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United States District Court, W.D. Texas, Austin Division.

VISTA HEALTH PLAN, INC., and Vista Service Corporation, Plaintiffs,
v.
UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; Secretary Alex M. Azar; Centers for Medicare and Medicaid Services; and Administrator Seema Verma, Defendants.

CAUSE NO. 1:18-CV-824-LY
|
Signed 09/21/2020

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ORDER

LEE YEAKEL, UNITED STATES DISTRICT JUDGE

***1** Before the court in the above-styled and numbered cause are Plaintiffs Vista Health Plan, Inc. and Vista Service Corporation's Motion for Summary Judgment or, in the Alternative, for Partial Summary Judgment filed on January 31, 2020 (Doc. #32), Defendants United States Department of Health and Human Services, Secretary Alex M. Azar, Centers for Medicare and Medicaid Services, and Administrator Seema Verma's[1] Motion for Summary Judgment and Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment filed on February 28, 2020 (Doc. # 33), Vista's Response to Defendants' Motion for Summary Judgment and Reply to Defendants' Response to Vista's Motion for Summary Judgment filed on May 1, 2020 (Doc. #39), and HHS's Reply in Support of Motion for Summary Judgment filed on May 22, 2020 (Doc. #40). Having considered the motions, responses, replies, amended administrative record, and applicable law, the court renders the following order.

I. Jurisdiction and Venue

Federal courts have original jurisdiction over "all civil actions arising under the Constitution, laws, or treaties of the United States." 28 U.S.C. § 1331. This action arises under the Administrative Procedure Act ("APA"). 5 U.S.C. § 702. Venue is proper because a substantial part of the events or omissions giving rise to the claim occurred in Texas. 28 U.S.C. § 1391(e)(1).

II. Background

The **Affordable Care Act** expanded healthcare coverage by providing tax credits and establishing online exchanges where insurers could sell plans. 26 U.S.C. § 36B; 42 U.S.C. §§ 18081, 18082. Once an insurer lists a plan on an exchange, the insurer must accept every employer and individual in the state that applies for coverage and may not tether premiums to a particular applicant's health. 42 U.S.C. §§ 300gg(a), 300gg–1(a). In other words, the **Affordable Care Act** "ensure[s] that anyone can buy insurance." *King v. Burwell*, 576 U.S. 473, 493 (2015).

Insurers are incentivized to participate in the **Affordable Care Act** exchanges through access to millions of new customers with tax credits worth "billions of dollars in spending each year." *Id.* at 485. But the exchanges pose risks, too—including a lack of reliable data with which to estimate the cost of covering the expanded pool of new customers. *Maine Cmty. Health Options v. United States*, 140 S. Ct. 1308, 1315–16 (2020). The uncertainty could have given insurers pause and affected the rates they set. *Id.* To encourage insurers to enter those marketplaces, the **Affordable Care Act** creates several programs to defray insurers' costs and cabin their risks. 42 U.S.C. § 18031(b)(1). To protect plans operating in the marketplaces from adverse selection, the **Affordable**

Care Act includes a three-part premium-stabilization program—reinsurance, risk corridors, and risk adjustment. 2014 Final Rule, 78 Fed. Reg. 15,411 (March 11, 2013).

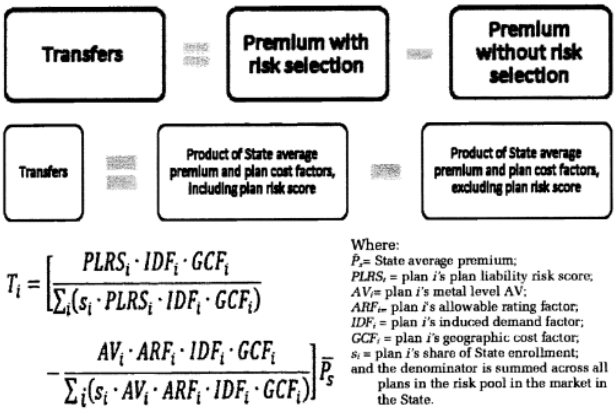
***2** This case centers around the risk-adjustment program, which provides payments to "health insurance issuers that attract higher-risk populations, such as those with chronic conditions, and reduce the incentives for issuers to avoid higher-risk enrollees." *Id.* The goal of the risk-adjustment program is "that premiums should reflect the differences in plan benefits, quality, and efficiency, and not the health status of the enrolled population." *See* Center for Consumer Info. & Ins. Oversight, *HHS-Operated Risk Adjustment Methodology Meeting*, 79 (Mar. 24, 2016) ("2016 White Paper"). The Affordable Care Act tasked HHS with developing the program as follows:

> (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).
>
> (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. 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.

42 U.S.C. § 18063. With this statutory guidance, HHS developed a risk-adjustment methodology to convert actuarial risk into charge or payment amounts for particular plans in a state-market risk pool to "provide plans with enough additional revenue to cover their actual risk exposure beyond the premiums they are able to collect, or in other words, to compensate for excess actuarial risk due to risk selection." 2016 White Paper at 79.

In broad terms, the risk-adjustment methodology involves three steps. First, models that use demographic and diagnostic data calculate the actuarial risk of each enrollee to determine the relative cost of insuring the enrollee. *See* 2014 Final Rule, 78 Fed. Reg. 15,411 (March 11, 2013). 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, the plan's risk score is multiplied by a statewide-average premium. *See id.* HHS expected this methodology to lead to lower premiums for plans that are chosen by higher-risk enrollees due to risk-adjustment payments, and higher premiums in plans that are chosen by low-risk enrollees due to risk-adjustment charges. 2016 White Paper at 79.

***3** The following three graphics are included in the 2014 Final Rule showing the risk-adjustment methodology in increasing levels of complexity:



78 Fed. Reg. 15,431 (March 11, 2013).

III. General Standard and Scope of Review

On cross-motions for summary judgment, the court reviews each party's motion independently, views the evidence and makes inferences in the light most favorable to the non-moving party, and determines for each whether a judgment may be rendered under the appropriate standard. *See Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299, 304 (5th Cir. 2010). The scope of judicial review under the APA is as follows:

> To the extent necessary to decision and when presented, the reviewing court shall decide all relevant questions of law, interpret constitutional and statutory provisions, and determine the meaning or applicability of the terms of an agency action. The reviewing court shall—
>
> **(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.
>
> In making the foregoing determinations, the court shall review the whole record or those parts of it cited by a party, and due account shall be taken of the rule of prejudicial error.

5 U.S.C. § 706. If challenging agency action, "[s]ummary judgment is the proper mechanism for deciding, as a matter of law, whether an agency's action is supported by the administrative record and consistent with the APA standard of review." *American Stewards of Liberty v. Department of Interior*, 370 F. Supp. 3d 711, 723 (W.D. Tex. 2019) (quotations omitted), *appeal dismissed*, 960 F.3d 223 (5th Cir. 2020); *see Shell Offshore Inc. v. Babbitt*, 238 F.3d 622, 627 (5th Cir. 2001).

It is a "foundational principle of administrative law" that judicial review of agency action is limited to "the grounds that the agency invoked when it took the action." *Michigan v. EPA*, 135 S. Ct. 2699, 2710 (2015). Considering only contemporaneous explanations for agency action instills confidence that the reasons given are not simply "convenient litigating position[s]." *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 155 (2012) (internal quotations omitted). As the Supreme Court recently noted:

> Justice Holmes famously wrote that "[m]en must turn square comers when they deal with the Government." But it is also true, particularly when so much is at stake, that "the Government should turn square comers in dealing with the people." The basic rule here is clear: An agency must defend its actions based on the reasons it gave when it acted.

***4** *Department of Homeland Sec. v. Regents of the Univ. of Cal.*, No. 18-587, 2020 WL 3271746, at *11 (U.S. June 18, 2020) (internal citations omitted). Review of the administrative record is vital because permitting agencies to invoke *post hoc* justifications can upset the orderly functioning of the process of review, forcing both litigants and courts to chase a moving target. *See id.* at * 10.

