No. 20-50963

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

VISTA HEALTH PLAN, INCORPORATED; VISTA SERVICE CORPORATION,

Plaintiffs-Appellants,

v.

UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; XAVIER BECERRA, Secretary, U.S. Department of Health and Human Services; CENTERS FOR MEDICARE AND MEDICAID SERVICES; SEEMA VERMA, Administrator of the Centers for Medicare and Medicaid Services,

Defendants-Appellees.

On Appeal from the United States District Court
for the Western District of Texas, Austin Division,
No. 1:18-cv-824 (Hon. Lee Yeakel)

BRIEF FOR DEFENDANTS-APPELLEES

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CERTIFICATE OF INTERESTED PERSONS

***Vista Health Plan v. U.S. Dep't of HHS*, No. 20-50963 (5th Cir.)**

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this appeal:

Plaintiffs-appellants:
Vista Health Plan Inc.
Vista Service Corporation

Defendants-appellees:
United States Department of Health and Human Services
Xavier Becerra, Secretary of Health and Human Services
Centers for Medicare and Medicaid Services (CMS)
Chiquita Brooks-LaSure, Administrator, CMS*
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* The current CMS Administrator, Chiquita Brooks-LaSure, should be substituted on the official caption pursuant to Fed. R. App. P. 43(c)(2).

STATEMENT REGARDING ORAL ARGUMENT

Appellants have requested oral argument. The government does not believe that argument is necessary, but stands ready to present argument if it would assist the Court in its deliberations.

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STATEMENT OF JURISDICTION

Plaintiffs invoked the district court's jurisdiction under 28 U.S.C. § 1331 and asserted statutory and constitutional claims under the Administrative Procedure Act (APA). ROA.185; *see* ROA.194-99. The district court issued its final ruling and entered judgment on September 21, 2020. ROA.2474-2516. Plaintiffs filed a timely notice of appeal on November 20, 2020. ROA.2517-18.

"Generally, district court orders remanding to an administrative agency are not final orders." *Adkins v. Silverman*, 899 F.3d 395, 400 (5th Cir. 2018). On one of plaintiffs' claims, the district court stated it would remand to the Department of Health and Human Services (HHS) for any further proceedings necessary to adjudicate plaintiffs' request for reconsideration of its 2018 risk-adjustment charges. *See* ROA.2503 ("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 [45 C.F.R. §] 156.1220."). As HHS has reaffirmed by letter of July 19, 2021 (*see* Gov't 8/9/21 Mot. for Judicial Notice (MJN) ex. B), however, the agency had already denied plaintiffs' request for reconsideration in November 2019. Because that request is not pending, no additional "proceedings consistent with Section 156.1220" are required or possible under the district court's order. ROA.2503. Under these "peculiar circumstances," *Memorial Hosp. Sys. v. Heckler*, 769 F.2d 1043,

1044 (5th Cir. 1985), the district court's order constitutes a final dismissal of all of plaintiffs' claims, and this Court has appellate jurisdiction under 28 U.S.C. § 1291.

STATEMENT OF THE ISSUES

The Affordable Care Act created a permanent "risk adjustment" program in each State, under which funds are transferred from insurance plans with lower actuarial risk to those with higher actuarial risk, to stabilize insurance markets and eliminate incentives for insurers to compete based on enrollees' health status. HHS implements the risk-adjustment program through annual payment rules issued through notice and comment. After a district court in New Mexico—in a decision later reversed by the Tenth Circuit, *see New Mexico Health Connections* (*NMHC*) *v. U.S. Dep't of HHS*, 946 F.3d 1138 (10th Cir. 2019)—vacated HHS's rules in part on the theory that they were insufficiently explained, HHS reissued the same rules with additional explanation in order to prevent an imminent crisis in insurance markets.

Plaintiffs, an insurer and parent corporation that sold policies on the individual market in Texas, challenges its risk-adjustment charges for the 2017 and 2018 benefit years on numerous grounds. The questions presented are:

1. Whether HHS properly reissued its risk-adjustment methodology for benefit years 2017 and 2018.

2. Whether HHS's payment transfer formula is consistent with the statute and otherwise reasonable.

3. Whether the district court properly granted summary judgment on Vista's constitutional claims.

STATEMENT OF THE CASE

A. Statutory and Regulatory Background

1. The Affordable Care Act's Risk-Adjustment Program

In the Patient Protection and Affordable Care Act (ACA), Congress enacted "a series of interlocking reforms designed to expand coverage" in the individual and small-group health insurance markets. *King v. Burwell*, 576 U.S. 473, 478-79 (2015). Among other measures, the ACA prohibits insurers from denying coverage or charging higher premiums based on an individual's health status. *Id.* at 481. The ACA also established "Health Benefit Exchange[s]" in each State in which health insurance issuers may compete for customers, many of whom receive federal subsidies to help them pay for insurance. *Id.* at 482-83.

Although Congress prohibited insurers from denying coverage or charging higher premiums based on health status, it was aware that sicker individuals would generally continue to result in higher costs for insurers (because they receive more care), while healthier individuals would generally result in lower costs for insurers. Insurers would thus have incentives to design their plans to discourage enrollment by sicker individuals. For example, a plan could offer lower premiums by excluding from its provider networks certain specialty hospitals and doctors that treat high-cost conditions. *See, e.g.*, Mark A. Hall, *Risk Adjustment Under the Affordable Care Act: Issues and Options*, 20 Kan. J.L. & Pub. Pol'y 222, 224 (2011). Such plans would be attractive

to healthier individuals due to their low costs, but unattractive to individuals who may need access to specialized care. *Id.*

To counteract those incentives, section 1343 of the ACA (codified at 42 U.S.C. § 18063) directed HHS to establish a permanent "risk adjustment" program.[1] Under this program, monetary charges are collected from plans with healthier-than-average enrollees in a given State, and payments are made to plans with sicker-than-average enrollees in that State. By thus redistributing "actuarial risk" among plans, the risk-adjustment program both "reduce[s] the incentives for issuers to avoid higher-risk enrollees" and compensates insurers whose plans "attract higher-risk populations, such as those with chronic conditions." 78 Fed. Reg. 15,410, 15,411 (Mar. 11, 2013). In this way, the risk-adjustment program advances the goal "that premiums should reflect the differences in plan benefits and plan efficiency, not the health status of the enrolled population." *Id.* at 15,417; *see NMHC v. U.S. Dep't of HHS*, 946 F.3d 1138, 1146 (10th Cir. 2019) (recognizing program's purpose to "stabilize health insurance premiums, encourage health insurers to provide plans on the exchanges, and discourage insurers from eluding enrollment of sicker individuals").

