offer evidence on the general issues involved in the less formal proceedings before administrative agencies entrusted with the responsibility of fact finding. Recognition of this general principle has caused this Court to say on a number of occasions that the reviewing court should pass by, without decision, questions which were not urged before the Board of Tax Appeals.

Hormel v. Helvering, 312 U.S. 552, 556 (1941). In a different case, the Supreme Court explained why fairness to the agency itself -- as well as fairness to litigants -- justifies an issue exhaustion requirement:

> We have recognized in more than a few decisions . . . that orderly procedure and good administration require that objections to the proceedings of an

> administrative agency be made while it has opportunity for correction in order to raise issues reviewable by the courts. . . . Simple fairness to those who are engaged in the tasks of administration, and to litigants, requires as a general rule that courts should not topple over administrative decisions unless the administrative body not only has erred but has erred against objection made at the time appropriate under its practice.

United States v. L.A. Tucker Truck Lines, Inc., 344 U.S. 33, 36-37 (1952)(footnote omitted).

The Supreme Court has recognized, however, that the relationship between administrative tribunals and federal courts is not perfectly analogous to the relationship between trial courts and appellate courts. See Sims v. Apfel, 530 U.S. at 109-10. If an administrative adjudication is not similar to a traditional trial, then the reasons for requiring litigants to initially raise issues at trial do not necessarily apply to that adjudication. See Sims v. Apfel, 530 U.S. at 109 ("[T]he desirability of a court imposing a requirement of issue exhaustion depends on the degree to which the analogy to normal adversarial litigation applies in a particular administrative proceeding.").

> Where the parties are expected to develop the issues in an adversarial administrative proceeding, it seems to us that the rationale for requiring issue exhaustion is at its greatest. . . . Where, by contrast, an administrative proceeding is not adversarial, we think the reasons for a court to require issue exhaustion are much weaker.

Sims v. Apfel, 530 U.S. at 110. Cf. Begay v. Pub. Serv. Co. of N.M., 710 F. Supp. 2d 1161, 1191 (D.N.M. 2010)(Browning, J.)(discussing the Supreme Court's recognized exceptions to the exhaustion requirement). Sims v. Apfel's broad language, which refers to administrative proceedings generally, would, if taken literally, expel issue exhaustion from cases where courts review administrative rulemaking, because agency rulemaking is nothing like adversarial litigation. See 5 U.S.C. § 553 (setting out notice-and-comment procedures for agency rulemaking). Courts have not applied that language literally, however, and the distinct line of

cases outlining issue exhaustion vis-à-vis administrative rulemaking remains good law. See Dep't of Transp. v. Public Citizen, 541 U.S. 752, 764 (2004)(applying -- years after Sims v. Apfel -- a judge-made issue exhaustion requirement while reviewing whether an agency's decisionmaking process in a National Environmental Policy Act, 42 U.S.C. §§ 4321 to 4370m-12 ("NEPA"), case); Advocates for Highway & Auto Safety v. Federal Motor Carrier Safety Admin., 429 F.3d 1136, 1148 (D.C. Cir. 2005) (rejecting an argument that, under Sims v. Apfel, "it is inappropriate to apply the general principles of issue waiver to administrative rulemaking"). See also Jeffrey S. Lubbers, Fail to Comment at Your Own Risk: Does Issue Exhaustion Have a Place in Judicial Review of Rules?, 70 Admin. L. Rev. 109, 142-49 (2018) (collecting post-Sims v. Apfel cases, from United States Courts of Appeals, applying issue exhaustion).

2. Administrative Rulemaking.

On the flip side, issue exhaustion vis-à-vis rulemaking through the comment process is largely a judicial, not statutory, imposition. See Lubbers, supra, at 124 (stating he has found only two statutes explicitly requiring issue exhaustion in the rulemaking context -- the Clean Air Act, 42 U.S.C. § 7606(d)(7)(B), and the Securities Act of 1934, 15 U.S.C. § 78y(c)(1) -- yet courts are requiring issue exhaustion in unrelated cases). In Department of Transportation v. Public Citizen, the Supreme Court wrote that "[p]ersons challenging an agency's compliance with NEPA must 'structure their participation so that it . . . alerts the agency to the [parties'] position and contentions,' in order to allow the agency to give the issue meaningful consideration." 541 U.S. at 764 (second alteration in original)(quoting Vermont Yankee Nuclear Power Corp. v. Nat. Res. Def. Council, 435 U.S. 519, 553 (1978)). It then stated that the challengers "forfeited any objection to the [Environmental Assessment ("EA")] on the ground that it failed adequately to discuss potential alternatives to the proposed action," because the

challengers had not raised "these particular objections to the EA" in their comments. Dep't of Transp. v. Public Citizen, 541 U.S. at 764-65. Further, in deciding a challenge to reimbursement rates under Medicare, the United States Court of Appeals for the Ninth Circuit stuck to its precedent that "a party's failure to make an argument before the administrative agency in comments on a proposed rule barred it from raising that argument on judicial review." Universal Health Servs. v. Thompson, 363 F.3d 1013, 1019 (9th Cir. 2004)(citing Exxon Mobil Corp. v. EPA, 217 F.3d 1246, 1249 (9th Cir. 2000)). It also distinguished Sims v. Apfel for "turn[ing] on the unique nature of Social Security benefit proceedings and offer[ing] no guidance relevant to rulemaking." 363 F.3d at 1020.

The Tenth Circuit has also discussed issue exhaustion in the rulemaking context. Where nobody has made their dissatisfaction with a particular issue known through the comment process, "such issue has been waived." N.M. Envtl. Improvement Div. v. Thomas, 789 F.2d 825, 835 (10th Cir. 1986). Courts' "refusal to consider issues not presented to the agency" is sound policy, because courts "may not substitute [their] judgment for that of the agency on matters where the agency has not had an opportunity to make a factual record or apply its expertise." N.M. Envtl. Improvement Div. v. Thomas, 789 F.2d at 835. Thus, it is a "well-settled rule" in this circuit that,

> [u]nless the issue with the proposed action is "so obvious that there is no need for a commentator to point [it] out," or some other extraordinary extenuating circumstance exists, failing to raise an issue during the administrative proceedings precludes a plaintiff from later raising that objection for the first time in court.

Village of Logan v. U.S. Dep't of Interior, 557 F. App'x 760, 769 (10th Cir. 2014)(unpublished)(quoting Dep't of Transp. v. Public Citizen, 541 U.S. at 764-65).

The United States Court of Appeals for the Second Circuit has recognized:

> Two kinds of exhaustion doctrine are currently applied by the courts, and the distinction between them is pivotal. Statutory exhaustion requirements are mandatory, and courts are not free to dispense with them. Common law (or "judicial") exhaustion doctrine, in contrast, recognizes judicial discretion to employ a broad array of exceptions that allow a plaintiff to bring his case in district court despite his abandonment of the administrative review process.

Bastek v. Federal Crop Ins., 145 F.3d 90, 94 (2d Cir. 1998). See also Jarita Mesa Livestock Grazing Ass'n v. U.S. Forest Serv., 140 F. Supp. 3d 1123, 1165 (D.N.M. 2015)(Browning, J.). The courts have thus created some exceptions to waiver. For example, because it is the agency's responsibility to ensure compliance with its enabling statute, when the agency produces and relies on a report with obvious flaws, "there is no need for a commentator to point them out specifically in order to preserve its ability to challenge a proposed action." Dep't of Transp. v. Public Citizen, 541 U.S. at 765. Other courts have recognized a number of limits on the issue exhaustion doctrine in the rulemaking context, such as the "key assumption" rule and where an agency has shown an awareness of the issue. Lubbers, supra, at 149-55.

ANALYSIS

While the Court is not convinced that HHS' Motion satisfies rule 59(e) standards in asking the Court to reconsider its MOO, the Court has reconsidered its ruling. There are a number of problems with HHS' prior position and its current position regarding the risk adjustment program. HHS has flip-flopped between stating that Congress designed the program to be budget neutral and that the program must be budget neutral because of a lack of funding authority. Many of HHS' problems with the Court's MOO start with this change in position. Now that HHS has abandoned its view that the statute compelled budget neutrality, it must come to grips with the reality that it -- not Congress -- made the decision to embrace budget neutrality. Once HHS grips that reality, it must decide what to do following the Court's conclusion that this

decision was arbitrary and capricious. The Court stands by both its initial determination that HHS' risk adjustment formula is arbitrary and capricious and that vacating the formula and remanding to HHS for further consideration is the appropriate remedy. Accordingly, the Court denies the Motion.

I. HHS' DECISION TO USE THE STATEWIDE AVERAGE PREMIUM IN ITS RISK ADJUSTMENT FORMULA -- INSTEAD OF EACH INSURER'S OWN AVERAGE PREMIUM -- WAS ARBITRARY AND CAPRICIOUS.

HHS began to consider how to structure risk adjustment -- and whether to use state average premiums or insurer average premiums when determining risk adjustment transfers -- on July 15, 2011:

> We believe the payments and charges methodology should mitigate the financial impact of adverse selection on risk adjustment covered plans, while limiting overall issuer uncertainty. We have identified two methods that may achieve those goals -- multiplying plan average actuarial risk by the State average normalized premiums and multiplying plan average actuarial risk by the specific premiums collected for each plan. To determine the precise value of payments and charges using State average normalized premiums, plan average premiums are first normalized to the actuarial value of their benefits by dividing each plan's premiums by the plan's actuarial value. . . . .
>
> Next, States would use these normalized average premiums as the basis for the State normalized average premiums, weighted by enrollee months, for all plans in a specific risk pool. . . . Next, the amount by which a plan's average actuarial risk deviates from the state average actuarial risk is calculated. . . .
>
> The alternative methodology uses plan-specific premiums as the basis for calculating the gross plan charges and gross plan payments, assuming that health plan premiums reflect State average actuarial risk and the expectation that risk adjustment accounts for favorable or adverse selection. Under this methodology, the deviation in actuarial risk is multiplied by the aggregated plan premiums to determine the gross plan charges and total plan payments that should be collected from or disbursed to health plans through risk adjustment.

Standard Related to Reinsurance, Risk Corridors and Risk Adjustment, 76 Fed. Reg. 41,930, 41,939 (dated July 15, 2011)(A.R.000011)("Standards"). Two months later, HHS published a more detailed analysis regarding the two alternatives that the Standards set out, i.e., using state

average premiums and using each insurer's average premium. See Risk Adjustment Implementation Issues at 14 (dated September 12, 2011)(A.R.004380)("White Paper")("The [Standards] identified two basic approaches to establish the baseline premium; this section expands discussion."). HHS relied on that analysis when it published its proposed risk adjustment methodology. See HHS Notice of Benefit and Payment Parameters for 2014, 77 Fed. Reg. 73,118, 73,139 (A.R.000134)("2014 Proposed Rule")("In the Risk Adjustment White Paper, we presented several approaches for calculating risk adjustment transfers using the State average premium and plans' own premiums."). The proposed rule used state average premiums in its risk adjustment formula. See 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134). In March 2013, HHS finalized its "proposal to base the payment transfer formula on the State average premium." 2014 Final Rule, 78 Fed. Reg. at 15,432 (A.R.000249).