"[W]hen a party seeks review of agency action under the APA, the district judge sits as an appellate tribunal." *American Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001); *see e.g., Redeemed Christian Church of God v. United States Citizenship & Immigration Servs.*, 331 Fed. Supp. 3d 684, 694 (S.D. Tex. 2018). The function of the district court is to determine whether or not the evidence in the administrative record permitted the agency to make the decision it did. *Redeemed Christian*, 331 Fed. Supp. 3d at 694. Summary judgment serves as the mechanism for deciding, as a matter of law, whether the agency action is supported by the administrative record and otherwise consistent with the APA's standard of review. *Id.*

IV. Factual Background

Vista is a small insurer that was approved by the Texas Department of Insurance ("TDI") to enter the

health-insurance market in May 2016. For 2017, Vista's first full year of business, HHS assessed risk-adjustment charges of over $4.3 million, accounting for over 50% of Vista's premium revenue for that year. For 2018, Vista's second year participating in the **Affordable Care Act** marketplaces, HHS assessed risk-adjustment charges over $8 million, approximately 57% of the year's premium revenue. The 2017 risk-adjustment-charge invoice caused Vista to be placed under TDI supervision at the beginning of 2018, and, by the end of the year, TDI directed Vista to stop selling policies. Vista notified its enrollees that policies would not be renewed in 2019. Vista continues to pay claims but discontinued all policies as of May 31, 2019. Vista seeks relief under the APA, claiming that the risk-adjustment program is invalid. HHS has agreed not to attempt to collect the risk-adjustment transfer charges until Vista's claims are resolved.

V. Claims

The court can deduce nine distinct claims against HHS.[2] The court will address each claim in turn. However, the court will limit its review to those issues briefed and will not reach every allegation brought in Vista's complaint.

A. Standard of Review for Claims (1) through (7)

***5** Vista's first through seventh claims are entitled to traditional Rule 56 summary-judgment adjudication applied to the administrative record because they implicate questions of law outside the scope of agency decision-making, or where the law accords the agency no special deference. Summary judgment is appropriate if the record shows "that there is no genuine issue as to any material fact and the moving party is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a); *Celotex Corp. v. Catrett*, 477 U.S. 317, 323–25 (1986). A dispute regarding a material fact is "genuine" if the evidence is such that a reasonable jury could return a verdict in favor of the nonmoving party. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986).

Notably, there is no exception to the principle of record review where a claim under the APA is based on a violation of constitutional rights. *See, e.g.*, *Robinson v. Veneman*, 124 F. App'x 893, 895 (5th Cir. 2005) ("The administrative record is also reviewed to determine whether the challenged action was 'contrary to constitutional right, power, privilege, or immunity.' ") (quoting 5 U.S.C. § 706(2)(B)). Courts afford agencies no deference when interpreting the Constitution. *See Rust v. Sullivan*, 500 U.S. 173, 190–91 (1991).

(1) The Individual Mandate as an Inseverable Provision

Vista claims that *Texas v. United States*[3] eliminated the risk-adjustment program's rational basis by holding the individual mandate unconstitutional. However, *Texas* is inapplicable to Vista's claims involving risk-adjustment charges from 2017 and 2018, because its holding is premised on Congress's reduction of the individual mandate to zero dollars, a provision that did not become effective until January 2019. *See id.* at 390 ("Now that the shared responsibility payment amount is set at zero, the provision's saving construction is no longer available Most fundamentally, the provision no longer yields the essential feature of any tax because it does not produce at least some revenue for the Government.") (internal quotations omitted).

Vista also claims, seemingly in the alternative, that *National Federation of Independent. Business v. Sebelius*, 567 U.S. 519 (2012) held the individual mandate as unconstitutional, invalidating the risk-adjustment program's rational basis for its existence. However, *Sebelius* upheld the individual mandate as constitutional. *See id.* at 575 ("Section 5000A is therefore constitutional, because it can reasonably be read as a tax."). Regardless of Vista's claims about the risk-adjustment program's rational basis, the individual mandate was constitutional at all relevant times. The court will grant HHS summary judgment on the inseverable-provision claim.

(2) Retroactive Rulemaking and Deficiencies Under the APA

The rulemaking procedures outlined in the APA govern how HHS promulgates rules. *See* 5 U.S.C. § 551(1). HHS is required to provide the public with adequate notice of a proposed rule and a subsequent meaningful opportunity to comment on the rule's content. *Id.* § 553 (b)-(c). A Final Rule must be published in the Federal Register not less than 30 days before the rule's effective date, subject to an exception for good cause. *See id.* § 553(d)(1)-(3).

The timeline of relevant events is as follows. On January 30, 2018, the United States District Court for the District of Massachusetts validated the use of statewide-average premiums in the risk-adjustment methodology. *See Minuteman Health, Inc. v. United States Dep't of Health & Human Servs.*, 291 F. Supp. 3d 174, 205 (D. Mass. 2018) ("not unreasonable or irrational for HHS to use the statewide average premium"). On February 28, 2018, the United States District Court for the District of New Mexico issued a contrary ruling, invalidating the use of statewide-average premiums in the risk-adjustment methodology pending a further explanation of HHS's reasons for its budget-neutral operation of the program. *See New Mexico Health Connections v. United States Dep't of Health & Human Servs.*, 312 F. Supp. 3d 1164, 1211 (D.N.M. 2018). HHS requested reconsideration of the New Mexico ruling and conducted a hearing on June 21, 2018. HHS appeared to have put all its eggs in the reconsideration basket because insurers were not provided substantive guidance on the implications of the New Mexico ruling until July 7, 2018.[4]

***6** On July 7, 2018, the Centers for Medicare & Medicaid Services ("CMS") issued a press release advising insurers that "the [New Mexico] ruling prevents CMS from making further collections or payments under the risk adjustment program, including amounts for the 2017 benefit year, until the litigation is resolved."[5] Two days later, CMS published the risk-adjustment payments and charges for 2017, including a disclaimer that CMS would not collect charges or distribute payments while the motion for reconsideration of the New Mexico ruling was pending.[6]

On July 12, 2018, CMS again told insurers that "CMS will not collect or pay the specified amounts at this time. CMS will inform stakeholders of any update to the status of collections or payments at an appropriate future date," and that "CMS is actively litigating this case and appreciates issuers' patience while this case is in litigation."[7]

Between July 7, 2018, and July 25, 2018, HHS faced building pressure to reach an expedient resolution.[8] During the reconsideration of the New Mexico ruling, a congressional letter urged the agency to heed the plaintiff's contention that "[a]s the Court did not require any changes to the agency's formula if a proper justification were put forth, any disruptive effect flows solely from the agency's apparent unwillingness to engage in the task that the Court set for it—a purely self-inflicted wound."[9] HHS received letters imploring the agency to resolve the impasse resulting from the July 7 announcement swiftly.[10]

***7** On July 27, 2018, CMS issued a memorandum advising issuers that it had decided to republish the previously adopted rules with further explanation in accordance with the New Mexico ruling, and would send out charge invoices in September 2018.[11] Payments would begin in October 2018. Three days later, the New 2017 Final Rule was published, stating:

> This final rule adopts the HHS-operated risk adjustment methodology previously published at 81 FR 12204 for the 2017 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the program. This rule does not make any changes to the previously published HHS-operated risk adjustment methodology for the 2017 benefit year.

New 2017 Final Rule, 83 Fed. Reg. 36,457 (July 30, 2018). HHS did not allow notice and comment on the New 2017 Final Rule and included an explanation for its good-cause exception. *See id.* A New 2018 Proposed Rule was published on August 10, 2018, and proceeded through notice-and-comment procedures. The New 2018 Proposed Rule stated:

> This rule proposes to adopt the HHS-operated risk adjustment methodology that was previously published at 81 FR 94058 for the 2018 benefit year with an additional explanation regarding the use of statewide average premium and the budget neutral nature of the risk adjustment program. This rule does not propose to make any changes to the previously published HHS-operated risk adjustment methodology for the 2018 benefit year.

New 2018 Proposed Rule, 83 Fed. Reg. 39,644 (August 10, 2018). The New 2018 Final Rule was published on December 10, 2018. Based on that timeline, Vista brings the following two issues.

i. Retroactivity

Vista contends the New 2017 and New 2018 Final Rules violate the APA's prohibition on retroactive rulemaking because the rules were promulgated after the conduct they regulated took place. *See* 5 U.S.C. § 551(4). The fact that the rules regulated past conduct is not in dispute—the New 2017 Final Rule was published on July 30, 2018, and applies to activities that took place in 2017; the New 2018 Final Rule was published on December 10, 2018, and

applies to activities that took place in 2018—the dispute is whether this constitutes retroactive rulemaking.