Congress designed the risk-adjustment program to be administered by States. The ACA provides that "each State shall *assess a charge*" on insurers if "the actuarial risk of [their] enrollees … for a year is *less than* the average actuarial risk of all enrollees

[1] The government understands Vista's repeated use of the phrase "rate adjustment" (Br. 1, 2, 15, 17, 28, 30) to refer to the risk-adjustment program.

in all plans or coverage in such State for such year." 42 U.S.C. § 18063(a)(1) (emphases added). Likewise, the statute provides that "each State shall *provide a payment*" to insurers "if the actuarial risk of [their] enrollees … is *greater than* the average actuarial risk of all enrollees in all plans and coverage in such State for such year." *Id.* § 18063(a)(2) (emphases added).

Although Congress contemplated that each State would run its own program, Congress directed HHS to operate the risk-adjustment program in any State that opted not to do so itself. *See* 42 U.S.C. § 18041(c)(1)(B)(ii). Beginning with the 2017 benefit year, HHS has run the risk-adjustment program in every State.

2. HHS Regulations Implementing The Risk-Adjustment Program

Congress assigned HHS, in consultation with the States, the complex task of devising a way to measure and compare actuarial risk among plans and then to distribute that risk in monetary terms among eligible plans in each risk pool in each State. *See* 42 U.S.C. § 18063(b) (directing HHS to "establish criteria and methods to be used in carrying out the risk adjustment" program and to "include[]" them in certain "standards and requirements" to be prescribed by regulation, as required by 42 U.S.C. § 18041(a)(1)(C)-(D)).

To that end, HHS engaged in a two-year process that included input from state insurance commissioners, public meetings, expert analysis by HHS's contractor, the publication of a white paper, and notice-and-comment rulemaking. That process

culminated in a March 2013 final rule, in which HHS set forth the risk-adjustment methodology to be used in 2014, the program's first year, in States where HHS was responsible for running the program. *See* 78 Fed. Reg. at 15,417-34. Since then, HHS has built upon the methodology by making technical improvements and other annual updates each year.

From the outset, HHS designed the risk-adjustment program to be budget neutral, meaning that payments to higher-risk plans are funded entirely by charges collected from lower-risk plans. *See, e.g.*, 78 Fed. Reg. at 15,441. HHS's payment methodology is accordingly structured so that total charges to plans with healthier members equal total payments to plans with less-healthy members.

In broad terms, HHS's risk-adjustment methodology involves three steps. *NMHC*, 946 F.3d at 1148-50. First, for each individual enrolled in an insurer's plan, an actuarial risk score is computed using demographic and diagnostic data (including age, sex, and past medical diagnoses) to determine the predicted cost of insuring that enrollee. 78 Fed. Reg. at 15,419. Second, the risk scores for all of the plan's enrollees are aggregated to determine the plan's average risk score. *Id.* at 15,432. Third, a plan's (adjusted[2]) risk score is multiplied by the statewide average premium, yielding

[2] HHS's formula incorporates certain technical adjustments that account for certain permissible differences in plan design that might otherwise distort risk comparisons across plans. These adjustments—which are not at issue in this litigation—include adjustments for plan allowable premium rating, actuarial value, induced demand, and geographic cost. 78 Fed. Reg. at 15,430-31.

the dollar amount that a given insurer will pay as a charge, or receive as a payment, for that plan for that year. *See id.* at 15,430-34.

In deciding to use the statewide average premium for purposes of that third step, HHS explained that this choice would ensure that the transfer formula yields balanced charges and payments, and would enhance insurers' ability to predict their likely risk-adjustment charge or payment. *See NMHC*, 946 F.3d at 1163-65; 77 Fed. Reg. 73,118, 73,139 (Dec. 7, 2012) (explaining that "transfers net to zero when the State average premium is used as the basis for calculating transfers"). HHS also explained that use of the statewide average premium would avoid giving insurers an incentive to set their premiums higher or lower in an effort to inflate or deflate their expected risk-adjustment payment or charge (respectively), such as could occur if transfers were scaled as a percentage amount of a plan's own premium. *Id.*

For every year since the program's inception, HHS has conducted notice-and-comment rulemaking prospectively to develop the risk-adjustment methodology to be used for the forthcoming benefit year, and has done so far enough in advance to permit insurers to rely on HHS's methodology in setting their annual rates and benefits before those rates must be approved by state regulators. *See, e.g.*, 81 Fed. Reg. 94,058, 94,072-73 (Dec. 22, 2016) (explaining the importance of setting rules far in advance). Though HHS has used the annual rulemaking process as an opportunity to refine its risk-adjustment rules, it has not reconsidered the entire methodology anew each year, and thus has "s[ought] to balance stakeholders' desire for a stable model …

with introducing model improvements as additional data becomes available." 78 Fed. Reg. at 15,418.

Although the rules for a given benefit year are thus set well in advance, the actual transfer of risk-adjustment funds does not occur until later, after the necessary final data becomes available. After a given benefit year ends, plans must make their relevant enrollment and claims data available to HHS, typically by April 30 of the following year. *See* 45 C.F.R. § 153.730. HHS then determines each plan's charge or payment amount and publicly announces it two months later, by June 30. *See id.* § 153.310(e). Any insurer that takes issue with the calculation of its charge or payment amount for a given benefit year may seek administrative reconsideration within an ensuing 30-day period. *Id.* § 156.1220(a)(3)(ii). HHS then collects charges and uses those collections to make payments to issuers. *Id.* § 153.610(d)-(e).

B. Factual Background

This case concerns HHS's administration of the risk-adjustment program for the 2017 and 2018 benefit years and, in particular, actions taken by HHS to ensure the successful operation of the program in light of a (later reversed) district court decision that erroneously vacated HHS's rules in relevant part. *See NMHC v. U.S. Dep't of HHS*, 312 F. Supp. 3d 1164 (D.N.M. 2018), *rev'd*, 946 F.3d 1138 (10th Cir. 2019).

1. The Original 2017 And 2018 Final Rules

Following issuance of a proposed rule and an opportunity for comment, *see* 80 Fed. Reg. 75,487 (Dec. 2, 2015), HHS published its risk-adjustment methodology

for the 2017 benefit year in March 2016, *see* 81 Fed. Reg. 12,204 (Mar. 8, 2016) (2017 Rule). In its 2017 Rule, HHS "continue[d] to use the same risk adjustment methodology finalized in the 2014 Payment Notice," while making certain technical improvements and updates not at issue here. *Id.* at 12,217.

For the 2018 benefit year, HHS again issued a proposed rule and solicited public comment, *see* 81 Fed. Reg. 61,456 (Sept. 6, 2016), and then published its final rule in December 2016, *see* 81 Fed. Reg. 94,058 (Dec. 22, 2016) (2018 Rule). The 2018 Rule included several updates to the risk adjustment methodology not at issue here.

In the 2018 Rule, HHS also considered and rejected a suggestion by several commenters that HHS modify its payment transfer formula to "use a plan's own actual average premium instead of the Statewide average premium." 81 Fed. Reg. at 94,100. HHS explained that the commenters' approach would not only "lead to substantial volatility in transfer results," but also would yield "even higher transfer charges for low-risk low-premium plans," given the need to provide "even greater transfer payments" to "high-risk, high-premium plans." *Id.* HHS also declined to "cap transfers as a percent of premiums or by issuer size," explaining that such a cap would harm insurers who cover higher-risk enrollees "and thereby undermine the effectiveness of the risk adjustment program." *Id.* at 94,101.