In the MOO, the Court identified an unexplained gap in HHS' reasoning. Throughout its decision-making process, HHS acted as if risk adjustment charges must equal risk adjustment payments. See 2014 Final Rule, 78 Fed. Reg. at 15,441 (A.R.000258)("The Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers."); 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134)("The approaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero."); White Paper at 15 (A.R.000661)("Since payment and charge transfers will be budget neutral, a method is needed to balance them if payments are greater than charges or vice versa."). HHS never articulated why it acted as if budget neutrality were a risk adjustment requirement, but the Court inferred that HHS believed that the ACA requires budget neutrality from the agency's statement that, "[t]he Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue distribution among issuers." 2014 Final Rule, 78 Fed.

Reg. at 15,441 (A.R.000258). The Court determined, however, that the ACA imposes no such requirement.[19] The Court also considered the possibility that HHS decided to impose a budget-neutrality requirement for public policy reasons, but the Court could find no indication that HHS actually made such a decision. Consequently, the Court concluded that HHS did not adequately explain its decision to employ state average premiums in its risk adjustment formula instead of using each insurer's own premium.

HHS now launches a three-pronged attack on the Court's conclusion. First, HHS argues that, "under black-letter principles of administrative law, HHS was not required to explain -- and NMHC was largely foreclosed from challenging -- HHS's budget-neutral approach to the risk adjustment program, because at no point during the 2014-2017 rulemakings did NMHC or any other commenter challenge or question that approach." Motion at 2. Second, HHS contends that "Congress's failure to appropriate additional funds for risk-adjustment payments" means risk adjustment charges were the only funds available for risk adjustment payments, so "HHS's budget-neutral approach was not a discretionary policy choice." Motion at 2-3. Third, HHS avers that, "even if HHS had possessed the requisite budget authority to implement the program in a manner that was not budget neutral . . . any decision about whether to exercise that authority would not have been subject to judicial review." Motion at 3. Each of those prongs fails, however.

[19]HHS does not challenge the Court's determination that the ACA neither requires nor forbids risk adjustment to be operated budget neutrally, see MOO at 60, 312 F. Supp. 3d at 1206; in fact, HHS' litigation position is that it "has never contended that the text of section 1342 [codified at 42 U.S.C. § 18063] requires the program to be budget neutral," just that it was "designed" that way, Motion at 12.

A. THE WAIVER RULE DOES NOT FORECLOSE HEALTH CONNECTIONS' CHALLENGE TO HHS' DECISION.

"One of the basic procedural requirements of administrative rulemaking is that an agency must give adequate reasons for its decisions." Encino Motorcars, LLC v. Navarro, 136 S. Ct. 2117, 2125 (2016). Administrative agencies "must examine the relevant data and articulate a satisfactory explanation for its action including a 'rational connection between the facts found and the choice made.'" Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. 29, 43 (1983)(quoting Burlington Truck Lines, Inc. v. United States, 371 U.S. 156, 168 (1962)).

> Normally, an agency rule would be arbitrary and capricious if the agency has relied on factors which Congress has not intended it to consider, entirely failed to consider an important aspect of the problem, offered an explanation for its decision that runs counter to the evidence before the agency, or is so implausible that it could not be ascribed to a difference in view or the product of agency expertise. The reviewing court should not attempt itself to make up for such deficiencies . . . .

Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. at 43. "[A] reviewing court may not set aside an agency rule that is rational, based on consideration of the relevant factors and within the scope of the authority delegated to the agency by the statute." Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. at 42.

The scope of an agency's obligation to explain -- vis-à-vis informal rulemaking -- depends, in part, on the notice and comment process. The agency must publish its proposed rule in the Federal Register, see 5 U.S.C. § 553(b), and "give interested persons an opportunity to participate in the rule making through submission of written data, views, or arguments." 5 U.S.C. § 553(c). The agency must then "consider[] the relevant matter presented" and "incorporate in the rules adopted a concise general statement of their basis and purpose." 5 U.S.C. § 553(c). While "a reviewing court may not set aside an agency rule that is rational,

based on consideration of the relevant factors and within the scope of the authority delegated to the agency by the statute," Motor Vehicle Mfs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. at 42, "[a]n agency's failure to respond to relevant and significant public comments generally 'demonstrates that the agency's decision was not based on a consideration of the relevant factors,'" Lilliputian Sys., Inc. v. Pipeline & Hazardous Materials Safety Admin, 741 F.3d 1309, 1312 (D.C. Cir. 2014). Thus, agencies act arbitrarily and capriciously when they fail to respond to a comment raising a significant problem with a proposed rule.

If no commenter raises a potential problem, however, then the agency has no duty to address that problem or to "respond" to a non-existent comment. See Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin., 429 F.3d 1136, 1150 (D.C. Cir. 2005)("[A] party will normally forfeit an opportunity to challenge an agency rulemaking on a ground that was not first presented to the agency for its initial consideration."). See also Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. at 51 ("Nor do we broadly require an agency to consider all policy alternatives in reaching decision."). The Tenth Circuit has applied this rule:

> The EPA solicited comments on the very issue that [the plaintiff, EID,] now protests. Neither EID nor anyone else advanced any dissatisfaction to the EPA through comments and documents in the record. Under these circumstances, we hold that such issue has been waived. If EID wished that the EPA consider a different formula which required EPA to study other information, it had a responsibility to place such information in the record.
>
> EID was obligated to make its record before the agency. It failed to do so. Thus, we decline to consider any inferences which EID urges upon us for the first time on appeal.

N.M. Envtl. Improvement Div. v. Thomas, 789 F.2d at 835. Judicial restraint is one rationale for this waiver rule, i.e., "the courts are not authorized to second-guess agency rulemaking

decisions; rather, the role of the court is to determine whether the agency's decision is arbitrary and capricious for want of reasoned decisionmaking." Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin., 429 F.3d at 1150. Another rationale is that it would be unfair to overturn an administrative decision unless the agency had a chance to consider the issue, i.e., unless the agency "has erred against objection made at the appropriate time under its practice." Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin., 429 F.3d at 1150 (internal quotation marks omitted)(quoting United States v. L.A. Tucker Trucker Lines, 344 U.S. at 37). The Court refers to this rule as an issue exhaustion requirement. See Jarita Mesa Livestock Grazing Ass'n v. U.S. Forest Serv., 61 F. Supp. 3d 1013, 1064 (D.N.M. 2014)(Browning, J.)("[T]he Court finds that the Plaintiffs did not satisfy the issue-exhaustion requirement in the proceedings before the Forest Service, because they did not specifically raise their First Amendment retaliation issue in a way that the Forest Service could be expected to understand and respond to it.").

The waiver rule does not apply, however, when an agency, for whatever reason, considers a potential issue. See Garcia-Carbajal v. Holder, 625 F.3d 1233, 1238 (10th Cir. 2010)(Gorsuch, J.)("If the BIA decides an argument is worth *sua sponte* taking up and issuing a final agency decision on, thereby exhausting all available agency processes to hear and resolve that argument, we will not stand in its way."); NRDC v. EPA, 824 F.2d 1146, 1151 (D.C. Cir. 1987)(en banc)("This court has excused the exhaustion requirements for a particular issue when the agency has in fact considered the issue."). If an agency addresses an issue -- even if the agency does so on its own initiative -- then an administrative record exists for a court to review; likewise, when an agency addresses an issue sua sponte, then the agency had a fair opportunity to consider the issue. For example, the en banc United States Court of Appeals for the District of

Columbia Circuit permitted the Natural Resource Defense Council ("NRDC"), which "did not participate in the rulemaking proceedings," to challenge an EPA rule, because the EPA's notice of proposed rulemaking made it "clear that the EPA actually did consider the issue raised by the NRDC." NRDC v. EPA, 824 F.2d at 1250-51.

HHS considered whether to use each insurer's average premium instead of state average premiums when calculating risk adjustment transfers. See Standards, 76 Fed. Reg. at 41,939 (A.R.000011). HHS sets out its reasoning in the 2014 Proposed Rule:

> In the Risk Adjustment White Paper, we presented several approaches for calculating risk adjustment transfers using the State average premium and plans' own premiums. The approaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero. These examples also demonstrated that the balancing adjustments could introduce differences in premiums across plans that were not consistent with features of the plan . . . . A balancing adjustment would likely vary from year to year, and could add uncertainty to the rate development process . . . .
>
> Therefore, we propose a payment transfer formula that is based on the State average premium for the applicable market, as described in section III.B.3.a. of this proposed rule. The State average premium provides a straightforward and predictable benchmark for estimating transfers. As shown in the examples in the Risk Adjustment White Paper, transfers net to zero when the State average premium is used as the basis for calculating transfers.

2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134). It was, accordingly, appropriate for the Court, in its MOO, to review whether HHS' reasoning underlying that decision passes muster under the APA. See Advocates for Highway & Auto Safety v. Fed. Motor Carrier Safety Admin., 429 F.3d at 1150 ("[T]he courts are not authorized to second-guess agency rulemaking decisions; rather, the role of the court is to determine whether the agency's decision is arbitrary and capricious for want of reasoned decisionmaking.").

HHS argues, on the contrary, that "the Court's holding is based on a claim . . . that HHS's budget-neutral approach was independently arbitrary and capricious for lack of a satisfactory explanation for the basis of that approach." Motion at 11. That characterization of the MOO is not accurate, because the Court considered budget neutrality only insofar as HHS implicitly used budget neutrality to justify its decision to base its risk adjustment formula on statewide average premiums. See MOO at 67, 312 F. Supp. 3d at 1209 ("That HHS erroneously reads the ACA's risk adjustment provisions to require risk adjustment payments equal risk adjustment charges infects its analysis of the relative merits of using a state's average premium when calculating risk adjustment transfers instead of using a plan's own premium."). Specifically, HHS justified its decision to structure its risk adjustment formula using statewide average premiums by identifying problems that an alternative formula using each insurer's average premium would produce. See 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (A.R.000134)("[A]pproaches that used plans' own premiums resulted in unbalanced payment transfers, requiring a balancing adjustment to yield transfers that net to zero."); 2014 Proposed Rule, 77 Fed. Reg. at 73,139 (identifying problems that a balancing adjustment would produce). The Court recognized that those problems arise only if risk adjustment payments must equal risk adjustment transfers, so HHS' reasoning implicitly assumes that risk adjustment must be budget neutral. See MOO at 67, 312 F. Supp. 3d at 1209 (recognizing that, if risk adjustment does not need to be budget neutral, then "HHS' risk adjustment methodology could use a plan's own premium instead of a state's average premium without imposing a balancing adjustment," in which case, "the problems that HHS identifies with imposing a balancing adjustment . . . do not justify HHS' aversion to using a plan's own premium to calculate risk adjustment transfers").