An agency may not promulgate retroactive rules absent express congressional authority. *Bowen v. Georgetown Univ. Hosp.*, 488 U.S. 204, 208 (1988). A statutory provision operates retroactively when it "impair[s] rights a party possessed when he acted, increase[s] a party's liability for past conduct, or impose[s] new duties with respect to transactions already completed." *Landgraf v. USI Film Prod.*, 511 U.S. 244, 280(1994). The Fifth Circuit has applied the *Landgraf* test governing statutory retroactivity, *Vela v. City of Houston*, 276 F.3d 659, 673 (5th Cir. 2001), and the same test applies in the administrative context, *see National Mining Ass'n v. United States Dep't of Interior*, 177 F.3d 1, 8 (D.C. Cir. 1999). "The conclusion that a particular rule operates retroactively comes at the end of a process of judgment concerning the nature and extent of the change in the law and the degree of connection between the operation of the new rule and a relevant past event ... familiar considerations of fair notice, reasonable reliance, and settled expectations offer sound guidance." *Landgraf*, 511 U.S. at 270 (quotations omitted).

***8** It is undisputed that HHS is not authorized to promulgate retroactive rules governing the risk-adjustment methodology. But the parties dispute whether the regulations are retroactive. HHS argues that the New 2017 Final Rule and the New 2018 Final Rule do not change the landscape because both rules simply adopt the previous rules methodology with further explanation to comply with the New Mexico ruling. Vista contends that although the rules "essentially apply the same standard[, it] does not save them from being new rules."

In analyzing both new rules, the court first looks to see whether either effect a substantive change from the agency's prior regulation or practice. *See National Mining Ass'n*, 177 F.3d at 8. HHS implemented the risk-adjustment program through rules promulgated in separate notice-and-comment proceedings for the 2014-2018 benefit years.[12] Each successive rule effectively employed the same risk-adjustment transfer formula as the previous year's rule.[13]

Neither the New 2017 nor the New 2018 Final Rules made any changes to the published HHS-operated risk-adjustment methodologies previously adopted for 2017 and 2018. 2018 Final Rule, 83 Fed. Reg. 63,419–20 (December 10, 2018). Issuers were aware of the 2017 risk-assessment methodology upon publication on March 8, 2016, and the 2018 methodology upon publication on December 22, 2016. 2017 Final Rule, 81 Fed. Reg. 12,204 (March 8, 2016); 2018 Final Rule, 81 Fed. Reg. 94,058 (December 22, 2016). HHS adopted the identical methodology it had promulgated in advance of the 2017 and 2018 benefit years. New 2017 Final Rule, 83 Fed. Reg. 36,459 (July 30, 2018) (explaining that "amounts previously calculated by HHS" under the prior 2017 rule "have not changed by virtue of [the new 2017] rule's issuance"); New 2018 Final Rule, 83 Fed. Reg. at 63,419 (December 10, 2018) (2018 methodology unchanged).

Rather than "increase a party's liability for past conduct, or impose new duties with respect to transactions already completed," *Landgraf*, 511 U.S. at 268, the new 2017 and 2018 rules simply reinstated the obligations all regulated entities had already anticipated and acted in reliance upon. During the remedial rulemaking process for the new 2018 rule, "[m]any commenters stated that no changes should be made to the risk-adjustment methodology for the 2018 benefit year because issuers' rates for the 2018 benefit year were set based on the previously finalized methodology." New 2018 Final Rule, 83 Fed. Reg. 63,422 (December 10, 2018). Additionally, "issuers relied on the 2018 HHS-operated risk adjustment methodology that used statewide average premium during rate setting and when deciding in calendar year 2017 whether to participate in the market(s) during the 2018 benefit year." *Id.* at 63,422–23. Because neither the New 2017 Final Rule nor the New 2018 Final Rule was retroactive under the *Landgraf* test, the court will deny Vista's request for summary judgment and grant summary judgment to HHS on Vista's retroactivity claim.

ii. Deficiencies under the APA

***9** The second issue raised by Vista is that the New 2017 Final Rule was published without allowing interested persons to comment. 5 U.S.C. § 553(c). It is undisputed that HHS violated traditional APA procedures. However, HHS claims a good-cause exception to the notice-and-comment procedures for the New 2017 Final Rule. The court finds HHS's claim of good cause inconsistent with the law but will grant summary judgment to HHS on other grounds.

To qualify for a good-cause exception, an agency must find that using the traditional rulemaking procedure is "impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(B). An agency invoking the good-cause exception must "incorporate[ ] the finding and a brief statement of reasons therefor in the rules issued." 5

U.S.C. § 553(b)(B). The good-cause exception to notice and comment "should be read narrowly in order to avoid providing agencies with an escape clause from the requirements Congress prescribed." *United States v. Johnson*, 632 F.3d 912, 928 (5th Cir. 2011) (internal quotations omitted).

Section 553 is "one of Congress's most effective and enduring solutions to the central dilemma it encountered in writing the APA reconciling the agencies' need to perform effectively with the necessity that the law must provide that the governors shall be governed and the regulators shall be regulated, if our present form of government is to endure." *New Jersey Dep't of Envtl. Prot. v. United States EPA*, 626 F.2d 1038, 1045 (D.C. Cir. 1980) (quotations omitted). "This exception should be read narrowly. It is an important safety valve to be used where delay would do real harm. It should not be used, however, to circumvent the notice and comment requirements whenever an agency finds it inconvenient to follow them." *United States Steel v. EPA*, 595 F.2d 207, 214 (5th Cir. 1979) (citation and footnote omitted).

(a) Impracticability

"[T]he mere existence of deadlines for agency action, whether set by statute or court order, does not in itself constitute good cause for a § 553(b)(B) exception." *Id.* at 213. A contrary rule would encourage administrative gamesmanship because "an agency unwilling to provide notice or an opportunity to comment could simply wait until the eve of a statutory, judicial, or administrative deadline, then raise up the 'good cause' banner and promulgate rules without following APA procedures." *Council of S. Mountains, Inc. v. Donovan*, 653 F.2d 573, 581 (D.C. Cir. 1981). "When a federal agency creates time pressures upon itself as a result of its own lack of immediate action, such conduct further supports a finding that no good cause existed to depart from the standard rulemaking procedures." *Texas Food Indus. Ass'n v. United States Dep't of Agric.*, 842 F. Supp. 254, 260 (W.D. Tex. 1993); *see e.g., National Ass'n of Farmworkers Orgs. v. Marshall*, 628 F.2d 604, 622 (D.C. Cir. 1980) ("[T]ime pressure posed by the impending harvest seasons was due in large part to the Secretary's own delays. The Department waited nearly seven months ... we cannot sustain the suspension of notice and comment to the general public which includes parties, such as plaintiffs who are primarily concerned with the health of their children.").

(b) Public Interest

The invocation of good cause for the public interest generally requires an agency to show that delaying the rule at issue would create "a significant threat of serious damage to important public interests." *Mobil Oil Corp. v. Department of Energy*, 610 F.2d 796, 802-03 (Temp. Emer. Ct. App. 1979). Such significant threats encompass situations where the announcement of a proposed rule would precipitate activity by affected parties that would harm the public welfare. *Mack Trucks, Inc. v. EPA*, 682 F.3d 87, 95 (D.C. Cir. 2012). For example, cases involving price controls have warranted an exception because of the market distortions caused by the announcement of future controls. *See DeRieux v. Five Smiths, Inc.*, 499 F.2d 1321, 1332 (Temp. Emer. Ct. App. 1974); *Nader v. Sawhill*, 514 F.2d 1064, 1068 (Temp. Emer. Ct. App. 1975). The exception has also been upheld as applicable to regulations concerning gas stations, where "[t]he gasoline shortage was a temporary, but highly disruptive, national emergency" and "[t]he long lines and violence required immediate action." *Reeves v. Simon*, 507 F.2d 455, 458-59 (Temp. Emer. Ct. App. 1974). Courts have emphasized the need for similarly serious threats to justify invoking the good cause exception. *See, e.g., Mack Trucks, Inc.*, 682 F.3d at 93 (citing "possible imminent hazard to aircraft, persons, and property" and rules of "life-saving importance" necessary to "stave off any imminent threat to the environment or safety or national security"); *Hawaii Helicopter Operators Ass'n v. Federal Aviation Admin.*, 51 F.3d 212, 214 (9th Cir. 1995) (citing a "recent escalation of fatal air tour accidents").