2. The New Mexico Litigation

In 2016, two issuers brought APA lawsuits challenging aspects of HHS's risk-adjustment methodology, including its reliance on the statewide average premium.

A district court in Massachusetts squarely rejected the first challenge. *See Minuteman Health, Inc. v. U.S. Dep't of HHS*, 291 F. Supp. 3d 174 (D. Mass. 2018). But in March 2018, a district court in New Mexico sustained the other challenge in part and ordered the nationwide vacatur of HHS's risk-adjustment rules for benefit years 2014 through 2018 to the extent they rely on the statewide average premium. *See NMHC*, 312 F. Supp. 3d at 1207-12, 1218-19.

The New Mexico court agreed with HHS that its risk-adjustment rules were consistent with the statute and thus substantively lawful. But the court declared that HHS had not adequately explained its reasons for implementing the risk-adjustment program on a budget-neutral basis, which had informed the agency's decision to use the statewide average premium. The court acknowledged that "there may be excellent policy reasons" for those choices, *id.* at 1210, but nonetheless held that those reasons were not adequately described in the relevant *Federal Register* notices.

The government filed a timely Rule 59(e) motion seeking reconsideration of that ruling. On the merits, the government identified the numerous ways in which the record supported and explained HHS's rules. On the issue of remedy, the government urged the New Mexico court to at least allow the challenged rules to remain in effect while HHS provided the additional explanation that the court thought necessary, arguing that it was essential to keep the program's implementing rules in place to protect the settled expectations of insurers that had relied on HHS's published risk-adjustment methodology.

The district court indicated at a June 2018 hearing that its schedule would not permit it to rule on the government's motion until around Labor Day. ROA.2031. The district court eventually denied reconsideration, and the government appealed the final judgment.

In December 2019, the Tenth Circuit vacated and reversed the district court's ruling. *See NMHC*, 946 F.3d at 1167-68. The court of appeals concluded that HHS had adequately justified the budget neutrality of the risk-adjustment program; that "HHS was not arbitrary or capricious in choosing to use the statewide average premium in its formula"; that "HHS acted reasonably in explaining" its choices; and that the district court thus erred in concluding that further explanation was required and in vacating the rules on that erroneous basis. *Id.* at 1145, 1167.[3]

3. The Reissued 2017 Final Rule

In the meantime, while the government's motion for reconsideration was pending before the New Mexico court, HHS was finalizing its payment and charge calculations for the preceding 2017 benefit year. *Cf.* 45 C.F.R. § 153.310(e) (requiring notice to issuers of risk-adjustment payments and charges by June 30 of the year

[3] With respect to the 2017 and 2018 benefit years, the Tenth Circuit concluded that the plaintiff's challenge became moot in light of HHS's promulgation of the Reissued 2017 and 2018 Rules, described immediately below. 946 F.3d at 1160-61. But the Tenth Circuit's reasoning in upholding the lawfulness of HHS's rules for the other benefit years would have applied equally to the original 2017 and 2018 rules. *Cf. id.* at 1148 (noting that "[e]ach succeeding rule" after 2014 "employed the same methodology as the previous rules").

following the benefit year). But because of the district court's order, HHS could not effectuate those transfers, which totaled some $10.4 billion nationwide. HHS accordingly informed the public that "[t]he [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." ROA.1599 (July 7, 2018); *see also* ROA.2109-11 (July 12, 2018) (given "active[] litigat[ion]," "CMS will not collect or pay the specified amounts at this time," and "will inform stakeholders of any update to the status of collections or payments at an appropriate future date").

In response, the national trade association representing health insurers warned that the New Mexico court's (as-yet-unreversed) March 2018 decision would have "serious and time-sensitive ramifications for the functioning of the market for individual and small group health plans." ROA.2062. Specifically, insurers were facing imminent deadlines to submit to state regulators the terms of the plans they intended to offer for the 2019 benefit year—terms that would be affected by the past validity and prospective effectiveness of the risk-adjustment program. ROA.2063. And the insurers argued that, at a minimum, the continued suspension of the risk-adjustment rules was unjust given that "all health plans have relied on the risk adjustment methodology that was in effect at the time that they made their business decisions." ROA.2062. The insurers' warnings of serious imminent harm were echoed by demands for urgent action by numerous other stakeholders, including state insurance regulators and Members of Congress. *See* ROA.1643-57, 2485-86.

To avert a looming crisis in insurance markets, HHS reissued its rules for the 2017 benefit year on an emergency basis. *See* 83 Fed. Reg. 36,456 (July 30, 2018) (Reissued 2017 Final Rule). In the Reissued 2017 Final Rule, HHS adopted the identical risk-adjustment methodology that it had previously published in the original 2017 final rule. In the preamble, HHS provided additional explanation for its longstanding decision to operate the risk-adjustment program in a budget-neutral manner. *Id.* at 36,457-59.

HHS also made the Reissued 2017 Final Rule immediately effective without undertaking a further round of notice and comment. *See* 5 U.S.C. § 553(b)(B) (authorizing agency to promulgate rule immediately if "the agency for good cause finds … that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest"). HHS explained that "immediate administrative action is imperative to maintain the stability and predictability in the individual and small group insurance markets." 83 Fed. Reg. at 36,459. It noted that "immediate action" would protect "settled expectations," given that "[i]ssuers have already accounted for expected risk adjustment transfers in their rates for the 2017 benefit year" and any failure to make those transfers could affect their rate-setting for future years. *Id.* HHS also determined that a second round of notice and comment was "unnecessary" because the Reissued 2017 Final Rule "adopt[ed] the same HHS-operated risk adjustment methodology issued in the 2017 Payment Notice final rule," as to which HHS had already "received and considered comments." *Id.* at 36,460.

4. The Reissued 2018 Final Rule

To forestall an analogous crisis in the summer of 2019, HHS also conducted a rulemaking to reissue its rule for the 2018 benefit year. HHS issued a proposed rule proposing to readopt the same methodology that it had previously published for the 2018 benefit year, 83 Fed. Reg. 39,644 (Aug. 10, 2018), and, after public comment, it promulgated the new final rule in December 2018. *See* 83 Fed. Reg. 63,419 (Dec. 10, 2018) (Reissued 2018 Final Rule).

In the Reissued 2018 Final Rule, HHS explained that commenters were "overwhelmingly in favor of HHS finalizing the rule as proposed" and had "encouraged HHS to do so as soon as possible." 83 Fed. Reg. at 63,422. The majority of commenters agreed that "no changes should be made to the risk adjustment methodology for the 2018 benefit year" that HHS had previously promulgated, "because issuers' rates … were set based on the previously finalized methodology." *Id.*

5. Plaintiffs' Risk-Adjustment Charges For 2017 And 2018

Plaintiffs-appellants are Vista Health Plan, Inc. and its parent company, Vista Service Corporation (collectively Vista). Vista was licensed by Texas state regulators to begin operating as a health insurer in May 2016. ROA.184, 2442. Vista marketed "low premium" plans in both the individual and small-group markets, principally in central Texas. ROA.189, 191. Given this "low-price strategy," ROA.189, Vista's

advisers predicted its plans would attract healthier-than-average enrollees and that Vista could expect to pay significant risk-adjustment charges. ROA.2435-36.