In an effort to discern HHS' analytical path, the Court considered the possibility that HHS' budget-neutrality assumption reflects a conscious decision on the agency's part to structure risk adjustment in a budget neutral way. See MOO at 66-68, 312 F. Supp. 3d at 1209. See also Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2125 (stating that an agency's obligation to explain its decisions "is satisfied when the agency's explanation is clear enough that its 'path may reasonably be discerned.'" (quoting Bowman Transp., Inc. v. Ark.-Best Freight Sys., Inc., 419 U.S. 281, 286 (1974))); In re FCC 11-161, 753 F.3d 1015, 1115 (10th Cir. 2014)(permitting courts to rely on an agency's implicitly adopted rationales when reviewing agency action, if they reflect a "fair and considered judgment" (internal quotation marks omitted)(quoting S. Utah Wilderness All. v. Office of Surface Mining Reclamation & Enf't, 620 F.3d 1227, 1236 (10th Cir. 2010))). The Court ruled out that possibility, because the administrative record indicates that HHS did not actually make such a decision. See MOO at 69, 312 F. Supp. 3d at 1210 ("That HHS, in designing its risk adjustment methodology, never considered whether budget neutrality was sound public policy means that HHS cannot now appeal to budget neutrality's public policy benefits to justify its decision."). See also Encino Motorcars, LLC v. Navarro, 136 S. Ct. at 2127 ("It is not the role of the courts to speculate on reasons that might have supported an agency's decision."). The administrative record indicates instead that HHS believed that the ACA requires risk adjustment and that "HHS' only decision" -- vis-à-vis budget neutrality -- was "to comply with a supposed statutory requirement." MOO at 68, 312 F. Supp. 3d at 1210. See 2014 Final Rule, 78 Fed. Reg. at 15,441 (A.R.000258)("The Affordable Care Act risk adjustment program is designed to be a budget-neutral revenue redistribution among issuers."). Because the ACA is unambiguous insofar as it imposes no such requirement, see MOO at 62-63, 312 F. Supp. 3d at 1207, the Court concluded that HHS did not

sufficiently explain its reasons for using statewide average premiums in its risk adjustment formula by articulating a rational connection between the facts it found and the choice the agency made, see MOO at 70-71, 312 F. Supp. 3d at 1211-21.

B. HHS WAS FREE TO ADOPT A RISK ADJUSTMENT FORMULA THAT DID NOT, AS A MATTER OF MATHEMATICS, GUARANTEE BUDGET NEUTRALITY.

HHS argues that "binding principles of constitutional and appropriations law . . . mandated budget neutrality in light of Congress's failure to appropriate additional funds." Motion at 13. It follows, according to HHS, that the agency's assumption that risk adjustment payments must equal risk adjustment charges was valid, so the agency's decision to base its risk adjustment formula on state average premiums -- which relied on that assumption -- was not arbitrary and capricious.[20] The keystone of HHS' appropriations argument is the agency's

[20]HHS cannot use an appeal to appropriations law to justify the structure of its risk adjustment formula vis-à-vis the 2014-2017 benefits years, because the administrative record contains no indication that HHS actually employed this line of reasoning when adopting the risk adjustment formula for those years. See Burlington Truck Lines, Inc. v. United States, 371 U.S. at 168-69 ("The courts may not accept appellate counsel's *post hoc* rationalizations for agency action; [SEC v. Chenery Corp., 332 U.S. 194 (1947)] requires that an agency's discretionary order be upheld, if at all, on the same basis articulated in the order by the agency itself . . . ."). See also Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 213 (1988)("Deference to what appears to be nothing more than an agency's convenient litigating position would be entirely inappropriate."); Inv. Co. Inst. v. Camp, 401 U.S. 617, 628 (1971)("Congress has delegated to the administrative official and not to appellate counsel the responsibility for elaborating and enforcing statutory commands.").

Nevertheless, the Court must grapple with the substance of HHS' appropriations argument for two reasons. First, the 2018 Final Rule contains an oblique reference to HHS' appropriations constraints, which the Court reads as a terse presentation of the Motion's appropriations argument:

> A few commenters noted that the budget neutrality of the risk adjustment program leads to inadequate compensation for enrollees' risk and recommended a non-budget neutral risk adjustment program as with Medicare Advantage. . . .
>
> Response: In the absence of additional funding for the HHS-operated risk

assertion that -- because HHS cannot compel the states to subsidize risk adjustment, and no congressional appropriation for risk adjustment exists -- risk adjustment charges are the only available funding source for risk adjustment payments. See Motion at 15 ("HHS could not -- absent another source of appropriations -- have designed the risk adjustment program in a way that required payments in excess of collections consistent with binding appropriations law.").

That keystone assertion is false. The ACA contemplates risk adjustment as a state-run program, see 42 U.S.C. § 18063(a) (directing states to "assess" risk adjustment charges and to "provide" risk adjustment payments), so the ACA does not appropriate any federal funds for that state-run program. The ACA assigns risk adjustment responsibilities to HHS only if a state fails to establish an Exchange or does not take the actions the HHS Secretary determines necessary to implement risk adjustment. See 42 U.S.C. § 18041(c). When HHS implements risk adjustment, the ACA authorizes it to "take such actions as are necessary" for that purpose, 42 U.S.C.

> adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner and note that Medicare Part D risk adjustment transfers are also calculated in a budget neutral manner.

2018 Final Rule, 81 Fed. Reg. at 94,101 (A.R.009638). See Bowman Transp., Inc. v. Ark.-Best Freight Sys., Inc., 419 U.S. at 286 (requiring courts to "uphold a decision of less than ideal clarity if the agency's path may reasonably be discerned"). Second, even though the administrative record contains no indication that HHS considered appropriations law when crafting its risk adjustment formula for 2014-2017, the agency argues that, "given the constitutional and budgetary constraints limiting HHS's discretion, the agency's failure to explain its approach . . . was harmless." Motion at 18 n.8. See 5 U.S.C. § 706(2) (admonishing courts reviewing administrative decisions that "due account shall be taken of the rule of prejudicial error"). According to HHS, Congress' failure to appropriate money for risk adjustment prevented the agency from adopting a non-budget-neutral risk adjustment formula, so failing to consider such formulae could not have affected the outcome, i.e., it was harmless error. See Motion at 18 n.8; Tr. at 34:7-10 (Powers)("I think that our main point is that if that was an error, the failure to consider those alternatives, or discuss those issues, that was an error that's harmless."). See also PDK Labs. Inc. v. U.S. Drug Enf't Admin., 362 F.3d 786, 799 (D.C. Cir. 2004)("In administrative law, as in federal civil and criminal litigation, there is a harmless error rule . . . . If the agency's mistake did not affect the outcome, if it did not prejudice the petitioner, it would be senseless to vacate and remand for reconsideration.").

§ 18041(c)(1), but that authorization is not an appropriation, so it does not permit HHS to spend any federal money -- including the risk adjustment charges that HHS collects -- on risk adjustment payments, see U.S. Const. art. I, § 9, cl. 7 ("No money shall be drawn from the Treasury, but in Consequence of Appropriations made by Law . . . ."); 31 U.S.C. § 1301(d) ("A law may be construed to make an appropriation out of the Treasury . . . only if the law specifically states that an appropriation is made . . . ."). See also Government Accountability Office, Principles of Federal Appropriations Law 2-23 (4th ed. 2016)("GAO Redbook")("Though the making of an appropriation must be expressly stated, a statute need not use the word 'appropriation.' If the statute contains a specific direction to pay and a designation of the funds to be used . . . then this amounts to an appropriation.").[21]

Instead, HHS must rely on the CMS program management appropriation to fund risk adjustment payments when HHS implements risk adjustment on behalf of the states.[22] That

[21]The GAO publishes the GAO Redbook, which is a treatise on federal fiscal law. The GAO advises other agencies, such as HHS, on federal appropriations law. See Appropriations Law, GAO: U.S. GOV'T ACCOUNTABILITY OFF., https://www.gao.gov/legal/appropriations-law-decisions (last visited Oct. 10, 2018).

[22]HHS is correct that, even though it operates risk adjustment on behalf of the states, anti-commandeering principles prevent the agency from requiring the states to subsidize risk adjustment. See Hodel v. Va. Mining & Reclamation Ass'n, Inc., 452 U.S. 264, 288 (1981)(concluding that a regulatory scheme that permitted -- but did not require -- states to implement federal standards was permissible, because "the States are not compelled to enforce the . . . standards, to expend any state funds, or to participate in the federal regulatory program in any manner whatsoever"). Because HHS cannot pry open the coffers of state governments, HHS must operate risk adjustment with federal funds exclusively.

It is not true, however, that HHS' inability to force states to spend money on risk adjustment requires HHS' risk adjustment methodology to be budget neutral. See Reply at 9 (asserting that a non-budget neutral risk adjustment methodology would be unconstitutional, because HHS cannot require states to fund risk adjustment and the ACA tasks HHS with crafting a risk adjustment methodology "that could be used by states to administer their own risk adjustment programs"). The ACA directs HHS to establish "criteria and methods" for risk adjustment, 42 U.S.C. § 18063(b), "which a State may either implement itself or yield to a

appropriation provides a fixed dollar amount, i.e., a $3,669,744,000 lump sum, to CMS "[f]or carrying out" enumerated statutory provisions as well as CMS' "other responsibilities," and it supplements that fixed dollar amount with "such sums as may be collected from authorized user fees." Consolidated and Further Continuing Appropriations Act, 2015, Pub. L. No. 113-235, 128 Stat. 2130, 2477-78 (2014)(appropriating money for fiscal year 2015)("Program Management Appropriation").[23] Because HHS delegated to CMS its responsibility, under 42 U.S.C. § 18041(c)(1), to implement risk adjustment programs on behalf of states that fail to do so for themselves -- which is to say, all of them, see supra at 5-6 -- making risk adjustment payments is one of CMS' responsibilities. See Delegation of Authorities, 76 Fed. Reg. 53,903, 53,903-04 (dated Aug. 30, 2011). CMS can, thus, spend its program management funds -- including both CMS' lump sum and the user fees it collects, e.g., risk adjustment charges -- to make risk

federally administered program," Hodel v. Va. Mining & Reclamation Ass'n, Inc., 452 U.S. at 289. See 42 U.S.C. § 18041(c) (directing HHS to implement risk adjustment for states that elect not to do so for themselves). Because states can choose not to implement risk adjustment, in which case "the full regulatory burden will be borne by the Federal Government," non-budget neutral risk adjustment regulations would not compel states to spend their own funds on risk adjustment. Hodel v. Va. Mining & Reclamation Ass'n, Inc., 452 U.S. at 288. Risk adjustment is, thus, "a program of cooperative federalism that allows the States, within limits established by federal minimum standards, to enact and administer their own regulatory programs, structured to meet their own particular needs." Hodel v. Va. Mining & Reclamation Ass'n, Inc., 452 U.S. at 289.