(c) Unnecessary

***10** "[T]he analysis of whether notice and comment is unnecessary is confined to those situations in which the administrative rule is a routine determination, insignificant in nature and impact, and inconsequential to the industry and to the public." *Mack Trucks, Inc.*, 682 F.3d at 94 (internal quotations omitted); *see United States v. Garner*, 767 F.2d 104, n.24 (5th Cir. 1985) ("[E]xercise of this discretion, at least in prohibiting the [government agency] from refinancing its own loans, went beyond the

mere technical implementation of a statute that makes notice and comment procedures unnecessary").

(d) Analysis

HHS included a statement of its good-cause exception in its July 30, 2018 publication of the New 2017 Final Rule. 83 Fed. Reg. 36,460 (July 30, 2018). Its principal argument appears to be that the uncertainty and delay risked dramatic premium increases for customers in 2019, and that delay could cause high-risk insurers to become insolvent because they relied on risk-adjustment payments. However sympathetic the court is with HHS's goals and the awkward situation in which HHS found itself after realizing it probably bet the wrong way on reconsideration, HHS's claim of good cause in this context is only a response to the "sort of pressing urgency that always exists," *see Gold E. Paper (Jiangsu) Co. v. United States*, 918 F. Supp. 2d 1317, 1327 (Ct. Int'l Trade 2013), and would function as the exact kind of escape clause based on self-imposed timelines that is impermissible. *See United States Steel Corp.*, 595 F.2d at 213.

The healthcare industry was not imperiled by a clearly articulated delay to facilitate APA procedure, and the risk-assessment methodology is not the kind of technical or inconsequential rule that can warrant notice and comment being unnecessary. HHS provides additional justifications, but the court concludes that none rise to the standard of good cause.

HHS had options to create certainty in the market following the New Mexico ruling but instead decided to stay silent, fight the district judge's instructions, and then equivocate at the last minute. The fact that HHS did not take up the issue until two months before invoices were to be sent out is not good cause for denying the public its right to lawful administrative procedure.

(e) Harmless Error

Although HHS is not entitled to a good-cause exception for failing to comply with notice-and-comment procedures for the New 2017 Final Rule, there is a harmless-error doctrine in administrative law.[14] *Johnson*, 632 F.3d at 930. Notice-and-comment rulemaking's goal is to "assure[ ] fairness and mature consideration of rules having a substantial impact on those regulated." *Pennzoil Co. v. Federal Energy Regulatory Comm'n*, 645 F.2d 360, 371 (5th Cir. 1981). Notice-and-comment procedures allow an agency to educate itself and to disclose its thinking on matters that will affect regulated parties. *See id.* However, these goals may be achieved where an agency's decision-making process addressed substantive claims identical to those proposed by the party asserting error, even if there were procedural deficiencies. *Id.* "[W]hen a party's claims were considered, even if notice was inadequate, the challenging party may not have been prejudiced." *Id.* at 930–31.

***11** The party who claims deficient notice bears the burden of proving that any such deficiency was prejudicial. *See Air Canada v. Department of Transp.*, 148 F.3d 1142, 1156 (D.C. Cir. 1998), as amended (Sept. 24, 1998) ("As incorporated into the APA, the harmless error rule requires the party asserting error to demonstrate prejudice from the error."); 5 U.S.C. § 706 ("[D]ue account shall be taken of the rule of prejudicial error"). If a party fails to carry that burden, the agency's decision must be upheld. *Sierra Club v. Slater*, 120 F.3d 623, 637 (6th Cir. 1997) (faulty notice "that has no bearing on the ultimate decision or causes no prejudice shall not be the basis for reversing an agency's determination"); *Idaho Farm Bureau Fed'n v. Babbitt*, 58 F.3d 1392, 1405 (9th Cir. 1995) ("Failure to provide notice and comment is harmless when the agency's mistake had no bearing on the procedure used or the substance of the decision.").

Determining whether a deficiency under the APA is harmless demands a case-specific inquiry involving "an estimation of the likelihood that the result would have been different ... and a hesitancy to generalize too broadly about particular kinds of errors when the specific factual circumstances in which the error arises may well make all the difference." *Shinseki v. Sanders*, 556 U.S. 396, 411-12 (2009). Vista fails to demonstrate prejudice from HHS's deficiencies under the APA. Applying the previous retroactivity analysis, the court finds no cognizable prejudice to Vista stemming from HHS's failure to follow APA procedures when issuing the New 2017 Final Rule.

HHS adopted the identical methodology that issuers had relied on. Vista's injury lies with the risk-adjustment program's existence, not HHS's deficient administrative procedure regarding the New 2017 Final rule. This court does not conclude that deficiencies under the APA concerning the New 2017 Final Rule are harmless in all instances, but only that Vista fails to present cognizable prejudice from the New 2017 Final Rule's APA

deficiencies. The court will, therefore, grant HHS summary judgment on Vista's APA deficiency claims as they relate to the New 2017 Final Rule.

(3) Regulatory Taking

The court agrees with Vista that "the takings claim may be ripe for summary judgment." Vista contends that a successful health insurer can hope for a margin of between 2%-5% per year and that HHS's risk adjustment charges of over 50% of premium revenue for 2017 and 57% for 2018 amount to a confiscatory regulatory taking. Vista supports its claim by reference to the affidavit of Paul Tovar, Chairman of the Board of Directors of Vista.[15] The following facts from Tovar's affidavit are taken as true for purposes of summary-judgment analysis.

Beginning in November 2014, Tovar spent at least $485,000 working to obtain approval for Vista to enter the Texas insurance market. In May 2016, TDI approved Vista to enter the Health Maintenance Organization insurance market. This approval represented TDI's finding that Vista "met the TDI monetary reserve requirements ... provider network accessibility and availability standard, ... and passed the TDI Managed Care Quality Assurance Examinations with no deficiencies or corrective action needed."

As enrollment grew, Tovar personally guaranteed loans from Vista Service Corporation to Vista Health Plan for $2.4 million, of which $1,962,393.68 remains unpaid. "In order to obtain TDI approval, Vista had to demonstrate that it had sufficient cash reserves to satisfy TDI's financial reserve requirements for the payment of claims and liabilities," and "Vista also had to obtain TDI approval of its premium rates ... TDI did not reject those premiums in light of any anticipated Rate Adjustment Transfer payment under the [**Affordable Care Act**] that [was] foreseeably due for 2017 or 2018."

***12** Vista employed actuaries to predict its risk-adjustment liability, and in early 2018, "[Vista's consulting firm] Milliman cautioned that the [Rate Adjustment Transfer] assessment could be 'as much as $800,000.' " Tovar recounts that "no one, not TDI, not me, not the board, not Vista360Health executives or staff, not [Vista's attorneys] Bailey & Associates, and initially, not Milliman, foresaw that the [Rate Adjustment Transfer] assessment for 2017 would be over $4,300,000." However, also in early 2018,[16] Milliman provided Vista with a relatively accurate estimate of $4 million for the 2017 risk-adjustment liability; that estimate was submitted to TDI on March 15, 2018. Because of this risk-assessment liability, Vista was placed under supervision by TDI and, by the end of 2018, TDI directed Vista not to sell insurance in 2019.

Tovar is poised to lose his entire investment because of the risk-adjustment transfers: "I had a reasonable expectation that my investment would at least be recouped ... to date I have received nothing on my investment." "Since the end of May 2019, Vista has been paying off claims and winding down ... the economic impact of the CMS's [Rate Adjustment Transfer] regulations ... made it impossible to stay in business [and] are the reason Vista had to shut down."

The Takings Clause provides: "[N]or shall private property be taken for public use, without just compensation." U.S. Const. amend. V. The aim is to prevent the government "from forcing some people alone to bear public burdens which, in all fairness and justice, should be borne by the public as a whole." *Armstrong v. United States*, 364 U.S. 40, 49 (1960). While takings problems are more commonly presented when "the interference with property can be characterized as a physical invasion by government, than when interference arises from some public program adjusting the benefits and burdens of economic life to promote the common good." *Penn Cent. Transp. Co. v. City of N.Y.*, 438 U.S. 104, 124 (1978) (citation omitted), economic regulation may nonetheless amount to a taking, *see Calder v. Bull*, 3 U.S. 386, 1 L. Ed. 648 (1798) (opinion of Chase, J.) ("It is against all reason and justice" to presume that the legislature has been entrusted with the power to enact "a law that takes property from A and gives it to B").