For benefit year 2017, Vista was assessed total risk-adjustment charges of roughly $4.3 million across the individual and small group markets. ROA.183, 2443-48. For 2018, Vista was assessed total risk-adjustment charges of roughly $8.6 million across both markets. ROA.183, 207-21. Vista has not yet paid those charges, which HHS is forbearing on collecting pending the outcome of this litigation. ROA.91, 94.

C. Procedural Background

1. In its amended complaint, Vista asserts numerous challenges against the Reissued 2017 and 2018 Final Rules, HHS's calculation of Vista's risk-adjustment charges, and the risk-adjustment program more generally. ROA.182-202. Vista maintains that the charges assessed against it for the 2017 and 2018 benefit years were more than it had originally expected to pay, and alleges that those charges contributed to a decision by state regulators to place Vista under supervision and later direct it to cease operations. ROA.183; *cf.* ROA.2449-53 (order of supervision). The government moved for summary judgment on all claims, explaining that HHS had lawfully promulgated its risk-adjustment rules and properly applied those rules to Vista. ROA.2182-2205.[4]

[4] Vista cross-moved for summary judgment on certain claims, ROA.2153-63, and opposed the government's motion for summary judgment on all claims, ROA.2420-31.

2. The district court granted the government's motion. ROA.2474-2515. The court "deduce[d] nine distinct claims" in Vista's amended complaint, then addressed each one in turn. ROA.2481.

As relevant here, the district court rejected Vista's argument that the Reissued 2017 and 2018 Final Rules were impermissibly retroactive. The court explained that "[r]ather than … 'impose new duties with respect to transactions already completed,'" the reissued rules "simply reinstated the obligations [that] all regulated entities had already anticipated and acted in reliance upon" in light of "the published HHS-operated risk-adjustment methodologies previously adopted for 2017 and 2018." ROA.2488-89 (quoting *Landgraf v. USI Film Prods.*, 511 U.S. 244, 268 (1994)).

The district court similarly rejected Vista's argument that the Reissued 2017 Final Rule should be vacated on procedural grounds. Though the court concluded that HHS lacked adequate cause to bypass notice and comment, it held that any error was harmless because Vista identified no "cognizable prejudice … stemming from HHS's failure to follow APA procedures," given that the Reissued 2017 Final Rule simply "adopted the identical methodology that issuers had relied on." ROA.2495.

The district court also rejected Vista's argument that HHS's reliance on the statewide average premium was inconsistent with the ACA or otherwise arbitrary and capricious. Agreeing with the Tenth Circuit in *NMHC*, the district court concluded that HHS's "interpretation of Section 18063 is entitled to *Chevron* deference" and that

"HHS's use of a state's average premium as a cost-setting factor … was reasonable" and adequately justified by the agency record. ROA.2506-07.

The district court also generally rejected Vista's constitutional claims. It concluded that Vista's invocation of equal protection principles was misplaced because "small insurers are not an inherently suspect class" and the risk-adjustment program is clearly supported by a rational basis. ROA.2501. As to Vista's procedural due process claim, the district court perceived a factual gap and "remand[ed] the issue to HHS" for any remaining proceedings necessary on Vista's "request for reconsideration as to the 2018 risk-adjustment charges." ROA.2503. HHS has since advised Vista that no such further proceedings are necessary because Vista's request for reconsideration was denied in November 2019. *See* MJN exs. A & B.

Finally, the district court entered judgment against Vista's regulatory takings claim. ROA.2495-2501. It noted that this case "does not present the classical taking in which the government directly appropriates private property," but rather a claim arising from a "'public program adjusting the benefits and burdens of economic life to promote the common good.'" ROA.2498 (quoting *Penn Cent. Transp. Co. v. New York City*, 438 U.S. 104, 124 (1978)). Applying the *Penn Central* factors, the court rejected Vista's claim, explaining that the risk-adjustment program applies only to "insurers that decide to participate in the individual and small-group markets "; "[t]he risk-adjustment program existed for years before Vista entered the market"; and Vista

could have avoided risk-adjustment charges by "enrolling higher-risk members." ROA.2499-2501.

SUMMARY OF ARGUMENT

The Affordable Care Act requires HHS to establish—and, unless a State chooses otherwise, to operate itself—an annual risk-adjustment program in each State through which money is collected from insurers whose enrollees are healthier than average, and distributed to insurers whose enrollees are less healthy than average. In advance of each benefit year, HHS promulgates a risk-adjustment methodology through notice-and-comment rulemaking, so that insurers can rely on that methodology when they set premiums for the coming year.

In 2018, a district court in New Mexico vacated HHS's risk-adjustment rules in part (on grounds later reversed on appeal) and failed to act expeditiously on the government's motion for reconsideration. HHS's resulting inability to effectuate transfers for the 2017 benefit year caused a crisis that not only held up some $10.4 billion in transfers, but also threatened insurers' urgently time-sensitive planning for future benefit years. To resolve that crisis, HHS reissued the 2017 and 2018 rules *in toto*, without substantive change, and included a lengthier policy discussion intended to satisfy the New Mexico court's judgment. The sufficiency of that explanation became irrelevant after the Tenth Circuit reversed the New Mexico court's judgment on the government's appeal.

I. HHS acted well within its authority in promulgating the Reissued 2017 and 2018 Final Rules. Those rules are not retroactive in any legal sense because they did not change insurers' legal obligations for their past conduct. Instead, the reissued rules simply reaffirmed the insurers' existing obligations, thereby protecting their settled expectations. Even if the reissued rules were regarded as retroactive, they were necessarily authorized by Congress's directive that HHS implement a risk-adjustment program for the 2017 and 2018 benefit years.

HHS committed no procedural error in forgoing notice and comment procedures for the Reissued 2017 Final Rule. The APA expressly allows an agency to proceed in that manner where, as here, the agency finds "for good cause" that notice and comment would be "impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(B). HHS duly made such a finding here, and that finding was clearly reasonable given the turmoil in the insurance markets caused by the New Mexico court's (erroneous) vacatur of the prior rules. In any event, as the district court here explained, Vista has failed to show how it was prejudiced by its inability to participate in a second round of notice and comment on the same 2017 rule.

II. The district court correctly rejected Vista's claims that HHS's risk-adjustment rules are contrary to the text of the ACA or arbitrary and capricious. The ACA requires HHS to translate an insurer's "actuarial risk" into a dollar payment or charge. HHS has consistently employed the statewide average premium as that factor. Both the Tenth Circuit in *NMHC* and the district court here (among other

courts) correctly held that this approach was permissible. Vista's contrary arguments rest on a basic misunderstanding of how HHS's payment transfer formula works.

