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September 23, 2019

Catherine O'Hagan Wolfe, Clerk of the Court
United States Court of Appeals for the Second Circuit
40 Foley Square
New York, NY 10007

Re: *UnitedHealthcare of N.Y., Inc. v. Lacewell*, No. 18-2583

Dear Ms. Wolfe:

This Office represents defendant-appellee Linda A. Lacewell, Superintendent of Financial Services of the State of New York. We submit this letter in response to the Court's August 7, 2019, order directing supplemental letters in response to the amicus brief filed by the United States Department of Health and Human Services (HHS).

I. This Court should reject HHS's attempt to recharacterize its prior position on DFS's regulation.

HHS's brief radically reverses the position that the agency took in a series of regulatory publications that expressly endorsed States taking temporary measures under state law to mitigate unexpectedly high risk-

adjustment payments. HHS now adopts the same "fundamentally mistaken assumption" as plaintiffs: "that the ACA Risk Adjustment Program is the only risk adjustment program the ACA permits to exist." DFS Reply Br. 3. By contrast, in all prior statements, HHS drew a distinction between (a) adjustments calculated by HHS under the ACA Risk Adjustment Program, and (b) adjustments made by States under their own state authority. DFS Br. 12-16. HHS also recognized that it could not fix the federal risk-adjustment process before 2020, and expressly determined that States should continue to engage in risk adjustment under state authority during this transitional period.

Two of HHS's many past statements are particularly relevant. First, in May 2016, HHS "encourage[d] States to examine whether any local approaches, under State legal authority," could address "the effects of unanticipated risk adjustment charge amounts." 81 Fed. Reg. 29,146, 29,152 (May 11, 2016). Second, in November 2017, HHS "recognized some State regulators' desire to *reduce the magnitude* of [federal] risk adjustment charge amounts for some issuers," and concluded that "a State that wishes to make an *adjustment for the magnitude* of these transfers . . . may take temporary, reasonable measures under State

authority to mitigate effects under their own authority." 82 Fed. Reg. 51,052, 51,072-73 (Nov. 2, 2017) (emphases added). In other words, HHS specifically recognized and endorsed State regulators' use of separate state authority to "make an adjustment for the magnitude of . . . transfers" required by the ACA Risk Adjustment Program, which is exactly what DFS did.

In parallel with these public endorsements of State regulatory authority, HHS was consulting with DFS about DFS's proposal to address the particularly acute harms that New York's market was experiencing. HHS does not dispute DFS's detailed account of these extensive discussions. *See* HHS Br. 15 n.2; DFS Br. 13-14. In 2016, DFS described to HHS how its regulation would operate, making clear that the regulation would rely on New York's pre-existing risk-adjustment statutes to require that certain insurers make further transfers after payments were made under the federal ACA Risk Adjustment Program (*see* Powell 2d Decl. ¶¶ 42-43, 47-48; *see also* JA 101-102). In October 2017, DFS gave HHS a detailed walkthrough of how the regulation would work—and HHS not only failed to object, but sent DFS an e-mail offering to help DFS "operationalize" its regulation (*see* Powell 2d Decl. ¶ 49).

In an April 2018 rulemaking—published after the promulgation of DFS's regulation—HHS responded to commenters' pointed concern that New York had potentially violated federal law by "already tak[ing] action to *reduce transfers* under the State's authority . . . without HHS approval." 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018) (emphasis added). Far from disapproving of New York's approach, HHS repeated its previous position that "States that take such actions and *make adjustments* do not generally need HHS approval" and may act "under their own State authority." *Id.* (emphasis added).

HHS's current attempts to disclaim the plain meaning of its past statements are not credible. First, HHS's brief relies heavily on the following sentence in its April 2018 rulemaking: "the flexibility finalized in this rule involves a reduction to the risk adjustment transfers calculated by HHS and will require HHS review as outlined above." 83 Fed. Reg. at 16,960. HHS now argues that this "language made clear that a reduction to the risk-adjustment transfers" is not what it meant by "local approaches under State legal authority." HHS Br. 12.

HHS is incorrect because the quoted sentence concerns only "the flexibility finalized *in this rule*." That reference is to the April 2018

rulemaking's proposal of a *new* procedure—not effective until 2020—that will allow States to request "State-specific adjustments to the HHS risk adjustment methodology," subject to "HHS review." 83 Fed. Reg. at 16,956, 16,960; *see also* 45 C.F.R. § 153.320(d) (codification of final rule). But this language is not about actions taken by States under their own legal authority at all—let alone actions taken after a State had conferred with HHS and followed the agency's direction. To the contrary, HHS described the details of the new procedure for State-level adjustments proposed "in this rule," *id.*—including its requirement of HHS approval—to *distinguish* it from prior "local approaches under State legal authority," which did "not generally need HHS approval." *Id.*

Second, HHS's brief implausibly argues that the "permissible local approaches" it meant to approve in its prior statements were limited to changes other than the approach that DFS ultimately adopted—suggesting, in particular, that New York could have adopted measures that would have *weakened* its insurance markets by "relaxing its rating requirements" or permitting more poorly capitalized companies to offer insurance. *See* HHS Br. 13-14. The brief cites nothing whatsoever from prior rulemakings that would support this new characterization of the

agency's past statements. *See id.* at 13 (saying only that "we are informed by HHS" about this new position).