This case does not present the classical taking in which the government directly appropriates private property for the government's use. This case involves risk-adjustment payments and charges that are budget neutral and transfer funds between insurers. Here, the alleged taking arises from a "public program adjusting the benefits and burdens of economic life to promote the common good." *Penn Cent. Transp. Co.*, 438 U.S. at 124.

The inquiry into a challenged regulation's constitutionality involves an evaluation of the "justice and fairness" of the government action. *Id.* at 523. There is no set formula for identifying a "taking" forbidden under the Fifth Amendment, and courts have relied instead on *ad hoc*, factual inquiries into the circumstances of each particular case. *Ruckelshaus v. Monsanto Co.*, 467 U.S. 986, 1005 (1984); *Kaiser Aetna v. United States*, 444 U.S.

164, 175 (1979).

When deciding whether a taking is forbidden, three factors have particular significance: (1) the character of the governmental action; (2) the economic impact of the regulation on the claimant; and (3) the extent to which the regulation has interfered with distinct investment-backed expectations. *Connolly v. Pension Ben. Guar. Corp.*, 475 U.S. 211, 224–25 (1986). The claimant has a "substantial burden in proving that government action inflicts an unconstitutional taking." *United States Fid. & Guar. Co. v. McKeithen*, 226 F.3d 412, 416 (5th Cir. 2000).

i. The severity of economic impact

***13** There is no doubt that HHS's risk-adjustment charges had a significant economic impact on Vista. For summary judgment, the court accepts Vista's contention in Tovar's affidavit that the risk-adjustment charges caused Vista's insolvency and caused TDI to order Vista to stop participating in the market. The court assumes that the risk-adjustment charges for 2017 and 2018 "are the reason Vista had to shut down," and put Tovar's investment in jeopardy.

ii. The character of the governmental action

The risk-adjustment program does not physically invade or permanently appropriate any Vista asset for the government's use. Instead, the risk-adjustment charges levied on Vista would be transferred to an insurer that has a higher-risk insured population. Balancing the actuarial risk of insurance plans eliminates the incentive for insurers to design plans for specifically low-risk or high-risk individuals and incentivizes focus on plan quality. The risk-adjustment program's interference with the property rights of insurers that decide to participate in the individual and small-group markets arises from a public program that adjusts the benefits and burdens of economic life to promote the common good, and under consistent precedent, does not constitute a taking requiring compensation. *See Penn Cent. Transp. Co.*, 438 U.S. at 124.

Though the risk-adjustment program appears to have severe implications for small insurers that sell low-risk-low-price plans, it would be substituting the court's judgment for HHS's to hold that this was inconsistent with Section 18063. If Vista was able to maintain the same level of efficiency while also enrolling higher-risk members, Vista would benefit from risk-adjustment payments. The risk-adjustment program prevents plans with the same risk score from owing or receiving different amounts based on individual pricing decisions, discouraging plans that cover sicker enrollees from charging higher premiums. Vista argues that the premiums it would have to charge to account for the subsequent risk-adjustment charge would not be competitive. However, the risk-adjustment program relies on plans that cover healthier enrollees charging higher premiums to enable payments to plans that that cover sicker enrollees. *See* New 2018 Final Rule, 83 Fed. Reg. at 63,424 (December 10, 2018) (commenters "strongly opposed the use of a plan's own premium" because "issuers that traditionally attract high-risk enrollees would be incentivized to increase premiums in order to receive larger risk adjustment payments"). The balance of the **Affordable Care Act's** expansion of health-insurance coverage relies on innovative small insurers creating products that do not harbor low-risk enrollees.

iii. Reasonable investment-backed expectations

The final *Connolly* inquiry is whether the risk-adjustment program interfered with reasonable investment-backed expectations. Vista knew or should have known that it would be subject to expensive risk-adjustment charges if it enrolled a low-risk population. Vista contends that TDI's approval of its financial reserves and premium rates, given the foreseeability of risk-adjustment charges, functioned to justify its investment-backed expectations. But, as previously discussed, the risk-adjustment methodology was effectively the same since its inception in 2014.

The administrative record is replete with evidence that HHS's priority for implementation of Section 18063 was supporting plans with high-risk enrollees rather than making exceptions that contravene the text and purpose of the statute for low-risk-low-price plans. Even before TDI authorized Vista to enter the market in May 2016, Vista could have found comments on Federal Register rules discussing the risk-adjustment program's devastating effect on new and small insurers that enrolled a low-risk cohort.[17] The risk-adjustment program existed for years before Vista entered the market. If Vista managed to

create plans that served a higher-risk population, it is doubtful that Vista would be arguing that the payments it receives are unlawful regulatory takings from companies with lower-risk profiles. Vista's investment-backed expectations included, or should have included, an assessment of Section 18063.

***14** Vista's claim is irreconcilable with the reasoning of *Connolly*. Further, Vista has not met its substantial burden to show that risk-adjustment charges are an unconstitutional taking. The court will, therefore, grant HHS summary judgment on Vista's regulatory-taking claims.

(4) Disparate Impact

Vista develops its regulatory-taking argument into a claim that new and small insurers are unfairly burdened by risk-adjustment charges compared to large and established insurers that have claims data to establish a predictable risk pool—"in this manner the [Rate Adjustment Transfer] methodology did not assess insurance carriers on an equal basis."

But Vista has an exceptionally high burden for its equal-protection claim because small insurers are not an inherently suspect class, and the risk-adjustment program does not trammel fundamental rights. *See Cornerstone Christian Sch. v. University Interscholastic League*, 563 F.3d 127, 139 (5th Cir. 2009). The court applies rational-basis review and will grant HHS summary judgment on Vista's equal-protection, regulatory-taking, and arbitrary-and-capricious claims.

(5) Procedural Due Process

Vista maintains that "Vista Health Plan should have had an individual hearing on its *actual* risk." In support of this claim, Vista relies on a distinction between "(1) agency adjudications, in which there *is* an administrative record; (2) agency rulemaking, in which there is no evidentiary record; and (3) challenges that agency regulations violate constitutional rights." It is undisputed that Vista did not receive an agency adjudication, and that "such an omission is a denial of procedural due process." HHS responds that Vista is not entitled to a hearing and that HHS's notice-and-comment decisions are not subject to procedural-due-process constraints.

Neither party discusses Title 45 Code of Federal Regulations Section 156.1220, but its relevancy necessitates mention. An issuer may file a request for reconsideration concerning the amount of a risk-adjustment payment or charge if the amount in dispute exceeds one percent of the applicable charge and the request is filed "within 30 calendar days of the date of the notification under § 153.310(e)." *See* 45 C.F.R. §§ 156.1220(a)(1)(ii), (2), (3)(ii). The scope of review for the reconsideration includes "the evidence and findings upon which the determination was based" and "will be provided to the issuer with a reasonable opportunity to review and rebut the evidence." *See id.* § 156.1220(a)(5). Reconsideration decisions regarding risk-adjustment charges are neither final nor binding and are subject to the outcome of a request for an informal hearing. *See* § 156.1220(a)(6). This request must be made within 30 days of receipt of the reconsideration decision and may be submitted "for review by the CMS hearing officer." *See id.* § 156.1220(b)(1)-(2). In the informal hearing,

> the CMS hearing officer will review only the documentary evidence provided by the issuer and HHS, and the record that was before HHS when HHS made its reconsideration determination. The issuer may be represented by counsel in the informal hearing, and must prove its case by clear and convincing evidence with respect to issues of fact.

Id. § 156.1220(b)(3). "The decision of the CMS hearing officer is final and binding, but is subject to the results of any Administrator's review in accordance with paragraph (c)." *Id.* § 156.1220(b)(3). Paragraph (c) provides that the "Administrator of CMS has the discretion to elect to review the CMS hearing officer's decision or to decline to review the CMS hearing officer's decision." *Id.* § 156.1220(c)(2).

***15** The court concludes that there is a genuine dispute of material fact concerning Vista's right to administrative appeal that is not adequately resolved by reference to the administrative record. Vista's complaint includes a request for reconsideration as to the 2018 risk-adjustment charges sent on October 14, 2019, in response to HHS's risk-adjustment invoices dated August 13, 2019. While the regulation states that the request must be filed within 30 calendar days, the invoices Vista received state: "In order to present evidence or review the HHS records, you must submit a written request to CCIIOInvoices@cms.hhs.gov. Your request must be received within 60 calendar days from the date of this Initial Invoice." The record before the court does not include the result of that reconsideration or any evidence

of whether it took place.