[23]Public Law 113-235 contains CMS' program management appropriation for the 2015 fiscal year -- during which HHS collected risk adjustment charges and made risk adjustment payments for the 2014 benefits year -- but Congress made program management appropriations for the 2016-2018 fiscal years that are identical in all relevant respects, including the funding amount. See Consolidated Appropriations Act, Pub. L. No. 115-141, 132 Stat. 348, 726-27 (2018)(appropriating money for fiscal year 2018); Consolidated Appropriations Act, Pub. L. No. 115-31, 131 Stat. 135, 530 (2017)(appropriating money for fiscal year 2017); Consolidated Appropriations Act, Pub. L. No. 114-113, 129 Stat. 2242, 2611 (2015)(appropriating money for fiscal year 2016).

adjustment payments. See 31 U.S.C. § 1301(a) ("Appropriations shall be applied only to the objects for which the appropriations were made except as otherwise provided by law.").

No federal agency or court has addressed whether the $3,669,744,000 lump sum portion of CMS' program management appropriation can fund risk adjustment, but authorities analyzing whether that appropriation can fund an analogous premium stabilization program -- the risk corridors program -- confirm the Court's conclusion regarding risk adjustment. The ACA directs HHS to "establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016." 42 U.S.C. § 18062(a). As part of that risk corridors program, HHS collects money from insurers with low costs and makes payments to insurers with high costs. See 42 U.S.C. § 18062(b).

On February 7, 2014, then-Senator Jeff Sessions requested an opinion from the GAO "regarding the availability of appropriations to make payments to qualified health plans pursuant to . . . 42 U.S.C. § 18062," i.e., risk corridors payments. Dep't of Health & Human Servs.-Risk Corridors Program, B-325630, 2014 WL 4825237, at *1 (Comp. Gen. Sept. 30, 2014)("GAO Report"). The GAO Report provides that opinion, and it concludes: (i) making risk corridors payments is one of CMS' "other responsibilities"; (ii) CMS can use the lump sum portion of its program management appropriation on risk corridors payments; and (iii) CMS can use risk corridors charges to fund risk corridors payments, because those charges are "sums as may be collected from authorized user fees." GAO Report, 2014 WL 4825237, at *3 (internal quotation marks omitted)(quoting Consolidated Appropriations Act, 2014, Pub. L. No. 113-76, 128 Stat. 5, 374 (2014)). Thus, the GAO Report implicitly rejects HHS' argument that its "underlying budget requests reflect [that] the Program Management lump sum is for *program management expenses*, such as administrative costs . . . not for program payments themselves." Motion at 16

(emphasis in original).[24] The GAO Report, as an opinion letter, does not receive Chevron deference, see Christensen v. Harris Cty., 529 U.S. 576, 587 (2000), but it is still entitled to respect as "a body of experience and informed judgment to which courts and litigants may properly resort for guidance," Skidmore v. Swift & Co., 323 U.S. 134, 140 (1944). See Moda, 892 F.3d at 1326 (considering the GAO report and concluding that "GAO's opinion was correct").

The Federal Circuit's decision in Moda also supports the Court's conclusion that the Program Management Appropriation is available for risk adjustment payments. According to the Federal Circuit, the GAO Report accurately identifies the two possible funding sources for risk corridors payment -- the user fees that CMS collects, e.g., risk corridors charges, and the

[24]Additionally, the GAO Redbook explicitly rejects the notion that HHS' underlying budget requests restrict the Program Management Appropriation's permissible uses:

> How much flexibility does an agency have in spending a lump-sum appropriation? Is it legally bound by its original budget estimate or by expressions of intent in legislative history? How is the agency's legitimate need for administrative flexibility balanced against the constitutional role of the Congress as controller of the public purse?
>
> . . . .
>
> The answer to these questions is one of the most important principles of appropriations law. The rule, simply stated, is this: Restrictions on a lump-sum appropriation contained in the agency's budget request or in legislative history are not legally binding on the department or agency unless they are carried into (specified in) the appropriation act itself, or unless some other statute restricts the agency's spending flexibility. This is an application of the fundamental principle of statutory construction that legislative history is not law and carries no legal significance unless "anchored in the text of the statute." *Shannon v. United States*, 512 U.S. 573, 583 (1994). Of course, the agency cannot exceed the total amount of the lump-sum appropriation, and its spending must not violate other applicable statutory restrictions. The rule applies equally whether the legislative history is mere acquiescence in the agency's budget request or an affirmative expression of intent.

GAO Redbook at 6-6 to 6-7 (3d ed. 2006)(footnotes omitted).

$3,669,744,000 lump sum portion of the Program Management Appropriation, see Moda, 892 F.3d at 1326, but subsequently adopted appropriations riders to prevent the lump sum from funding risk corridors payments, see Moda, 892 F.3d at 1319. The Federal Circuit concludes that those riders evince a congressional intent to cap the United States' liability for risk corridors payments so that those payments would never exceed the risk corridors charges that the United States collects, i.e., the appropriations riders impose a de facto budget neutrality requirement. See Moda, 892 F.3d at 1325-26. Those riders refer to risk corridors payments only, Moda, 892 F.3d at 1319, so they do not apply to risk adjustment payments; it follows that the lump sum portion of the Program Management Appropriation can fund those payments and no de facto budget neutrality requirement applies to them.

HHS tries to distinguish Moda by observing that the Anti-Deficiency Act restrains the agency's ability to design its risk adjustment formula in a way that is not budget neutral, whereas Congress faced no such restriction when it enacted the risk corridors formula. See Notice Response at 1-2. Whether the Anti-Deficiency Act applies, however, is irrelevant to whether the lump sum portion of the Program Management Appropriation is available for risk adjustment payments. The Anti-Deficiency Act prevents "[a]n officer or employee of the United States Government" from incurring obligations "exceeding an amount available in an appropriation" or "before an appropriation is made"; it says nothing about whether particular funds are available for a particular purpose. 31 U.S.C. § 1341(a)(1). Thus, while HHS' observation is accurate -- Congress is not an officer or employee of the United States -- it does not successfully distinguish Moda; the Anti-Deficiency Act restricts agency action absent an available appropriation, but it is silent on whether a particular appropriation is available for a particular purpose. Consequently, the Federal Circuit's and the GAO's analysis concluding that the lump sum portion of the

Program Management Appropriation is available for risk corridors payments applies equally to risk adjustment payments. That this lump sum is available for risk adjustment payments means that HHS could have adopted a risk adjustment formula where risk adjustment payments might exceed risk adjustment charges.

C. WHETHER TO USE STATEWIDE AVERAGE PREMIUMS IN ITS RISK ADJUSTMENT FORMULA IS NOT A DECISION COMMITTED SOLELY TO HHS' DISCRETION.

HHS argues that, even if it "had the authority to design the risk adjustment program in a non-budget neutral matter, its decision not to exercise that authority would be committed to agency discretion as a matter of law and thus exempted from judicial review." Motion at 19. HHS is correct that courts cannot substantively review an agency's choices regarding how to spend lump sum appropriations. See Lincoln v. Vigil, 508 U.S. 182, 192 (1993)("The allocation of funds from a lump-sum appropriation is another administrative decision traditionally regarded as committed to agency discretion."); Lincoln v. Vigil, 508 U.S. at 193 ("[A]s long as the agency allocates funds from a lump-sum appropriation to meet permissible statutory objectives, § 701(a)(2) gives the courts no leave to intrude."). "[E]ven where Congress has not affirmatively precluded review, review is not to be had if the statute is drawn so that a court would have no meaningful standard against which to judge the agency's exercise of discretion." Heckler v. Chaney, 470 U.S. 821, 830 (1985). That a court cannot evaluate the substance of an agency decision does not mean, however, that courts cannot evaluate whether the agency followed appropriate procedures in reaching that decision. See Lincoln v. Vigil, 508 U.S. at 190, 195 (analyzing "whether it was error for the Court of Appeals to hold the substance of the Service's decision to terminate the Program reviewable under the APA" separately from whether "the

Court of Appeals's holding, . . . that before terminating the Program the Service was required to abide by the familiar notice-and-comment rulemaking provisions of the APA," was erroneous).

The Court does not agree with HHS' argument, for two distinct reasons. First, in its MOO, the Court reviews HHS' decision to use statewide average premiums rather than each insurer's own average premium in the agency's risk adjustment formula, and not a decision to spend the lump sum portion of the Program Management Appropriation on other priorities. See MOO at 67, 312 F. Supp. 3d at 1209 (reviewing HHS' "analysis of the relative merits of using a state's average premium when calculating risk adjustment transfers instead of using a plan's own premium"). Far from reviewing an agency decision regarding budget priorities, the Court concluded that HHS made no such decision when crafting its risk adjustment formula. See MOO at 68, 312 F. Supp. 3d at 1210 ("HHS never articulates any public policy decision to operate risk adjustment in a budget neutral way; HHS' only decision is to comply with a supposed statutory requirement."). Second, the Court does not, in its MOO, take issue with the substance of HHS' decision; instead, it concludes that HHS fails to satisfactorily explain its decision's rationale. See MOO at 70, 312 F. Supp. 3d at 1211 ("HHS offers, in its briefing, sound policy reasons for using the statewide average premium instead of the issuer's own premium . . . the agency does not, however articulate those reasons in the [administrative] record."). Hence, the Court does not -- in concluding that HHS acted arbitrarily and capriciously -- violate the APA by reviewing an action that is "committed to agency discretion by law." 5 U.S.C. § 701(a)(2).