III. The district court did not err in granting summary judgment on Vista's remaining claims. Vista's constitutional claims, like its statutory claims, were properly resolved on the administrative record, and Vista's request for reconsideration as to its 2018 risk-adjustment charges has been fully adjudicated at the administrative level. Vista thus is not entitled to further evidentiary proceedings before the agency. And the district court did not err in entering judgment on Vista's regulatory takings claim, both because Vista affirmatively invited that ruling and because the claim fails as a matter of law on multiple grounds.

STANDARD OF REVIEW

This Court reviews the agency's rules under the same standard applied by the district court. "The APA 'allows a federal court to overturn an agency's ruling only if it is arbitrary, capricious, an abuse of discretion, not in accordance with law, or unsupported by substantial evidence on the record,'" or contrary to constitutional right, power, or privilege. *Amrollah v. Napolitano*, 710 F.3d 568, 570-71 (5th Cir. 2013) (quoting *Buffalo Marine Servs. Inc. v. United States*, 663 F.3d 750, 753 (5th Cir. 2011)); *see* 5 U.S.C. § 706(2). The Court "may affirm on any grounds supported by the record." *Dominion Ambulance, LLC v. Azar*, 968 F.3d 429, 433 (5th Cir. 2020).

ARGUMENT

I. HHS PROPERLY REISSUED THE 2017 AND 2018 RISK-ADJUSTMENT PAYMENT RULES

On appeal, Vista does not dispute that HHS correctly calculated the amount of its risk-adjustment charges for the 2017 and 2018 benefit years in accordance with HHS's duly promulgated regulations. Instead, Vista attacks the regulations themselves, principally on procedural grounds. None of its challenges has merit.

A. Retroactivity Principles Did Not Bar HHS From Reissuing The 2017 And 2018 Payment Rules.

The district court correctly rejected Vista's argument that the Reissued 2017 and 2018 Final Rules have impermissible retroactive effect.

1. The Reissued 2017 And 2018 Final Rules Are Not Retroactive In Character.

a. The presumption against retroactivity rests on the "deeply rooted" principle that "the legal effect of conduct should ordinarily be assessed under the law that existed when the conduct took place." *Landgraf v. USI Film Prods.*, 511 U.S. 244, 265 (1994) (quotation marks omitted). But "[t]he conclusion that a particular rule operates 'retroactively'" comes only "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." *Id.* at 270. The mere fact that a regulation references past conduct does not make it retroactive, *id.* at 269 n.24; rather, the Court must carefully analyze "whether the regulation would have a retroactive

effect" as defined by precedent. *Perez Pimentel v. Mukasey*, 530 F.3d 321, 326 (5th Cir. 2008) (per curiam).

Consistent with *Landgraf* and the law in other circuits, this Court has stated that an agency regulation has a "retroactive effect" only if it "would impair rights a party possessed when he acted, increase a party's liability for past conduct, or impose new duties with respect to transactions already completed." *Handley v. Chapman*, 587 F.3d 273, 283 (5th Cir. 2009) (quoting *Fernandez-Vargas v. Gonzales*, 548 U.S. 30, 37 (2006)); *see also Perez Pimentel*, 530 F.3d at 326. "If a new rule is 'substantively inconsistent' with a prior agency practice and attaches new legal consequences to events completed before its enactment, it operates retroactively." *Arkema Inc. v. EPA*, 618 F.3d 1, 7 (D.C. Cir. 2010) (quoting *National Mining Ass'n v. Department of Labor*, 292 F.3d 849, 860 (D.C. Cir. 2002) (per curiam)). This inquiry is not rigidly formalistic, but instead requires a "commonsense, functional judgment," *Martin v. Hadix*, 527 U.S. 343, 357 (1999), in which "familiar considerations of fair notice, reasonable reliance, and settled expectations" help to guide the analysis, *Landgraf*, 511 U.S. at 270.[5]

The district court correctly concluded that the Reissued 2017 and 2018 Final Rules are not retroactive in the legal sense. Neither Rule "made any changes to the

[5] Vista mistakenly asserts that *Landgraf* is inapposite because it concerned a statute rather than a regulation, and "[a]gencies do not have the same powers as Congress," Br. 18-19. But there is no need to consider whether an agency has the power to issue a retroactive rule unless the challenged rule is actually retroactive in the first place. As to that threshold question, the analysis is the same whether the rule is statutory or regulatory. *Landgraf*, 511 U.S. at 270.

published HHS-operated risk-adjustment methodologies" that were "previously adopted for 2017 and 2018" through prospective rulemaking. ROA.2488. Rather, the Reissued Rules "simply reinstated the obligations all regulated entities had already anticipated and acted in reliance upon." ROA.2489; *see* 83 Fed. Reg. at 36,457 (Reissued 2017 Final Rule "adopts the HHS-operated risk adjustment methodology previously published … for the 2017 benefit year"). Because the Reissued Rules were neither "'substantively inconsistent'" with the agency's prior regulations nor "attache[d] new legal consequences" to an insurer's conduct during the affected benefit years, they are not retroactive in character. *Arkema Inc.*, 618 F.3d at 7; *see, e.g.*, *Perez Pimentel*, 530 F.3d at 326 (rejecting retroactivity-based challenge where "the new regulation" "'neither attache[d] a new disability to past conduct nor upset[] settled expectations'").

This Court's decision in *Handley v. Chapman* illustrates that principle. There, an inmate challenged the application of a new Bureau of Prisons (BOP) regulation in determining her eligibility for an early-release program. 587 F.3d at 282. This Court rejected the argument that applying the regulation to her would be retroactive. "The new regulation [wa]s virtually identical to its predecessor," and "[t]he BOP's policies as to Handley ha[d] not changed"; "[t]he only notable change" was that the new regulation provided a "detailed rationale for why inmates such as Handley are ineligible for early release consideration." *Id.* at 283. So too here: the Reissued Regulations simply reaffirmed the existing rules for the 2017 and 2018 risk-adjustment

programs while providing a more "detailed rationale" for HHS's operation of the program on a budget-neutral basis. *Accord, e.g.*, *Catholic Health Initiatives Iowa Corp. v. Sebelius*, 718 F.3d 914, 919-22 (D.C. Cir. 2013) (holding that HHS's reliance on a 2004 regulation in denying certain Medicare reimbursements for the 1997 cost-reporting period was not retroactive; the regulation "simply reiterated [a] prior rule of decision" that HHS had previously announced via adjudication, and even if that adjudication had not been "substantively sound," it sufficed for retroactivity purposes that the "prior adjudication d[id], in fact, establish the policy at issue").

b. Vista's contrary arguments misunderstand the legal analysis. Vista posits that the Reissued 2017 and 2018 Final Rules should be deemed retroactive "because the rules were promulgated after the conduct they regulated took place." Appellants' Br. (Br.) at 16. As explained, however, a rule "is not made retroactive merely because it draws upon antecedent facts for its operation." *Landgraf*, 511 U.S. at 269 n.24 (quotation marks omitted). Rather, a regulation is retroactive if it "effects a substantive change from the agency's prior regulation or practice." *National Mining Ass'n*, 292 F.3d at 860. Here, the Reissued 2017 and 2018 Final Rules reaffirmed—without *any* substantive change—the same rules that HHS already had promulgated. The Reissued Rules thus did not "*increase*[] Vista's liability for 2017 and 2018" (Br. 22 (emphasis added)); they simply reiterated it.