Because Vista requested reconsideration and the record before the court is incomplete, the court will deny HHS's request for summary judgment on the procedural-due-process claim and remand the issue to HHS for proceedings consistent with Section 156.1220.

(6) State-Law Nullification

Vista asserts that its "nullification of state insurance laws" claim is "not appropriate for summary judgment at this stage," but presents no cogent argument why that is the case. The **Affordable Care Act** expressly provides that it preempts any state law that "prevent[s] the application of the provisions" of Title I, which includes risk adjustment. 42 U.S.C. § 18041(d). Multiple circuits have held that state laws must yield to the **Affordable Care Act** where they interfere with its application.[18] Assuming *arguendo* a conflict between state and federal law, federal law prevails. *See* U.S. Const. art. VI, cl. 2. The McCarran–Ferguson Act's reverse preemption provision only applies where a federal statute does not "specifically relate[ ] to the business of insurance." 15 U.S.C. § 1012(b). The **Affordable Care Act** "specifically relates" to and regulates the "business of insurance." The court will grant HHS summary judgment on Vista's state-law-nullification claims.

(7) Priority of Payment

Vista requests a declaration that the United States should not be paid before other creditors because the United States acts solely as a pass-through conduit for the risk-adjustment payments and charges between insurers. Vista contends that its priority claim is ripe because of TDI's supervision. HHS responds that even though Vista is under TDI's supervision, the claim is not ripe because events have not yet occurred and may never occur, including whether Vista will ultimately fail to pay its risk-adjustment assessments and whether the United States will seek to collect on those assessments through administrative measures or judicial proceedings.

Claims are not ripe, and the court lacks jurisdiction to consider them, if based on speculative contingencies. *See Texas v. United States*, 523 U.S. 296, 300 (1998) ("A claim is not ripe for adjudication if it rests upon contingent future events that may not occur as anticipated, or indeed may not occur at all.") (internal quotations omitted). "[T]he plaintiff must show some hardship in order to establish ripeness." *Central & S.W. Servs., Inc. v. EPA*, 220 F.3d 683, 690 (5th Cir. 2000).

Thus, the court must first determine if Vista has shown that hardship will result if court consideration is withheld at this time. *See Choice Inc. of Tex. v. Greenstein*, 691 F.3d 710, 714-15 (5th Cir. 2012). The court recognizes that Tovar's guarantee of Vista Service Corporation's $2 million loan balance is troubling to Tovar. However, the plaintiffs, Vista has not explained how it would be injured if, in a hypothetical dispute among creditors, the United States was deemed entitled to payment ahead of some other creditor.

***16** Additionally, the court agrees with HHS that enough events have not yet occurred and may never occur to require the court to withhold judgment at this time. The court will decline to issue the declaration requested by Vista.

B. Standard of Review for Claim (8)

An agency's construction of an authorizing statute is subject to a two-step analysis to determine whether its action is consistent with congressional intent. *Chevron, U.S.A., Inc. v. National Res. Def. Council, Inc.*, 467 U.S. 837, 842 (1984). The analysis begins with "whether Congress has directly spoken to the precise question at issue." If Congress's intent is clear, "the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id.* at 842–43. "[I]f the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843. If Congress left a gap for the agency to fill, its interpretation is "given controlling weight unless [it is] arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 843–44.

The agency's construction is accorded substantial deference. *Id.* at 844; *see also United States v. Mead Corp.*, 533 U.S. 218, 227–28 (2001). "This broad deference is all the more warranted when ... the regulation concerns a complex and highly technical regulatory program, in which the identification and classification of relevant criteria necessarily require significant expertise and entail the exercise of judgment grounded in policy

concerns." *Thomas Jefferson Univ. v. Shalala*, 512 U.S. 504, 512 (1994) (internal quotations omitted). The court should not substitute its judgment for that of the agency. *See Mead Corp.*, 533 U.S. at 229 ("[A] reviewing court has no business rejecting an agency's exercise of its generally conferred authority to resolve a particular statutory ambiguity simply because the agency's chosen resolution seems unwise.").

(8) HHS's Statutory Interpretation

Vista contends that the following five issues may be decided "simply by comparing the rule to the statute" at summary-judgment: (1) use of the statewide-average premium instead of average state actuarial risk is inconsistent with Section 18063 because the statute expressly requires the use of risk, not premiums in the methodology; (2) the use of variables other than the actuarial risk in the risk adjustment methodology; (3) the lack of required consultation with states; (4) the determination of actuarial standards was improperly delegated to private third parties; and (5) the failure to account for disparate risk levels in different geographic markets. The court agrees that disposition is proper and will grant HHS summary judgment as to each.

HHS's interpretation of Section 18063 is entitled to *Chevron* deference because "Congress delegated authority to the agency generally to make rules carrying the force of law, and that the agency interpretation claiming deference was promulgated in ... notice-and-comment rulemaking, or by some other indication of a comparable congressional intent." *Mead Corp.*, 533 U.S. at 226–27. Congress delegated development of the methodology to HHS, so the court adopts "a deferential standard of review" that gives considerable weight to HHS's judgment. *See id.* at 843-44.[19] In fact, the substance of the mandate for HHS to develop the risk-adjustment methodology falls under a bullet point titled "In general." 42 U.S.C. § 18063(a).

***17** Because Section 18063 requires HHS to "assess a charge" 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," it is impossible to devise a formula without a cost measure. *See* 42 U.S.C. § 18063(a)(1). Formulas that consider only relative actuarial risk would yield a risk score but no way of turning the score into a dollar figure. HHS was mandated to develop a risk-adjustment methodology aligning payments and charges with actuarial risk. HHS's use of a state's average premium as a cost-setting factor with other variables was reasonable.

Vista's third issue—that HHS failed to consult with states as required by Section 18063—is unfounded.[20] Notice-and-comment rulemaking by its nature involves consultation of states so they can participate by submitting comments and letters. Only Massachusetts opted to implement its own risk-adjustment program, and HHS worked with Massachusetts to facilitate that program. *See* 2014 Final Rule, 78 Fed. Reg. 15,439 (March 11, 2013) ("HHS received an alternate risk adjustment methodology from one State, the Commonwealth of Massachusetts. We are certifying this methodology as a Federally certified methodology for use in Massachusetts.").

Vista's fourth issue is similarly flawed. Vista argues that HHS improperly delegated the determination of actuarial standards to private third parties and therefore failed to comport with the requirement that HHS develop the risk-adjustment methodology itself. However, nothing in the statute prevents HHS from contracting with third parties. HHS had an unambiguously broad mandate to which the court gives substantial deference. *See generally*, 42 U.S.C. § 18063.

Vista's fifth issue is patently false. HHS incorporates a geographic-cost-factor adjustment in the risk-adjustment formula. 2014 Final Rule, 78 Fed. Reg. at 15,433 (March 11, 2013). The court will, therefore, grant HHS summary judgment on Vista's statutory-interpretation claims.

C. Standard of Review for Claim (9)

The APA requires agencies to engage in "reasoned decision making," *Michigan v. EPA*, 576 U.S. 743, 750 (2015) (quotations omitted), and directs that agency actions be "set aside" if they are "arbitrary" or "capricious." 5 U.S.C. § 706(2)(A). Under this "narrow standard of review ... a court is not to substitute its judgment for that of the agency," *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 513 (2009) (quotations omitted), but instead to assess only whether the decision was "based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971).

***18** If the agency's grounds are inadequate, a court may

remand for the agency to offer "a fuller explanation of the agency's reasoning at the time of the agency action," *Pension Benefit Guaranty Corp. v. LTV Corp.*, 496 U.S. 633, 654, or to "deal with the problem afresh" by taking new agency action, *SEC v. Chenery Corp.*, 332 U.S. 194, 201.

To that effect, the district court reviews an agency's actions and holds them to 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.

Motor Vehicle Mfrs. Ass'n v. State Farm Auto Mut. Ins. Co. 463 U.S. 29, 43 (1983). Though the court may not provide a reasoned basis for the agency's action, 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).