II. VACATUR IS THE APPROPRIATE REMEDY.

According to the Tenth Circuit, when a Court concludes that an agency action is arbitrary and capricious, "[v]acatur of agency action is a common, and often appropriate form of injunctive relief granted by district courts." WildEarth Guardians v. U.S. Bureau of Land

Mgmt., 870 F.3d at 1239. WildEarth Guardians v. United States Bureau of Land Management does not cite any authority for that proposition. See 840 F.3d at 1239. The Tenth Circuit's assertion that vacatur is a form of injunctive relief implies that the traditional standard for injunctive relief applies to vacatur under the APA:

> According to well-established principles of equity, a plaintiff seeking a permanent injunction must satisfy a four-factor test before a court may grant such relief. A plaintiff must demonstrate: (1) that it has suffered an irreparable injury; (2) that remedies available at law, such as monetary damages, are inadequate to compensate for that injury; (3) that, considering the balance of hardships between the plaintiff and defendant, a remedy in equity is warranted; and (4) that the public interest would not be disserved by a permanent injunction.

eBay Inc. v. MercExchange, L.L.C., 547 U.S. 388, 391 (2006).

The Tenth Circuit has not, however, performed the traditional four-factor inquiry when vacating agency action -- or ordering a district court to vacate agency action on remand -- under the APA, which suggests that the Tenth Circuit does not fully treat vacatur as injunctive relief. See, e.g., Utah Envtl. Cong. v. Bosworth, 439 F.3d 1184, 1195 (10th Cir. 2006)(concluding that the United States Forestry Service acted arbitrarily and capriciously for failing to comply with the Endangered Species Act, 16 U.S.C. §§ 1531-44, and vacating the agency's action without any further analysis). See also WildEarth Guardians v. U.S. Bureau of Land Mgmt., 870 F.3d at 1239-40 (treating Utah Envtl. Cong. v. Bosworth and similar cases as good law). Further, the APA's text indicates that vacatur is the mandatory remedy for arbitrary and capricious agency action, which is at odds with the Tenth Circuit's statement that vacatur is a form of injunctive relief. See 5 U.S.C. § 706 ("The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusion found to be . . . arbitrary, capricious, an abuse of discretion, or

otherwise not in accordance with law . . . .").[25] See also Murphy v. Smith, 138 S. Ct. 784, 787 (2018)(Gorsuch, J.)("[T]he word 'shall' usually creates a mandate, not a liberty, so the verb phrase 'shall be applied' tells us that the district court has some nondiscretionary duty to perform." (quoting 42 U.S.C. § 1997e(d)(2))); Lexecon Inc. v. Milberg Weiss Bershad Hynes & Lerach, 523 U.S. 26, 35 (1998)("The Panel's instruction comes in terms of the mandatory 'shall,' which normally creates an obligation impervious to judicial discretion."). Likewise, Supreme Court precedent indicates that vacatur and injunctions are distinct types of relief:

> An injunction is a drastic and extraordinary remedy, which should not be granted as a matter of course. If a less drastic remedy (such as partial or complete vacatur of [the agency's] deregulation decision) was sufficient to redress respondents' injury, no recourse to the additional and extraordinary relief of an injunction was warranted.

Monsanto Co. v. Geertson Seed Farms, 561 U.S. 139, 165-66 (2010). Consequently, the Court concludes that WildEarth Guardians v. United States Bureau of Land Management indicates that

[25]On a clean slate, the Court would rely on the plain language, and not consider remand without vacatur. See Park 'N Fly, Inc. v. Dollar Park & Fly, Inc., 469 U.S. 189, 194 (1985)("Statutory construction must begin with the language employed by Congress and the assumption that the ordinary meaning of that language accurately expresses the legislative purpose."). Wandering into the equities of vacatur is not what the APA has directed the courts to consider or what Congress dictated. See 5 U.S.C. § 706(2)(A); Diné Citizens Against Ruining Our Env't v. Jewell, 312 F. Supp. 3d 1031, 1110 (D.N.M. 2018)(Browning, J.)(discussing how "the presumption is in favor of vacatur instead of remand without vacatur" and that the "statute's mandatory language supports that proposition"); Brian S. Prestes, Remanding Without Vacating Agency Action, 32 Seton Hall L. Rev. 108, 129-50 (2001)(discussing the legal arguments for and against remand without vacatur, and concluding the strongest argument is that against remand without vacatur as a remedy under the APA). See also, e.g., Kristin E. Hickman & Mark Thomson, Open Minds and Harmless Errors: Judicial Review of Postpromulgation Notice and Comment, 101 Cornell L. Rev. 261, 304-05 (2016)(discussing some issues with remand without vacatur as a remedy); Daniel B. Rodriguez, Of Gift Horses and Great Expectations: Remand Without Vacatur in Administrative Law, 36 Ariz. St. L.J. 599, 601 (2004)(discussing how remand without vacatur is used "to temper the draconian impact of hard look review," but that it "should be disfavored precisely because it facilitates the use of more aggressive judicial scrutiny of agencies' reasoning process"). Given that the Tenth Circuit has endorsed the idea of remand without vacatur, the Court will consider fully HHS' request.

vacatur under the APA is a form of discretionary relief akin to an injunction even though vacatur is not, strictly speaking, a form of injunctive relief. Vacatur is a form of "equitable relief," however, and so, upon a "balance [of] the equities," vacatur may not be appropriate in all cases. Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs, 781 F.3d 1271, 1290 (11th Cir. 2015). See Rio Grande Silvery Minnow v. Bureau of Reclamation, 601 F.3d 1096, 1139 (10th Cir. 2010)("Vacatur is an equitable remedy, indeed an 'extraordinary' one, and the decision whether to grant vacatur is entrusted to the district court's discretion." (citing U.S. Bancorp Mortg. Co. v. Bonner Mall P'ship, 513 U.S. 18, 26 (1994)); Diné Citizens Against Ruining Our Env't v. U.S. Office of Surface Mining Reclamation & Enf't, No. 12-cv-01275-JLK, 2015 WL 1593995, at *1 (D. Colo. April 6, 2016)(Kane, J.)("[C]ourts retain equitable discretion to fashion an appropriate remedy, and in some cases equitable principles counsel in favor of remand without vacatur." (citation omitted)(citing 5 U.S.C. § 702; Pac. Rivers Council v. U.S. Forest Serv., 942 F. Supp. 2d 1014, 1021 (E.D. Cal. 2013)(England, Jr., C.J.))).

Instead of applying the traditional test for injunctive relief, the United States Court of Appeals for the District of Columbia Circuit has developed a test to determine when a court should remand without vacatur of the agency's action. "The decision whether to vacate depends on 'the seriousness of the order's deficiencies (and thus the extent of doubt whether the agency chose correctly) and the disruptive consequences of an interim change that may itself be changed.'" Allied-Signal, Inc. v. Nuclear Regulatory Comm'n, 988 F.2d 146, 150-51 (D.C. Cir. 1993)(quoting Int'l Union, United Mine Workers of Am. v. Fed. Mine Safety & Health Admin., 920 F.2d 960, 967 (1990)). Courts primarily use this test where the agency's failure is a lack of explanation or reasoned decisionmaking. See, e.g., Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs, 781 F.3d at 1290 (applying the test "[i]n circumstances . . . where it is not

at all clear that the agency's error incurably tainted the agency's decisionmaking process" and not deciding "whether remand without vacatur is permissible when the agency has erred to such an extent as to indicate that its ultimate decision was unlawful"); Allied-Signal, Inc. v. Nuclear Regulatory Comm'n, 988 F.2d at 150 (providing the test after stating that "[a]n inadequately supported rule . . . need not necessarily be vacated); Int'l Union, United Mine Workers of Am. v. Fed. Mine Safety & Health Admin., 920 F.2d at 966 (providing the test after stating the court "commonly remand[s] without vacating an agency's rule or order where the failure lay in lack of reasoned decisionmaking but also where the order was otherwise arbitrary and capricious" (citations omitted)). The Tenth Circuit has not endorsed the District of Columbia Circuit's test or otherwise "specifically addressed the factors to be considered in determining whether vacatur is an appropriate remedy." Diné Citizens Against Ruining Our Env't v. U.S. Office of Surface Mining Reclamation & Enf't, 2015 WL 1593995, at * 2.

The Court set aside HHS' 2014-2018 rules for its failure to explain its budget-neutral approach to the program, which infected its decisionmaking with respect to its choice to use the statewide average premium in its formula. See supra at 82. Accordingly, with no Tenth Circuit guidance on the issue of appropriate remedy here, the Court finds the District of Columbia Circuit's test persuasive and will use it to evaluate the appropriate remedy for HHS' error. On balance, however, the Court still concludes that vacatur is the appropriate remedy. Further, there are no grounds to limit this vacatur to the state of New Mexico.

A. THE DEFICIENCIES IN HHS' 2014-2018 RISK ADJUSTMENT RULES OUTWEIGH ANY DISRUPTIVE CONSEQUENCES THAT VACATUR MAY IMPOSE.

Where "there is at least a serious possibility that the [agency] will be able to substantiate its decision on remand" and "the consequences of vacating may be quite disruptive," the equities

point to remanding to the agency without vacatur. Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n, 988 F.2d at 151. Remand without vacatur may also be appropriate "where it is not at all clear that the agency's error incurably tainted the agency's decisionmaking process" or where the agency's error "may turn out to be inconsequential." Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs, 781 F.3d at 1290. On the other hand, remand with vacatur is appropriate where "such fundamental flaws in the agency's decision make it unlikely that the same rule would be adopted on remand." Pollinator Stewardship Council v. EPA, 806 F.3d 520, 532 (9th Cir. 2015). Vacatur has also been found appropriate where an agency promulgated an administrative rule "without the notice-and-comment procedures mandated by the APA," and provided no explanation for not using those procedures. Alabama v. Centers for Medicare & Medicaid Servs., 674 F.3d 1241, 1244 (11th Cir. 2012). Another serious deficiency counseling vacatur is where the agency's reasoning behind a rule is "flimsy, and [the agency's] half-hearted attempt to defend its decision in this court is but another indication that [the rule] is a hopeless cause." Fox Television Stations, Inc. v. FCC, 280 F.3d 1027, 1053 (D.C. Cir. 2002).