HHS's new argument is not a plausible interpretation of its prior regulatory statements. For example, the November 2017 rulemaking, which HHS's brief does not even cite, recognized state regulators' interest in "reduc[ing] the magnitude of [federal] risk adjustment charge amounts" and endorsed States exercising their state-law authority to "make an adjustment for the magnitude of these transfers." 82 Fed. Reg. at 51,072-73. The April 2018 rulemaking likewise recognized that New York had "taken action to *reduce transfers* under the State's authority" and endorsed States taking action to "make adjustments" in this way. 83 Fed. Reg. at 16,960. And in multiple detailed exchanges that HHS does not dispute, DFS told HHS exactly what it was going to do—namely, require insurers to make additional transfers after the payments mandated by the ACA Risk Adjustment Program—and HHS not only failed to disapprove this proposal but offered to help operationalize it. Given this history, HHS's current suggestion that its prior statements intended only to authorize States to *weaken* market protections, rather

than to respond directly to the unexpectedly high risk-adjustment transfers that were the cause of their problems, defies belief.

HHS's failure even to acknowledge its radical change of position calls into serious question whether its new approach here is permissible. When an agency alters a prior policy, it must "at least 'display awareness that it is changing position,'" and take into account "serious reliance interests." *Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2126 (2016) (quoting *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009)). A change that ignores these considerations is arbitrary and capricious—and receives no interpretive deference. *See id.* at 2126-27. Here, HHS disavows any change of position and entirely ignores the fact that DFS relied in good faith on HHS's assurances.

At minimum, HHS's bait-and-switch—expressed for the first time in an amicus brief without prior notice to the parties, let alone the public—confirms that this lawsuit by a private insurer is the wrong forum to adjudicate either the fact or validity of a federal agency's views regarding a complex federal program that it has been delegated authority to administer. *See* DFS Br. 31-40; *Armstrong v. Exceptional Child Center, Inc.*, 135 S. Ct. 1378 (2015); *Davis v. Shah*, 821 F.3d 231, 245-46 (2d Cir.

2016). If HHS wishes now to change its position, it should do so formally through the regulatory and supervisory mechanisms available to it under the ACA—mechanisms that would ensure that HHS complies with its obligations under both the ACA and the Administrative Procedure Act, and that would enable DFS to directly challenge HHS's change of heart.

II. HHS's preemption arguments are meritless.

Relying on its implausible characterization of its own past statements, HHS now asserts, for the first time, that DFS's regulation "prevents the application of the ACA's risk adjustment program." HHS Br. 12. But this argument ignores the fact that the goal of risk adjustment under the ACA is to ensure that true actuarial risk is fairly distributed throughout a State's market. *See* 42 U.S.C. § 18063(a). HHS's brief does not dispute that "unforeseen defects" in the federal risk adjustment methodology led the ACA Risk Adjustment Program to fail to accomplish its statutory goal—destabilizing New York's market and resulting in the departure of at least one insurer. *See* DFS Br. 25; Br. for Amicus Curiae CareConnect Ins. Co. 1-2. Nor does HHS's brief dispute that DFS's regulation ameliorated these defects by arriving at a more accurate allocation of actuarial risk. Because DFS's regulation thus

promotes rather than impedes the "accomplishment and execution of the full purposes and objectives of Congress," *Hillman v. Maretta*, 569 U.S. 483, 490 (2013), HHS's new assertion of conflict preemption is meritless.

HHS also errs in asserting (at 14-16) that it lacked statutory authority to endorse DFS's regulation.[1] HHS is wrong to suggest (at 15) that its authority was limited to 42 U.S.C. § 18041(b)(2). That provision requires the Secretary to determine whether a State has "implement[ed] [federal] standards"—but only for such States that "elect[ed]" to administer the federal ACA Risk Adjustment Program themselves. 42 U.S.C. § 18041(b)(2). As HHS acknowledges (at 3-4), New York did not make such an election. For a State like New York that "is not an electing State," a separate provision gives HHS more general authority to "take such actions as are necessary to implement" risk adjustment. *Id.* § 18041(c).[2] HHS has never explained—and its amicus brief

[1] Contrary to HHS's assertion, its endorsement was not limited to "informal communications" (at 15) but was also expressed in multiple formal rulemaking statements (see *supra* at 2-3; DFS Br. 12-16).

[2] Plaintiffs' reproduction of § 18041(c) in the addendum (Add. 2) omits a paragraph break between "subtitles" and "the Secretary" at the end of § 18041(c)(1)(B)(ii)(II) and thus mistakenly conveys the impression that HHS's broad power to "take such actions as are necessary to implement" risk adjustment is limited to § 18041(c)(1)(B), which covers

conspicuously declines to discuss—why this broad grant of authority would not encompass the agency's endorsement of "local approaches, under State legal authority," 81 Fed. Reg. at 29,152, that HHS believes will improve risk adjustment within a State.

Because plaintiffs' claim of preemption here is limited to the 2017 and 2018 benefit years (*see* JA 152 & n.3), this case does not require the Court to decide whether the availability in 2020 of HHS's new procedure (see *supra* at 4-5) would preempt state-run risk adjustment under separate state authority in that year and beyond, as DFS explained at oral argument. *See* Audio of Oral Arg. at 25:50-26:30. But the view that HHS takes now—that States must suffer the consequences of the federal methodology's admitted defects until 2020, and that private insurers such as plaintiffs are entitled to a windfall at the expense of other, smaller insurance companies (*see* HHS Br. 14)—conflicts with Congress's goals in the ACA and should be rejected.

Respectfully submitted,

/s/ Matthew W. Grieco

Matthew W. Grieco

cc: Neal Kumar Katyal, Esq.

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only "electing State[s]." In fact, that authority extends as well to § 18041(c)(1)(A), which applies to a State that "is not an electing State."