(9) HHS's Decisions to use Statewide-Average Premiums

Vista contends that the risk-adjustment methodology's use of statewide-average premiums was "unreasonable" because it "penalizes Vista for offering low premium, high quality plans and rewards Vista's competitors, those who dominate the market, for keeping their prices high[, which is] a distortion of Congress's clear intent to create an affordable, competitive insurance marketplace." Vista also argues that the statewide-average premium "is substantially higher than Vista's premiums, not because [Vista's] population enters the market healthier, but because Vista proactively managed and coordinated the care delivered to its members." HHS's decision to use statewide-average premiums as opposed to a plan's own premiums is the issue under review for whether it was arbitrary and capricious.[21]

In 2011, HHS began the consultation process for the development of the risk-adjustment methodology by soliciting feedback on "the specific formulas and calculations ... to examine how various policy choices would affect risk adjustment transfer amounts and plan premiums." Center For Consumer Info. & Ins. Oversight, *Risk Adjustment Implementations Issues* (Sept. 12, 2011), at 29 ("2011 White Paper"). In its 2011 White Paper, the Center for Consumer Information and Insurance Oversight explained the benefits and drawbacks of statewide-average premiums and plans' own premiums as cost-setting factors, and invited the public to comment:

> Option 1a: Weighted State average premiums. This approach would calculate the baseline premium according to the enrollment-weighted average premium in the State. The State average could be calculated with or without adjustment for actuarial value of plans. Using a State average (without actuarial value adjustment) would result in balanced payments and charges, because the State average is a single dollar amount for all plans, and plan risk scores average to 1.0.
>
> ***19** ...
>
> Option 2: Plan's own premiums. This approach would use each plan's own premiums as the baseline premium. Relative to the prior options, charges would be lowest for low premium, low-risk plans under this approach, and payments would be highest for high risk, high premium plans. In this approach, the amount of charges and payments would be affected by each plan's premium. For 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. This could create disincentives for high-risk plans to operate efficiently or set lower prices.
>
> Conversely, among two plans with the same healthier than average risk mix, a lower premium plan would have lower charges, potentially creating incentives for low-risk plans to operate more efficiently and/or set lower premiums.

Id. at 14–15. The 2011 White Paper further noted:

> When payments are greater than charges, a low risk plan with low premiums would be charged less if the baseline premium is the plan's own premiums and payments are reduced to charges, as compared to what the plan would be charged if the baseline premium is the State average premium or the baseline premium is the plan's own premiums with charges increased to payments. Conversely, a high risk plan with high premiums would receive higher payments if the baseline premium is the plan's own premium and charges are increased to payments, as compared to the payments the plan would receive if the baseline premium is the State average premium, or the baseline premium is the plan's own premiums with payments

decreased to charges.

Id. at 16. The record contains recognition that the use of statewide-average premiums as the cost-setting factor in the risk-adjustment transfer formula may penalize low-priced insurers but provides adequate explanation for why, nonetheless, HHS chose to use the statewide-average premium in its methodology. *See* 2011 White Paper at 38. HHS also evaluated the argument that its methodology does not account for efficiencies or differences in care management. 2016 White Paper at 93 ("although a number of sources of premium variation – such as metal level, age, and geographic cost factors – are explicitly addressed in the transfer equation, others – such as network differences, plan efficiency, or effective care coordination or disease management – are not"). But, again, HHS made a reasoned choice to prioritize the use of statewide-average premiums because it "embeds an average level of efficiency," ensuring that "[a]ll plans receive a risk adjustment payment or charge sufficient for a plan with average efficiency." 2016 White Paper at 83. For example, in a section from the 2014 proposed rule titled "Rationales for a Transfer Methodology Based on State Average Premiums," HHS explains:

> In the [2011] 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 (for example, [actuarial value] 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).
>
> ***20** 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 examples in the Risk Adjustment White Paper, transfers net to zero when the State average premium is used as the basis for calculating transfers.
>
> Plan premiums differ from the State average premium due to a variety of factors, such as differences in cost-sharing structure or regional differences in utilization and unit costs. The proposed payment-transfer formula applies a set of cost-factor adjustments to the State average premium so that it will better reflect plan liability. These adjustments to the State average premium result in transfers that compensate plans for liability differences associated with risk selection, while preserving premium differences related to other cost factors described above.

2014 Proposed Rule, 77 Fed. Reg. at 73,139 (December 7, 2012). HHS noted it received comments supporting its decision:

> Comment: We received a number of comments in support of our proposal to use the State average premium as the basis for risk adjustment transfers. One commenter suggested that use of a plan's own premium may cause unintended distortions in the transfer formula. One commenter suggested that we use net claims, or approximate net claims by using 90 percent of the State average premium, as the basis for risk adjustment transfers.
>
> Response: The goal of the payment transfer formula is, to the extent possible, to promote risk-neutral premiums. We agree with commenters that use of a plan's own premium may cause unintended distortions in transfers. We also believe that both claims and administrative costs include elements of risk selection, and therefore, that transfers should be based on the entire premium. We are finalizing our proposal to base the payment transfer formula on the State average premium.

2014 Final Rule, 78 Fed. Reg. at 15,432 (March 11, 2013). In its post-mortem of the 2014 benefit year risk-adjustment program, the Center for Consumer Information and Insurance Oversight explains:

> The Statewide market average premium acts as a common scaling factor for both terms in the formula, both of which are expressed relative to the Statewide market average. The Statewide average premium will also reflect the Statewide cost level. Over the long run, the Statewide average premium is expected to equal the Statewide average cost (including allowable loading for administrative costs, surplus, and profit). The Statewide premium is therefore simultaneously a premium and a cost scaling factor. The Statewide average premium embeds an average level of efficiency. All plans receive a risk adjustment payment or charge sufficient for a plan with average efficiency.
>
> Two other reasons that transfers are scaled by the Statewide average premium, as opposed to, for example, the plan's own premium, are:

> • Using the Statewide average premium minimizes issuers' ability to manipulate their transfers by adjusting their own plan premiums.
>
> • Scaling all transfers to the same premium, combined with the assumption that the factors affecting premium requirements and allowable revenue have a multiplicative relationship, obviates any further adjustment of payments and charges to ensure that risk adjustment transfers for the entire market sum to zero.

***21** 2016 White Paper at 83.

As recounted in the 10th Circuit's reversal of the New Mexico ruling that sparked so much of the present controversy, HHS explained at least six different reasons for the adoption of a statewide-average premium over alternative measures of cost:

> (1) "reduce the impact of risk selection on premiums while preserving premium differences related to other cost factors," 2014 Proposed Rule, 77 Fed. Reg. at 73,139;
>
> (2) achieve "a straightforward and predictable benchmark for estimating transfers" each year, *id.*;
>
> (3) "promote risk-neutral premiums," 2014 Final Rule, 78 Fed. Reg. at 15,432;
>
> (4) avert "caus[ing] unintended distortions in transfers," *id.; see also* 2011 White Paper at 14 (using plans' own premiums "could create disincentives for high-risk plans to operate efficiently or set lower prices"); and
>
> (5) avoid disproportionately distributing costs to insurers when using balancing adjustments, 2011 White Paper at 16.
>
> [6] using the statewide average premium facilitates budget neutrality, making transfers "net to zero" without additional balancing adjustments. 2014 Proposed Rule, 77 Fed. Reg. at 73,139; *see* 2011 White Paper at 14.

New Mexico Health Connections v. United States Dep't of Health & Human Servs., 946 F.3d 1138, 1164–65 (10th Cir. 2019). Similar explanations are outlined in the new 2017 and 2018 rules. New 2017 Final Rule, 83 Fed. Reg. at 36,457 (July 30, 2018) (statewide-average premium "supports the overall goal of the risk adjustment program to encourage issuers to rate for the average risk in the applicable state market risk pool, and avoids the creation of incentives for issuers to operate less efficiently, set higher prices, develop benefit designs or create marketing strategies to avoid high risk enrollees"); New 2018 Final Rule, 83 Fed. Reg. at 63,424 (December 10, 2018). HHS notes in the New 2018 Final Rule that commenters "strongly opposed the use of a plan's own premium" because "issuers that traditionally attract high-risk enrollees would be incentivized to increase premiums in order to receive larger risk adjustment payments." *Id.*

Because HHS's decision to use statewide-average premiums in the risk-assessment methodology is based on a consideration of the relevant factors and no clear error of judgment is found in the record, the decision was not arbitrary and capricious. The court will grant summary judgment to HHS on Vista's unreasonableness claim.