The Court is cognizant that HHS started this rulemaking process with the belief that the states would be running their own risk adjustment programs, as the statute contemplates. See 42 U.S.C. § 18063; Motion at 4. Congress always charged, however, HHS with "establish[ing] criteria and methods to be used in carrying out the risk adjustment activities," so the methodology used in implementing the programs was always HHS' responsibility. 42 U.S.C. § 18063(b). That HHS ended up having to operate the programs for all fifty states as well does not excuse its deficiency in establishing the methodology -- the erroneous assumption the program must be budget neutral. Further, it is incongruous for HHS to now say that it never made this assumption, see Motion at 12 ("HHS has never contended that the text of section 1343

alone requires the program to be budget neutral . . . ."), because it continues to state Congress' statute "designed" the program to be budget neutral -- which is really no different from saying that the statute requires budget neutrality, see Motion at 12 (reiterating that HHS has contended only "that the program was '*designed* to be a budget-neutral revenue distribution among issuers'" (emphasis is original)); Tr. at 31:11-15 (Powers)("The agency's position has always been that the Risk Adjustment Program is designed to be budget neutral, as a matter of the ACA and the broader lack of appropriations, or budget authority conferred by Congress."); Tr. at 32:6-12 (Powers)("I think that [budget neutrality] was mandated by the absence of the authority or appropriations . . . [s]o rather than it having been commanded by Congress, it was that there was an absence of any authority to do it, to operate the program in any other way."). HHS also, however, attempts to justify budget neutrality as good policy. See 2018 Final Rule, 81 Fed. Reg. at 94,101 (A.R.009638)("In the absence of additional funding for the HHS-operated risk adjustment program, we continue to calculate risk adjustment transfers in a budget neutral manner . . . ."); Wu Decl. ¶ 9, at 3 ("Due to the absence of additional funding for the risk adjustment program, risk adjustment must balance payments and charges across plans."); Cross MSJ at 22 & n.4 (stating the program must be budget neutral, because the statute contemplates states administering the program, and does not require states or HHS to use general appropriations to administer payments). These two arguments do not mesh and, rather, contradict each other. This flip-flopping makes it more difficult to review HHS' decision-making process in choosing to use the statewide average premium in its formula, and underlines the Court's conclusion that this "decision" was arbitrary and capricious. HHS' attempt to change its position also implies that it is attempting to provide post hoc rationalization for a decision it was not aware it made, which cannot withstand APA review. See, e.g., Christopher v.

SmithKline Beecham Corp., 567 U.S. 142, 155 (stating deference is unwarranted "when it appears that the interpretation is nothing more than a 'convenient litigating position' or a '*post hoc* rationalization[n]' advanced by an agency seeking to defend past agency action against attack.'" (quoting Bowen v. Georgetown Univ. Hosp., 488 U.S. 204, 213 (1988); Auer, 519 U.S. at 462)); Motor Vehicle Mfrs. Ass'n v. State Farm Mut. Auto Ins., 463 U.S. at 50 ("[C]ourts may not accept appellate counsel's *post hoc* rationalizations for agency action.").

While it is conceivable that HHS may provide sound reasons for operating the program in a budget-neutral fashion, especially because it purports to have done so for 2019, see HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930, 16,954 (April 17, 2018), the Court does not appreciate HHS attempting to rationalize budget neutrality only now when it should have provided a conscious explanation when it proposed the formula in the first instance. The Court, therefore, concludes that HHS' deficiencies in promulgating the 2014-2018 rules to be great, and not merely, as HHS construes its deficiency, a "failure to provide a sufficient explanation to permit judicial review." Motion at 22. All the cases that HHS cites to justify its proposition that remand without vacatur is appropriate are thus distinguishable, for they remanded to obtain sufficient information on which to base their review. See, e.g., Camp v. Pitts, 411 U.S. 138, 142-43 (1973)(per curiam)("If . . . there was such failure to explain administrative action as to frustrate effective judicial review, the remedy was not to hold a de novo hearing but, . . . to obtain from the agency, either through affidavits or testimony, such additional explanation of the reasons for the agency decision as may prove necessary."); Dist. Hosp. Partners, L.P. v. Burwell, 786 F.3d 46, 60 (D.C. Cir. 2015)("Having decided that the Secretary's explanation is insufficient, . . . [we] remand to the Secretary for additional explanation."); Black Warrior Riverkeeper, Inc. v. U.S. Army Corps of Eng'rs, 781 F.3d at 1289

("The bottom line is we cannot now say that the Corps' ultimate conclusion . . . was unlawful. We, therefore, believe that the proper course is to remand the matter to the district court with instructions to remand to the Corps . . . ."). The APA will not allow the Court to accept HHS' lack of consideration here. See, e.g., Burlington Truck Lines, Inc. v. United States, 371 U.S. at 167 ("There are no findings and no analysis here to justify the choice made . . . . [T]he Administrative Procedure Act will not permit us to accept such . . . practice . . . ." (footnote omitted)).

The 2014-2018 rules are deficient in that HHS promulgated them with the erroneous belief that the ACA required the risk adjustment program be budget neutral. See MOO at 67-68, 312 F. Supp. 3d at 1209-10. This error, then, is much more than just the agency's failure to provide an explanation for its budget neutrality decision; this flaw is the agency making all its subsequent decisions assuming budget neutrality is a given and not making any decision on budget neutrality itself. There is no attempt to justify budget neutrality until 2016, in the 2018 Final Rule, when commenters noted that budget neutrality may not be furthering the risk adjustment program's goals. 2018 Final Rule, 81 Fed. Reg. at 94,101 (A.R.009638). Here, HHS provides an explanation which the Court finds inadequate to support the budget-neutrality decision -- "the absence of additional funding" -- but again this explanation contradicts HHS' position that Congress designed the statute to be budget neutral. 2018 Final Rule, 81 Fed. Reg. at 94,101 (A.R.009638). See supra at 84-91. While the Court is mindful that operating the program in a budget-neutral manner and using the statewide average premium to promote that goal may be the correct choice, that choice is one the agency must actually make instead of taking for granted. Building a rule on an erroneous assumption -- not even a conscious decision -- is at the heart of an arbitrary and capricious action, especially where the assumption may not

promote the authorizing statute's goals. See WildEarth Guardians v. U.S. Bureau of Land Mgmt., 870 F.3d at 1237. Thus, the 2014-2018 rules' deficiencies are not minor, and this fact supports vacatur.

Further, it is hard for the Court to determine the consequences of vacating the 2014-2018 rules, because HHS has not enlightened the Court on this front. To attempt to determine what will likely happen if it vacates the rule, and properly weigh the equities, the Court concludes it is proper to consider all the information it can as to better make an informed decision. It will thus consider the Wu Decl. and the Amici Statement to gain a sense of vacatur's consequences. These sources, however, are also unhelpful in enlightening the Court's understanding of the consequences.

The Wu Decl. first states that vacatur will prevent CMS from "invoic[ing] issuers, collect[ing] charges, or mak[ing] billions of dollars of disbursements in risk adjustment payments" for 2017 and 2018. Wu Decl. ¶ 13, at 4. Wu, Associate Deputy Director for Policy Coordination at the Center for Consumer Information and Insurance Oversight, makes this statement under oath. While CMS did initially state it would suspend payments in July, two and a half weeks later CMS expressly decided not to suspend payments. Once again, HHS told the Court something that, like every time HHS speaks to the Court, reveals its new position. The Court's experience with HHS' changing positions has not been good. HHS' hyperbole does not appear to be an equity that weighs against vacatur.

Second, Wu states that, for 2015-2016, "vacatur raises questions about the legal status of these already-administered payments and charges." Wu Decl. ¶ 14, at 4. Vacatur does not, itself, raise questions about the legal status of prior payments and charges; the merits of the decision of the MOO -- not just the remedies analysis -- has already done that. It is likely that

payees like Health Connections will seek this money back, regardless of what the Court chooses on the remedy.

Third, HHS then tries to frighten the Court by saying its decision will cause the sky to fall. Wu states that both consequences he has claimed may "create strong financial incentives for insurance companies to raise their rates, avoid sick enrollees, or otherwise attempt to insulate themselves against the financial uncertainty of riskier enrollees." Wu Decl. ¶ 15, at 4. Wu states that vacatur of the risk adjustment methodology will also impact the risk corridors program, forcing revisions of "billions of dollars of risk corridors calculations," disrupting expectations, and burdening health insurance companies. Wu Decl. ¶ 19, at 5. According to Wu, both the risk adjustment and risk corridors revisions will impact companies' medical loss ratio reporting as well. See Wu Decl. ¶ 21, at 5.

The statements in the Wu Decl. do not persuade the Court. The problem with Wu's predictions is that the Court issued its decision on February 28, 2018, and none of what Wu has predicted has come true. He has proven to be a poor prognosticator. First, insurance premiums are predicted to rise less in 2019 than they have in the past, and may go down for a few states. See Alison Kodjak, Analysts Predict Health Care Marketplace Premiums Will Stabilize for 2019 Coverage, NPR (Sept. 3, 2018, 5:06 AM), https://www.npr.org/sections/health-shots/2018/09/03/643457582/analysts-predict-health-care-marketplace-premiums-will-stabilize-in-2019. Second, insurance companies cannot avoid sick enrollees, because the ACA still requires them to cover people with pre-existing health connections and prevents them from charging these enrollees higher premiums.

Third, the Court notes that HHS has not been prevented in collecting payments under the risk adjustment program for 2017 and 2018, because it promulgated a new rule for 2017, and is

in the process of doing so for 2018. See Second HHS Notice at 1-2; Third HHS Notice at 1. Thus, although HHS temporarily suspended taking payments under the risk adjustment program -- for seventeen days -- it is now collecting and dispersing money owed. See Second HHS Notice at 2. The Court does agree that there is uncertainty as to the legality of payments collected and made during 2014-2016, but without knowing more about this issue it is difficult for the Court to consider this in equity.[26] Nonetheless, the Court concludes that the effect on prior payments weighs slightly against vacatur. The effect on the risk corridors program does not, however, weigh against vacatur, because, as Health Connections notes, "HHS has defaulted on its risk corridors obligations," so that program already faces havoc. Response at 20. The Court also does not believe that vacating the rules for 2014-2018 will create uncertainty for insurance companies as to rate-setting or cause them to raise premiums, as the administrative record shows that insurance companies are already unclear as to how the risk adjustment program affects them. See Daniel J. Perlman & David M. Liner, Milliman, Financial Analysis of ACA Health Plan Issuers at 3 (February 2016)(NMHC001007)("Over half of ACA health plan issuers recorded $0 in risk adjustment transfers . . . [which] could represent an acknowledgement that it was not possible to determine whether a receipt or payment was the more likely outcome .

[26]The Wu Decl. makes it seem as though the charges and payments administered for 2014-2016 will stand unless, after undergoing the new rulemaking process, HHS decides to change the rules for those years. See Wu Decl. at ¶ 14, at 4 ("[V]acatur raises questions about the legal status of these already-administered payments and charges while CMS engages in the additional rulemaking necessitated by the Court's decision."). It is thus unclear whether HHS would have to refund all the charges collected and "would be unable to recover those fees under a later-enacted rule," Allied-Signal, Inc. v. U.S. Nuclear Regulatory Comm'n, 988 F.2d at 151, or whether issuers will have to go to the Court of Federal Claims to recoup the money they paid. Further, because HHS does not raise the issue of retroactive rulemaking, the Court can only speculate as to how much of a concern this prediction is, if even a concern at all, so it is difficult to evaluate how this factor weighs in equity. According to Health Connections, it is one of only four CO-OPs left, so there not be many, if any, claims.