Vista suggests that the Reissued 2017 and 2018 Final Rules should nonetheless be deemed retroactive for idiosyncratic reasons unique to Vista. It asserts that during

July 2018—in the several weeks following HHS's announcement of a temporary suspension of its collections for the 2017 benefit year, and before issuance of the Reissued 2017 Final Rule—Vista had "made decisions … that prejudiced [its] substantial rights," including "stay[ing] in business longer than it had to," based on an "*absence* of the rules" governing the risk-adjustment program. Br. 13, 23; *see also* Br. 18, 27. That is, Vista claims that it made unilateral business decisions premised on a mistaken assumption that the (statutorily mandated) risk-adjustment program had been permanently terminated for the 2017 and 2018 benefit years because of the New Mexico litigation.

Vista's reliance-based argument fails for multiple independent reasons. As an initial matter, Vista did not argue in district court that the Reissued Rules should be considered retroactive because Vista assumed that the 2017 and 2018 risk-adjustment programs were cancelled. Instead, its claim below rested solely on a temporal observation that the Reissued Rules were promulgated "after the years (or late in the year with respect to 2018) to which they were to apply." ROA.2155.[6] Vista accordingly has forfeited any argument that the Reissued Rules should be deemed retroactive as to Vista based on insurer-specific reliance interests. *See, e.g.*, *Hardman v.*

[6] The factual declarations tendered by Vista in reply on summary judgment also nowhere asserted that Vista had relied on an alleged permanent cancellation of the risk-adjustment program. *Cf.* ROA.2432-38, 2463-64.

Colvin, 820 F.3d 142, 152 (5th Cir. 2016) ("Arguments not raised in the district court cannot be asserted for the first time on appeal.") (quotation marks omitted).

In any event, Vista's theory of reliance rests on a mischaracterization of relevant events. HHS never suggested that the 2017 and 2018 risk-adjustment programs were cancelled or that Vista would be permanently excused from paying charges due for those years. And HHS certainly did not "ch[o]ose to allow" the New Mexico district court's ruling "to stand," Br. 17, or take steps to "repeal" the rules at issue, Br. 18. On the contrary, HHS's public statements consistently made clear that it disagreed with the New Mexico court's decision and that it was suspending further collections or payments only temporarily until such time as it could reach a solution. *See, e.g.*, ROA.1599 (July 7, 2018) (noting that court's ruling prevented CMS "from making further collections or payments … until the litigation is resolved"); ROA.1638 (July 12, 2018) ("[I]n light of the current status of the litigation, CMS will not collect or pay the specified amounts at this time" but will provide an "update to the status of collections or payments at an appropriate future date."); ROA.1637 ("CMS is seeking a quick resolution to the legal issues raised *in a manner that restores the program* to the manner in which it has been administered for benefit years 2014-2018." (emphasis added)). Those statements could not reasonably have led Vista or any insurer to

believe that it could permanently escape liability for its 2017 and 2018 risk-adjustment charges.[7]

Plaintiffs thus fail in their effort (Br. 19-20) to analogize this case to *Bowen v. Georgetown University Hospital*, 488 U.S. 204 (1988). That case concerned a change to existing HHS regulations that set limits on the levels of costs reimbursable under the Medicare program. In 1981, the Secretary issued a new rule prospectively altering the method for calculating the "wage index," a factor used in the existing cost-limit calculation.[8] After that new rule was challenged and invalidated on procedural grounds, the Secretary did not seek further review, and instead "settled the hospitals' cost reimbursement reports by applying the pre-1981 wage-index method." *Id.* at 207. But in 1984, the Secretary then reissued the challenged rule, effective as of July 1981, and sought to recoup sums previously paid to the hospitals. In the litigation that followed, HHS acknowledged that its 1984 reinstatement of the 1981 rule had retroactive effect, because it disturbed the right of hospitals to have the pre-1981

[7] Nor did the New Mexico district court itself purport to cancel the risk-adjustment program for the 2017 and 2018 benefit years. As Vista acknowledges, that court simply suspended HHS's use of its adopted methodology "pending a further explanation of HHS's reasons for its budget-neutral operation of the program." Br. 6.

[8] Specifically, under the existing methodology, the "wage index" was calculated using the average salary levels for all hospitals in a given geographic area. Under the new methodology, wages paid by federal government hospitals would be excluded from that calculation. *Bowen*, 488 U.S. at 206.

wage index continue to apply through 1984. The disputed question in *Bowen* was, instead, whether HHS had authority to engage in that concededly retroactive action.

As explained above, no analogous retroactivity problem exists here. HHS did not decline to seek further review of the New Mexico court's erroneous ruling, and HHS never provided Vista any assurance that some other set of legal rules would apply for the 2017 or 2018 benefit years. On the contrary, HHS repeatedly made clear that it disagreed with the New Mexico court; that it was seeking further review of that decision; and that HHS was constrained to suspend collections and payments temporarily pending resolution of the litigation or further developments. *See* ROA.1599, 1602, 1637-42.

2. In Any Event, The Reissued Rules Were Necessary To Implement The ACA.

Even assuming that the Reissued 2017 and 2018 Final Rules should be regarded as retroactive in character, those rules were authorized by Congress as the only way to comply with the ACA's requirements.

Though an agency cannot promulgate retroactive rules without congressional authorization, which is usually "conveyed … in express terms," *Bowen*, 488 U.S. at 208, such authorization also exists when retroactivity is necessary to fulfill Congress's legislative command. In his *Bowen* concurrence, Justice Scalia noted the "unexceptional[] proposition that a particular statute may in some circumstances implicitly authorize retroactive rulemaking." *Id.* at 223 (Scalia, J., concurring). As one

example, Justice Scalia noted the situation in which a "statute prescribes a deadline by which particular rules must be in effect," but "the agency misses that deadline." *Id.* at 224-25. In instances where there is a conflict between the presumption against regulatory retroactivity and the substantive dictates of a particular statutory regime, "[s]omething ha[s] to yield," and what yields is the principle that an agency's power to issue retroactive rules must normally be granted expressly. *Id.* at 223.