VI. Conclusion

The court concludes that Vista's risk-adjustment charges for the 2017 and 2018 benefit years are legally valid, subject to the results of a proper agency adjudication. Accordingly,

IT IS ORDERED that Vista's Motion for Summary Judgment or, in the alternative, for Partial Summary Judgment filed on January 31, 2020 (Doc. #32) is **DENIED.**

***22 IT IS FURTHER ORDERED** that HHS's Motion for Summary Judgment and Memorandum in Opposition to Plaintiffs' Motion for Summary Judgment filed on February 28, 2020 (Doc. # 33) is **GRANTED IN PART** and **DENIED IN PART.** Except as to Vista's procedural-due-process claim, which is **DENIED AND REMANDED** to HHS for proceedings consistent with Title 45 Code of Federal Regulations Section 156.1220 and this order, the motion is **GRANTED.** Vista shall **TAKE NOTHING** by the eight other claims asserted against HHS.

All Citations

Slip Copy, 2020 WL 6380206

Footnotes

1 Throughout this order, Plaintiffs Vista Health Plan, Inc., and Vista Service Corporation will collectively be referred to as "Vista,"

and Defendants United States Department of Health and Human Services, Alex M. Azar, Centers for Medicare and Medicaid Services, and Seema Verma will collectively be referred to as "HHS."

2 (1) The invalidation of the individual mandate also invalidated the **Affordable Care Act** in its entirety, including the inseverable risk-adjustment program; (2) HHS conducted retroactive rulemaking and violated the APA's rulemaking procedures; (3) charges levied against Vista under the risk-adjustment program are unconstitutional regulatory takings; (4) risk adjustments' disproportionate impact on Vista relative to other insurers violates the Equal Protection Clause; (5) state law nullifies the risk-adjustment program; (6) the lack of an HHS evidentiary hearing violated Vista's right to procedural due process (7) the federal government should not have priority right of payment; (8) HHS acted in excess of statutory authority in its interpretation of Title 42 United States Code Section 18063; and (9) HHS's use of statewide-average premiums in the risk-adjustment transfer methodology was arbitrary and capricious.

3 *See* 945 F.3d 355, 389 (5th Cir. 2019), *cert. granted*, 140 S. Ct. 1262 (2020).

4 In its opinion denying reconsideration of the New Mexico ruling, the court quoted Nicholas Bagley, a professor at the University of Michigan Law School: "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...." *See New Mexico Health Connections v. United States Dep't of Health & Human Servs.*, 340 F. Supp. 3d 1112, 1143 (D.N.M. 2018).

5 CMS operates the risk-adjustment program on behalf of HHS on behalf of any state which does not elect to operate its own program. In 2017, HHS operated risk-adjustment programs on behalf of all states and the District of Columbia. Centers for Medicare & Medicaid Services Press Release (July 7, 2018), *United States District Court Ruling Puts Risk Adjustment On Hold.*

6 Centers for Medicare & Medicaid Services Summary Report (July 9, 2018), *Summary Report on Permanent Risk Adjustment Transfers for the 2017 Benefit Year.*

7 Centers for Medicare & Medicaid Services Memorandum (July 12, 2018), *Implications of the Decision by United Stated District Court for the District of New Mexico on the Risk Adjustment and Related Programs.*

8 *See* Letter to Secretary Azar and Administrator Verma from Congressman Frank Pallone, Jr. et al., July 17, 2018 ("We ask that you take immediate action to reverse this destructive decision ... we disagree with the agency's characterization that the suspension of the risk adjustment program is necessary. It is clearly within the agency's power to remedy the issue identified by the district court ... by issuing an Interim Final Rule ... it is unclear why the agency has not already done so, as the district court's decision was handed down in February, and it is now July."); Letter from Sens. Gary Peters and Robert Casey to Administrator Verma (July 17, 2018) ("CMS needs to act with the utmost urgency to resolve the $10.4 billion hold on the risk adjustment program.")

9 Letter from Rep. Frank Pallone, Jr., et al., to Secretary Azar and Administrator Verma (July 17, 2018) at fn.7 quoting *New Mexico Health Connections v. Burwell*, No. CIV 16-0878, Plaintiff's Memorandum of Law in Opposition to Defendants' Motion to Alter or Amend Judgment Pursuant to Rule 59(e), Doc. #63 (D.N.M. Feb 28, 2018).

10 Letter from Tim Jones, Change Healthcare, to Administrator Verma (July 12, 2018) ("I am writing to urge CMS to seek a swift resolution regarding the July 7 announcement"); Letter from Washington Insurance Commissioner Mike Kreidler to Administrator Verma (July 11, 2018) ("It is those consumers I seek to protect by urging you to resolve this suspension as quickly as possible"); Letter from State Health Exchange Leadership Network to Secretary Azar and Administrator Verma (July 12, 2018) ("CMS should also immediately issue interim final rules or other guidance to address the court's order and make the 2017 risk adjustment payments").

11 Centers for Medicare & Medicaid Services Memorandum (July 27, 2018), *Update on the HHS-operated Risk Adjustment Program for the 2017 Benefit Year.*

12 As used in the risk-adjustment program, a " 'benefit year' means a calendar year for which a health plan provides coverage for health benefits." 45 C.F.R. § 155.20.

13 *See* 2015 Final Rule, 79 Fed. Reg. 13,744, 13,753 (Mar. 11, 2014) ("We proposed to use the [2014] methodology in 2015"); 2016

Final Rule, 80 Fed. Reg. 10,750, 10,760 (Feb. 27, 2015), corrected by 2016 Final Rule, 80 Fed. Reg. 38,652 (July 7, 2015) ("We proposed to continue to use the same risk adjustment methodology finalized in [ ] 2014"); 2017 Final Rule, 81 Fed. Reg. 12,204, 12,217 (Mar. 8, 2016) (same); 2018 Final Rule, 81 Fed. Reg. 94,058, 94,100 (Dec. 22, 2016) ("The payment transfer formula is unchanged from what was finalized in [ ] 2014").

14 The harmless-error doctrine is reserved a limited role in administrative law. *United States Steel Corp.*, 595 F.2d at 215. "An overreaching harmless error doctrine would allow the agency to inappropriately avoid the necessity of publishing a notice of a proposed rule and perhaps, most important, [the agency] would not be obliged to set forth a statement of the basis and purpose of the rule, which needs to take account of the major comments—and often is a major focus of judicial review." *Johnson*, 632 F.3d at 931 (quotations omitted).

15 Vista Health Plan is a wholly-owned subsidiary of Vista Service Corporation. Tovar is the sole shareholder of Vista Service Corporation.

16 Specific "early 2018" dates of the inaccurate and accurate estimates are not found in the record.

17 *See NMHC Comments Filed On CMS-9937-P, "Patient Protection and* ***Affordable Care Act****; HHS Notice of Benefit and Payment Parameters for 2017"* (Dec. 2015) (explaining that risk-adjustment formula was "destabilizing and even eliminating new, small and rapidly growing state based plans"); *see e.g., Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans* (Nov. 4, 2015), (directly attributing insolvencies of CO-OPs created under ACA to use of statewide-average premium in risk-adjustment formula and explaining that statewide-average premium is not driven solely by relative actuarial risk, but also whether issuer can control costs.)

18 *See, e.g., St. Louis Effort for AIDS v. Huff*, 782 F.3d 1016, 1024–27 (8th Cir. 2015); *Coons v. Lew*, 762 F.3d 891, 902 (9th Cir. 2014).

19 In its motion for summary judgment, Vista notes that "the substance of the final [risk-adjustment] rules may be entitled to *Chevron* deference," but does not go on to define "substance" in a way that sheds light on why this point is conceded by Vista.

20 "Consistent with section 1321(c)(1) of the [**Affordable Care Act**], the Secretary is responsible for operating the risk adjustment program on behalf of any state that elected not to do so. For the 2017 benefit year, HHS is responsible for operation of the risk adjustment program in all 50 states and the District of Columbia. HHS sets the risk adjustment methodology that it uses in states that elect not to operate the program in advance of each benefit year through a notice-and-comment rulemaking process with the intention that issuers will be able to rely on the methodology to price their plans appropriately." New 2017 Final Rule, 83 Fed. Reg. 36,456 (July 30, 2018). "Congress designed the risk adjustment program to be implemented and operated by states if they choose to do so. Nothing in section 1343 of the [**Affordable Care Act**] requires a state to spend its own funds on risk adjustment payments or allows HHS to impose such a requirement. Thus, while section 1343 may have provided leeway for states to spend additional funding on the program if they voluntarily chose to do so, HHS could not have required additional funding within the HHS-operated risk adjustment methodology." *Id.* at 36,458.

21 The court does not address any of Vista's claims that appear to allege that the risk-adjustment methodology was improperly calculated in Vista's case.

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