. . ."); CHOICES, Improving Risk Adjustment to Improve the Market Today (March 29, 2016)(NMHC000190)("Transfer payments for Risk Adjustment have been difficult to predict, highly variable, and in some cases vary large in relation to insurers' premium amounts."). First, deciding whether one will be a payee or payor is so uncertain that insurers do not even make a receipt on financial statements; predictability is that poor. See Perlman & Liner, supra at 3 (NMHC001007). Second, there is at least a two-year gap between when premiums are set and when risk adjustment calculations are made, meaning the risk adjustment calculation may be impacted in ways insurers cannot predict when setting their rates. See Victoria Boyarsky & Rong Yi, Milliman, EHB, MLR and Risk Adjustment: Stakeholder Considerations on the 2019 Proposed Notice of Benefit and Payment Parameters at 6 (January 2018). So risk adjustment is a non-factor in setting premiums. Further, the record shows the program itself has harmed insurers and the insured, with exorbitant charges forcing some insurers to close their doors, decreasing market competition, and increasing premiums. See supra at 9-11. It is unclear how vacatur will impact medical loss ratio reporting, as HHS has not provided further information besides saying it will be impacted. On balance, then, these equities weigh slightly in favor of vacatur.

Finally, the Amici Statement discusses only AHIP and Blue Cross' surprise with HHS' suspension of the risk adjustment program and how the suspension affects the market. See Amici Statement at 1-2. It notes that the suspension "jeopardizes the future market participation of plans" and "creates profound uncertainty for future health plan pricing." Amici Statement at 2. The Amici Statement states that the suspension also brings uncertainty into insurers' "calculation of their medical loss ratio." Amici Statement at 3. While the Court appreciates that AHIP and Blue Cross filed this Statement, the concerns are mooted now, because the risk adjustment program is no longer suspended. Accordingly, none of these concerns add anything

to the Court's equitable considerations. The Court notes, however, that, because the Amici Statement came only after HHS suspended the program and does not discuss any harms to insurance companies resulting from vacatur of the prior years, it appears that insurance companies -- at least AHIP and Blue Cross -- do not seem to be concerned by this issue of remedies. The insurance companies did not file the Amici Statement after the Court issued its MOO on February 28, 2018, but only after HHS suspended payments.

In sum, it is difficult for the Court to determine how disruptive vacatur will be. So far -- nearly eight months after the MOO -- vacatur has not been very disruptive. Although HHS could arguably justify budget neutrality and the resulting decision to use the statewide average premium if the Court remanded without vacating the rules, the Court concludes this remedy would be contrary to the APA's mandate. HHS operated with the conclusion that the program had to be budget neutral, and all its reasoned decisionmaking stemmed from this erroneous assumption -- until commenters noted that budget neutrality may not promote the program's goals. This combined with HHS' later justification that it did not have money to operate the program any differently -- which again, was erroneous -- counsels that the Court should vacate the 2014-2018 rules. This situation is not a case where the Court did not have sufficient information to decide whether HHS had acted arbitrarily and capriciously. There is a sufficient record here to conclude HHS acted arbitrarily and capriciously. HHS merely providing additional justification for budget neutrality and the use of the statewide average premium would not fix its error in assuming that the ACA required the risk adjustment program to be budget

neutral. HHS must consciously make the decision to conduct the program in a budget-neutral manner and provide sufficient justification for this decision.[27]

Finally, the Court cannot, in an intellectually honest manner, limit vacatur of the rules to the state of New Mexico. The Court does not know how a court vacates a rule only as to one state, one district, or one party. The main Department of Justice lawyer advised that he was not sure if the department had ever asked for relief to be limited to one state before doing so in this case and did not know of anyone else in the United States asking for such relief. See Tr. at 91:14-92:7 (Court, Powers). The rules do not apply only to New Mexico; they apply nationwide and, thus, have nationwide harms. Further, the deficiencies with the rules are not specific to New Mexico but, again, rather inherent in the rules themselves. The Court vacates only the 2014-2018 rules as to the statewide average premium rules,[28] so this is a limited and tailored vacatur as to the deficiencies in the rules; the remaining provisions stand.[29]

---

[27]"[F]orcing an agency to supply better reasons for doing what it's already done is unlikely to mollify those who brought the initial challenge or to inspire agencies to craft higher-quality rules in the first place." Nicholas Bagley, Remedial Restraint in Administrative Law, 117 Colum. L. Rev. 253, 309 (2017).

[28]This vacatur is not a grant of a nationwide injunction, so the cases HHS cites to support its request for limiting vacatur to New Mexico are inapplicable. See L.A. Haven Hospice, Inc. v. Sebelius, 638 F.3d 644, 664-65 (9th Cir. 2011)(stating "that nationwide injunctive relief may be inappropriate where a regulatory challenge involves important or difficult questions of law"); Hospice of N.M., LLC v. Sebelius, 691 F. Supp. 2d 1275, 1294 (D.N.M. 2010)(Brack, J.) (discussing the plaintiff's request "that the Court impose a nationwide injunction"), aff'd, 435 F. App'x 749 (10th Cir. 2011)(unpublished). As described by Samuel L. Bray, professor at UCLA School of Law, a national injunction is where, "in non-class actions, federal courts are issuing injunctions that are universal in scope -- injunctions that prohibit the enforcement of a federal statute, regulation, or order *not only against the plaintiff, but also against anyone*." Samuel L. Bray, Multiple Chancellors: Reforming the National Injunction, 131 Harv. L. Rev. 417, 419 (2017)(emphasis in original). The Court did not in its MOO, and is not now, issuing a nationwide injunction prohibiting enforcement of the rule; it is, instead, "set[ting] aside and vacat[ing] the agency action as to the statewide average premium rules" and remanding to HHS. MOO at 71, 312 F. Supp. 3d 1211-12. Congress expressly allows a district court to enter a

vacatur order. See 5 U.S.C. § 706 ("The reviewing court shall . . . hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . ."). It is not ordering HHS to take some action or to refrain from taking some action. While the effects of vacatur and an injunction may be the same, they are separate forms of relief. See Monsanto Co. v. Geertson Seed Farms, 561 U.S. at 565-66.

[29] Professor Bagley also states that "it's possible that the New Mexico court meant to impose a nationwide injunction," and suggests that the DOJ policy is against nationwide injunctions. Bagley, supra. While Professor Bagley's position is not entirely clear, he seems to suggest that the Court issued a nationwide injunction, or, more likely, that HHS read the Court's MOO and used it to justify suspending risk adjustment payments, which suspension acts like a national injunction and that is inconsistent with DOJ's policy on national injunctions. Professor Bagley does not, however, state whether he is for or against national injunctions.

As an initial matter, the Court has already discussed that it did not issue a national injunction. See infra note 28. Second, even if it can be likened to an injunction order, Congress has expressly granted the power to district courts to vacate agency rules that are arbitrary and capricious, or unlawful. Third, Professor Bagley's questions seem more with what HHS did with the Court's MOO that what the Court did. Fourth, there seems to be some tension between the DOJ's position against nationwide injunctions and its hospitality to Chevron deference. See Assistant Attorney General John C. Cruden Delivers Remarks on the Enduring Nature of the Chevron Doctrine at the D.C. Bar's Administrative Law and Agency Practice Committee's Harold Leventhal Lecture (Nov. 10, 2015), available at https://www.justice.gov/opa/speech/assistant-attorney-general-john-c-cruden-delivers-remarks-enduring-nature-chevron.

Recently, there has been an influx of Professors, Justices, Congresspeople, and academia discussing the propriety of federal district court judges issuing "national injunctions," i.e., "injunctions that apply across the nation, controlling the defendant's behavior with respect to nonparties." Samuel L. Bray, Multiple Chancellors: Reforming the National Injunction, 131 Harv. L. Rev. 417, 418 (2017). The criticism seems to be mostly due to the fact that there have been twenty-nine preliminary injunctions entered against the current administration. The critics see these courts as blocking the democratic process. A few years ago, a more liberal administration criticized judges for blocking its executive orders and its laws, including the ACA. What seems clear is that the rule on national injunctions should not depend on whether the injunction blocks legislation the critics like. In the end, the discussion should be governed by more rational principles than whether the critics or proponents like or dislike the legislation.

Whether the nation will allow or not national injunctions is less of a legal issue and more of a policy issue. The critics have not really said that current law -- Congress or some statute -- precludes national injunctions; rather, critics mostly argue that prudential concerns counsel against national injunctions. Congress or the Supreme Court will have to make that call. It would be easy to be aggressive. As a conservative, cautious judge, the Court is inclined not to go any further than the case requires and leave nonparties' law for another day. It is not always clear whether a national injunction has been entered. For example, in this case, there is no national injunction, but vacatur may affect non-parties to this case. On the other hand, even

when an injunction limited to the parties, it may effectively impact nonparties. Finally, the national injunctions that seem to draw criticism the most are those against the federal government and not other entities, so it is unclear whether critics are concerned, for example, with national injunctions against corporations in some or all instances.

Critics of federal district court judges issuing national injunctions argue that this practice "encourages forum shopping and that it arrests the development of the law in the federal system." Bray, supra at 419. The grant of an injunction in one circuit, for example, may discourage plaintiffs from bringing similar challenges in different circuits, thus preventing other circuits from developing their views on the issue. See Bray, supra at 461. This reality means that, when the issue reaches the Supreme Court, it is "more likely to hear a case without the benefit of disagreement from the courts of appeals," and its "resolution may be accelerated and relatively fact-free," leading to a bad development of law. Bray, supra at 461-62. Criticism also stems from the fact that, in the multiple-judge federal system, a number of judges may be deciding the same issue in different courts, so conflicting injunction orders may issue. See Bray, supra at 420. According to critics, these conflicting orders creates absurdity in that, to carry out its policies, the United must win every case brought against it seeking to halt a policy, yet a plaintiff need win only once for the policy to be invalidated. See Suzanne Monyak, New House Bill Seeks to Bar Nationwide Injunctions, LAW360 (Sept. 10, 2018, 6:09 PM), https://www.law360.com/articles/ 1081108/new-house-bill-seeks-to-bar-nationwide-injunctions . Accordingly, the House Judiciary Committee has recently introduced a new bill -- the Injunctive Authority Clarification Act of 2018 -- which, as it is currently written, provides that "[n]o court of the United States . . . shall issue an order that purports to restrain the enforcement against a non-party of any statute, regulation, order, or similar authority, unless the non-party is represented by a party acting in a representative capacity pursuant to the Federal Rules of Civil Procedure." Injunctive Authority Clarification Act of 2018, H.R. 6730, 115th Cong. (2018), available at https://www.congress.gov/bill/115th-congress/house-bill/6730/text.