Thus, for example, in *National Petrochemical & Refiners Ass'n v. EPA*, 630 F.3d 145 (D.C. Cir. 2010), the D.C. Circuit considered an EPA rule that arguably had retroactive effects and where retroactivity was not expressly authorized by statute, but where EPA argued that Congress had "impliedly authorized" retroactivity by enacting a law directing EPA to "ensure" that certain specified renewable fuel volume requirements were met. *Id.* at 158 (quotation marks omitted). Noting that the D.C. Circuit has "treated Justice Scalia's concurring opinion [in *Bowen*] as substantially authoritative," *id.* at 162-63 (quoting *Celtronix Telemetry, Inc. v. FCC*, 272 F.3d 585, 588 (D.C. Cir. 2001) (brackets omitted)), the court of appeals accepted EPA's argument, finding that "EPA had clear albeit implicit authority under the [statute] to apply both the 2009 and 2010 volume requirements in the 2010 calendar year in order to achieve the statutory purpose." *Id.* at 163. The court also found it relevant that EPA's application of the challenged rule "d[id] not make 'the situation worse'" for regulated parties, because those parties "had ample notice" of the agency's intended regulatory

path based on prior exchanges, and thus EPA's rule did not strongly implicate the concerns on which the presumption against retroactivity is based. *Id.* at 163-64.

The reasoning discussed by Justice Scalia in *Bowen* and applied by the D.C. Circuit in *National Petrochemical & Refiners Ass'n* applies with even greater force here. Congress indisputably mandated the operation of a risk-adjustment program in the 2017 and 2018 benefit years. HHS did not miss any deadlines in setting up that program; rather, the substantive requirements were adopted through notice with comment rulemaking well in advance. Although the Reissued 2017 Final Rule was not issued until 2018, it would not have needed to issue at all if the New Mexico district court had not erroneously vacated HHS's original rules. Under those circumstances, further agency action was necessary to ensure timely implementation of the statutorily required risk-adjustment program for the 2017 and 2018 benefit years. And those Rules "d[id] not make 'the situation worse'" for affected insurers, *National Petrochemical*, 630 F.3d at 163, but rather protected settled expectations based in existing law. Under these circumstances, HHS had "clear albeit implicit authority" under the ACA to reissue its 2017 and 2018 rules. *Id.*

B. The Reissued 2017 Final Rule Was Procedurally Proper.

Vista fares no better in arguing that the Reissued 2017 Final Rule was procedurally deficient because HHS failed to undertake another round of notice and comment rulemaking. HHS had good cause to proceed via immediate final rule and, in any event, the district court correctly ruled that any procedural error was harmless.

1. HHS Had Good Cause To Forgo A Second Round Of Notice And Comment On The 2017 Rule.

Unless Congress specifies otherwise, agencies exercising statutory authority to promulgate binding regulations must follow the informal rulemaking procedures set forth in section 553 of the APA. Section 553(b) provides, however, that notice and comment is not required "when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest." 5 U.S.C. § 553(b)(B).

Though this good cause exception is not an "escape clause" to be routinely invoked, *United States v. Garner*, 767 F.2d 104, 120 (5th Cir. 1985), it is properly applied to "excuse[] notice and comment in emergency situations, or where delay could result in serious harm," *Jifry v. FAA*, 370 F.3d 1174, 1179 (D.C. Cir. 2004) (citation omitted). This Court sets aside an agency's good-cause determination only if it is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." *United States v. Johnson*, 632 F.3d 912, 928 (5th Cir. 2011) (citing *Garner*, 767 F.2d at 115-16) (quotation marks omitted).

a. For the reasons explained at length in the Reissued 2017 Final Rule, HHS had good cause to proceed without undertaking a further round of notice and comment. As HHS explained, the lengthy delay that this would occasion was both impracticable and contrary to the public interest because "immediate administrative

action [wa]s imperative to maintain the stability and predictability in the individual and small group insurance markets." 83 Fed. Reg. at 36,459. As HHS noted, "[i]ssuers have already accounted for expected risk adjustment transfers in their rates for the 2017 benefit year," and understood that the collected charges—"expected to total $5.2 billion"—would be paid out "in the September 2018 monthly payment cycle." *Id.* Indeed, for certain "plans providing coverage to sicker (and costlier) than average enrollees," HHS's "failure to make timely risk adjustment payments" could lead the plans to become insolvent. *Id.* More generally, a failure to effectuate transfers on a timely basis would damage "issuer confidence in the HHS-operated risk adjustment program," which in turn would harm the public by "lead[ing] to higher premiums in future benefit years as issuers incorporate a risk premium into their rates." *Id.*

HHS's finding of good cause was supported by the demands for urgent action from numerous stakeholders, including health insurance issuers and state insurance regulators. *See* ROA.1654-57, 2485-86. As discussed (*supra* p. 12), the trade association representing health insurers emphasized that it was critical to allow the 2017 risk-adjustment program to proceed on schedule.

Moreover, in July 2018, the ranking members of numerous House committees urged HHS to "take immediate action" to reinstitute the 2017 risk-adjustment program, declaring that "[i]t is clearly within the agency's power to remedy the issue

identified by the district court … by issuing an Interim Final Rule." ROA.1643-46.[9] Several U.S. senators similarly emphasized that HHS should "act with the utmost urgency to resolve the $10.4 billion hold on the risk adjustment program," "such as by releasing an interim final rule to address the issues raised by the New Mexico district court ruling." ROA.1647-48; *see* ROA.1648 ("We urge CMS to take immediate action by issuing an interim final rule …."). The urgency identified by these members of Congress—and their calls for immediate rulemaking without notice and comment (via "interim final rule")—underscore the reasonableness of HHS's decision to proceed in that manner.

That urgency alone was sufficient to justify HHS's good-cause finding. As HHS further explained, however, good cause also existed on the additional and independent basis that further notice and comment was "unnecessary." 83 Fed. Reg. at 36,460. The Reissued 2017 Final Rule made no substantive changes to the agency's existing regulations, but instead "adopt[ed] the same HHS-operated risk adjustment methodology issued in the 2017 Payment Notice final rule," which had been promulgated through notice and comment. *Id.* The public thus had already had a full and fair opportunity to comment on HHS's risk-adjustment methodology during prior rulemakings, and the "comments received in those [prior] rulemakings [we]re

[9] "When an agency finds that it has good cause to issue a final rule without first publishing a proposed rule, it often characterizes the rule as an 'interim final rule,' or 'interim rule.'" Office of the Federal Register, *A Guide to the Rulemaking Process* 9 (2011), https://go.usa.gov/xHZzm.

sufficiently current to indicate a lack of necessity to engage in further notice and comment." *Id.*; *cf. also, e.g.*, *Chlorine Inst., Inc. v. Occupational Safety & Health Admin.*, 613 F.2d 120, 123 (5th Cir. 1980) (per curiam) (concluding that "administrative agencies may correct inadvertent, ministerial errors" in previously issued regulations without undertaking a second round of notice and comment).

b. The district court mistakenly suggested that "[t]he healthcare industry w[ould] not [be] imperiled by a clearly articulated delay to facilitate APA procedure." ROA.2493. As discussed, however, health insurers and leading Members of Congress (among others) had urged precisely the contrary, and HHS determined in its expert regulatory judgment that immediate action was "imperative to maintain the stability" of the insurance markets. 83 Fed. Reg. at 36,459. Where, as here, an agency makes a robust and well-supported finding that one or more predicates for the good-cause exception are satisfied, the agency's decision cannot be set aside as arbitrary and capricious. A court "may not substitute [its] judgment for that of the agency" simply because it would weigh competing policy considerations differently or make a different predictive judgment about the magnitude of future harms. *Associated Builders & Contractors of Tex. v. NLRB*, 826 F.3d 215, 220 (5th Cir. 2016).