While the Court agrees that national injunctions often are anti-democratic and messy, the Court also is inclined to think that national injunctions have their place in a federal court's arsenal of equitable relief. There is nothing inherently wrong in a federal court issuing a national injunction. The criticisms against the national injunction do not completely move the Court from this stance. First, the Court notes that, as to the issue of forum shopping, prohibiting national injunctions will not solve this issue, and the Court is not convinced that forum shopping is a strong issue here. See Suzette M. Malveaux, Class Actions, Civil Rights, and the National Injunction, 131 Harv. L. Rev. F. 56, 57 (2017)("Forum shopping is hardly new and, in fact, the American legal system tacitly encourages with its charge that lawyers zealously represent their clients within the bounds of the law." (footnote omitted)). Zealous litigators are inclined to head to the Ninth Circuit as compared to the Tenth, regardless whether a national injunction is available or not. Second, the national injunction does not create bad development of law. Courts do not issue injunctions lightly. The standard to receive an injunction is high, and litigants have every incentive to zealously argue for their position. There must be some facts presented for a court to determine whether a plaintiff is likely to succeed on the merits of the case. While deciding an issue on such a bare record is not ideal, this is the standard for receiving a preliminary injunction. See Winter v. NDRC, 555 U.S. 7, 20 (2008)("A plaintiff seeking a preliminary injunction must establish that he is likely to succeed on the merits, that he is likely to

suffer irreparable harm in the absence of preliminary relief, that the balance of equities tips in his favor, and that an injunction is in the public interest."). The protections that Congress has put in place balance this uncertainty: (i) the requirement for a hearing, see Fed. R. Civ. P. 65(a); (ii) the requirement for "security in an amount that the court considers proper to pay the costs and damages sustained by any party found to have been wrongfully enjoined or restrained," unless the party seeking the injunction in the United States government, Fed. R. Civ. P. 65(c); (iii) the requirement that an order granting an injunction state the reasons for and the terms of the injunction, see Fed. R. Civ. P. 65(d)(1); (iv) the ability to stay an injunction during an appeal, see Fed. R. App. P. 8(a)(1)(c); and (v) the right to immediately appeal an injunction order, see 28 U.S.C. § 1292. Restraining the conduct of another is a serious remedy, but, as discussed, there are many safeguards in place to ensure this remedy is provided in a reasoned manner. That the Supreme Court may have to decide whether to overturn a preliminary injunction on a bare record is not ideal, but mnay6 times these cases involve a key legal issue and thus ultimately rarely create bad law. Again, the standard is based on the likelihood of success on the merits; there is not a ruling on the merits. Further, a preliminary injunction is just that -- preliminary. It is not meant to, and cannot, last forever. The decision to grant a permanent injunction is done with a full factual record once the merits have been decided, allowing for a full review at the Supreme Court when the law will be decided on the merits.

Critics of the national injunction also note the apparent lack of legal authority for federal courts to issue national injunctions. The argument is that, because equitable remedies must be grounded in traditional equity as it existed in the Court of Chancery in 1789 and because traditional equity had nothing similar to a national injunction, federal courts today lack the ability to issue national injunctions. See Bray, supra at 425. In traditional equity, the Court of Chancery, as it originated from the Crown, would not enjoin the Crown and would normally issue decrees affecting only the parties before it. See Bray, supra at 425-27. Broader relief could be obtained, however, where it resolved the "common claims of cohesive group," which allowed "a successful plaintiff to obtain an injunction protecting all similarly situated persons" and, thus, affecting nonparties. Bray, supra at 427.

The Court also has issues with this ground for prohibiting national injunctions. The federal government is one of checks and balances, and all three branches must work together to promote an organized society. "The legislative department has been committed the duty of making laws, to the executive the duty of executing them, and to the judiciary the duty of interpreting and applying them in cases brought before the courts." Commonwealth of Massachusetts v. Mellon, 262 U.S. 447, 488 (1923). The constitutional requirement of standing thus requires a plaintiff to show some concrete injury resulting from the law's enforcement, for a federal court to properly enjoin enforcement without stepping on the toes of the other two branches. See, e.g., Commonwealth of Massachusetts v. Mellon, 262 U.S. at 488. Where the complaint asserts merely "that officials of the executive department of the government are executing and will execute an act of Congress asserted to be unconstitutional," the court may not enjoin, because "[t]o do so would be, not to decide a judicial controversy, but to assume a position of authority over the governmental acts of another and coequal department," which courts do not have the power to do. Commonwealth of Massachusetts v. Mellon, 262 U.S. at 488-89. An unconstitutional statute or action, however, cannot be law; rather, it is "as inoperative as though it has never been passed." Norton v. Shelby Cty., 118 U.S. 425, 442

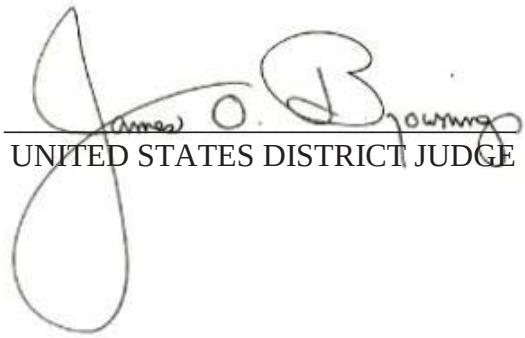
(1886). It is the federal judiciary's role to "say what the law is" and, thus, determine whether Congress' action violates the Federal Constitution. Marbury v. Madison, 5 U.S. (1 Cranch) 137, 177-78 (1803). Federal courts may not give weight to unconstitutional laws, for doing so "would be giving to the legislature a practical and real omnipotence, with the same breath which professes to restrict their powers within narrow limits." Marbury v. Madison, 5 U.S. (1 Cranch) at 178. Deciding the law of a case to uphold the Constitution as Marbury v. Madison counsels and enjoining the enforcement of an unconstitutional statute as to the plaintiff bringing the case certainly restricts the Legislature to a degree. This narrow relief is not enough for due justice in all situations. If there is a conviction is that "an act of the legislature, repugnant to the constitution, is void," Marbury v. Madison, 5 U.S. (1 Cranch) at 177, then it is not enough to enjoin enforcement only as to one person. This narrow relief provides no justice for those who, for some reason, cannot bring a case to prevent the executive from applying this void law to them.

Limiting the injunction also does nothing to prevent the broader effects of the void law. In effect, then, while the law is void as to the deciding case, it still stands as to everyone else who has not challenged it. This result means that the law, which should be void for conflicting with the Supreme Law of the land, is still influencing conduct. Thus, the Legislature still has "a practical and real omnipotence," and is still able to "do what is expressly forbidden." Marbury v. Madison, 5 U.S. (1 Cranch) at 178). Where a plaintiff has standing to challenge the law -- therefore showing an actual, concrete injury -- and shows that the law is unconstitutional, then to fully provide justice a federal court should have the power to void the statute and uphold the sanctity of the Constitution by striking the statute down, i.e., enjoining its enforcement broadly.

Critics also note a number of doctrinal inconsistencies that the issuance of national injunctions creates. These inconsistencies include: (i) national injunctions render meaningless the legal principle that nonmutual, offensive issue preclusion cannot be used against the federal government; (ii) the use of rule 23(b)(2) class actions are unnecessary if a national injunction provides the same relief to an individual plaintiff; (iii) the inability of nonparties to enforce an injunction order; and (iv) the ability of federal district court judges to "recognize and determine the law" for nonparties through a national injunction, when their decisions cannot and should not bind other district courts or create precedent or clearly established law. Bray, supra at 464-65. Again, these criticisms do not sway the Court's belief that national injunctions have their place in promoting a just society, but they counsel extreme caution in using them.

An injunction has been issued as to a party -- the defendant -- who had a full and fair chance to litigate. Enjoining that defendant's enforcement of an unconstitutional law means that law cannot stand. Should that defendant then attempt to enforce the law against a nonparty, that person would not be able to sue for contempt under the injunction, but would rather have to relitigate the issue. The point of the injunction is to attempt to prevent the defendant from enforcing the law at all, which a federal court could do because the defendant is a party in front of it. Finally, a national does not create binding precedent, and does not create clearly established law for qualified immunity purposes. A national injunction, as with any other injunction, is enforceable via contempt of court only by the court that issued the injunction. It is true that the national injunction is an "imperfect and crude form[] of justice," but the Court is inclined to believe that, without it, there are situations in which justice cannot be served. Malveaux, supra at 56.

IT IS ORDERED that: (i) the Defendants' Motion to Alter or Amend Judgment Pursuant to Federal Rule of Civil Procedure 59(e), filed March 28, 2018 (Doc. 57), is denied; (ii) the Plaintiff's Motion to Strike the Declaration of Jeffrey Wu or in the Alternative Grant Plaintiff Leave to Take Discovery, filed April 23, 2018 (Doc. 61), is denied; and (iii) the Motion of America's Health Insurance Plans and Blue Cross Blue Shield Association for Leave to File Statement on New Developments in Support of Rule 59(e) Motion as Amici Curiae, filed July 19, 2018 (Doc. 80), is granted.



UNITED STATES DISTRICT JUDGE

Counsel:

Nancy Ruth Long
Long Komer & Associates, P.A.
Santa Fe, New Mexico

-- and --

Barak A. Bassman
Leah Greenberg Katz
Marc D. Machlin
Sara Richman
Pepper Hamilton, LLP

In the end, there are sound policy reasons for and against national injunctions. Congress and/or the Supreme Court will decide the issue. On balance, the Court agrees with the criticism that they should be used sparingly and carefully, but that there is some room in the nation's democratic society for them. Cases have to get started somehow, and most get started in the district court, which either gets the issues right or wrong in the first instance.

Finally, if Congress or the Supreme Court limits national injunctions, it should not do so in a way that displays some form of elitism. The critics seem uncomfortable with national injunctions in Hawaii, California, or New Mexico, but less so if they come out of S.D.N.Y. or the District of Columbia. Again, that limitation would not be a national principle, but only would reflect a distaste for everyone and everything that is not on the East Coast.

Philadelphia, Pennsylvania

Attorneys for the Plaintiff

Chad A. Readler
Acting Assistant Attorney General
Joel McElvain
Assistant Branch Director
Arjun Garg
Serena Orloff
James R. Powers
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
Washington, D.C.

Attorneys for the Defendants