The district court's suggestion that HHS's good-cause discussion cited only "the 'sort of pressing urgency that always exists'" or "self-imposed timelines," ROA.2493, also reflects a misunderstanding of the situation HHS faced. In invoking the good-cause exception, HHS did not seek to escape the consequences of some

self-imposed bureaucratic delay. As explained, HHS acted in diligent fashion to issue regulations governing the 2017 benefit year, and when the New Mexico court erroneously vacated those regulations, it promptly sought relief from that decision. If the court had not erroneously vacated HHS's rules and then compounded its error by failing to timely grant the government's motion for reconsideration, there would have been no need for the Reissued 2017 Final Rule at all. The difficult position faced by HHS thus was not an "emergency … of its own making." *Tri-County Tel. Ass'n v. FCC*, 999 F.3d 714, 720 (D.C. Cir. 2021) (per curiam); *see id.* (sustaining agency's good-cause invocation where it was not to blame for the urgent circumstances it faced); *National Fed'n of Fed. Emps. v. Devine*, 671 F.2d 607, 610-11 (D.C. Cir. 1982) (per curiam) (similar where "the agency's action was required by events and circumstances beyond its control," including an adverse district court order imperiling the agency's administration of the federal employee health benefits program).

2. Any Error In Failing To Conduct A Second Round Of Notice-And-Comment Rulemaking Was Harmless.

In any event, as the district court concluded, Vista failed to carry its burden of showing any prejudice from HHS's reissuance of the 2017 rule without another round of notice and comment. *Cf.* 5 U.S.C. § 706 ("[D]ue account shall be taken of the rule of prejudicial error."). As discussed, the Reissued 2017 Final Rule simply reaffirmed the same substantive rules that HHS had already promulgated for 2017 through notice and comment. Vista does not explain how being given the ability to comment a

second time on those rules would have had any bearing on the risk-adjustment methodology that HHS would have adopted for 2017.[10] Thus, as the district court concluded, "Vista's injury lies with the risk-adjustment program's existence, not HHS's [allegedly] deficient administrative procedure" in promulgating the Reissued 2017 Final Rule. ROA.2495.

Vista's arguments on appeal simply repeat the same mistake. Vista asserts that it suffered prejudice because it "was placed under [state regulatory] supervision" as a result of its unpaid risk-adjustment charges for the 2017 benefit year. Br. 13. But that claimed injury is not attributable to any procedural deficiencies in the Reissued 2017 Final Rule. The charges assessed against Vista were incurred during 2017 according to then-governing rules; the amount of those charges was computed and publicly announced in June 2018; and the amount never changed thereafter. Vista cannot point to that monetary obligation as a source of prejudice from the Reissued 2017 Final Rule because that obligation already existed before the Reissued 2017 Final Rule was promulgated.

[10] The absence of any prejudice is underscored by the fact that conducting a second round of notice and comment for the 2018 rule had no apparent effect on regulatory outcomes. As discussed (*supra* p. 14), before promulgating the Reissued 2018 Final Rule, HHS had issued a proposed rule and invited a further round of comment. Nonetheless, the Reissued 2018 Final Rule was identical in substance to the proposed reissued rule and, indeed, to the original 2018 rule itself. That is both appropriate and unsurprising—the whole point of reissuing the 2017 and 2018 rules was to protect the settled expectations of issuers who had relied on the "previously finalized methodology" in the original rules. 83 Fed. Reg. at 63,422.

To the extent Vista claims it was prejudiced because it had mistakenly assumed that the risk-adjustment program for 2017 would be cancelled, that assumption was unreasonable as already discussed (*supra* pp. 26-27). HHS's repeated public statements made clear that risk-adjustment charges for 2017 had not been forgiven, but instead, their collection was merely being suspended pending a "quick resolution" that would "restore[] the program" as previously designed. ROA.1637.

II. HHS'S RISK-ADJUSTMENT METHODOLOGY IS REASONABLE AND CONSISTENT WITH THE STATUTE

The district court correctly rejected Vista's claim that HHS's risk-adjustment methodology for 2017 and 2018 was contrary to the ACA, ROA.2506-08, or otherwise arbitrary and capricious, ROA.2509-15.

A. For the reasons provided by the Tenth Circuit in rejecting the same arguments in *NMHC*, the agency acted both lawfully and reasonably in designing the aspects of the risk-adjustment methodology challenged here.

HHS gave thorough consideration to the question of what factor to use to convert measures of relative risk into dollar payments or charges. *See NMHC v. U.S. Dep't of HHS*, 946 F.3d 1138, 1151, 1163 (10th Cir. 2019) (describing 2011 HHS white paper discussing four options for establishing a "baseline premium" (quotation marks omitted)); ROA.1518-22 (white paper). HHS ultimately articulated "at least six different reasons for the adoption of a statewide-average premium over alternative

measures of cost." ROA.2514. As summarized by the Tenth Circuit and echoed by the district court, using the statewide average premium would:

> (1) "reduce the impact of risk selection on premiums while preserving premium differences related to other cost factors," (2) achieve "a straightforward and predictable benchmark for estimating transfers" each year, (3) "promote risk-neutral premiums," (4) avert "causing unintended distortions in transfers," (5) avoid disproportionately distributing costs to insurers when using balancing adjustments, and (6) facilitate budget neutrality, making transfers "net to zero" without additional balancing adjustments.

ROA.2199 (quoting *NMHC*, 946 F.3d at 1165) (brackets and citations omitted). For the reasons discussed at length by the Tenth Circuit, those goals are both permissible considerations under the statute and sufficient to explain the reasonableness of HHS's choices. *See NMHC*, 946 F.3d at 1162-67.

B. On appeal, Vista does not even cite or acknowledge the Tenth Circuit's decision in *NMHC*, much less elaborate an argument for why its reasoning was erroneous. Indeed, Vista fails to argue any error in the district court's conclusion that HHS acted rationally in concluding that the statewide average premium was preferred to other cost-scaling alternatives. This Court may properly hold Vista's substantive challenge to be forfeited for that reason. *See, e.g.*, *Binh Hoa Le v. Exeter Fin. Corp.*, 990 F.3d 410, 414 (5th Cir. 2021) ("When a party pursues an argument on appeal but does not analyze relevant legal authority, the party abandons that argument."); *Vetcher v. ICE*, 844 F. App'x 691, 695 (5th Cir. 2021) (per curiam) (holding claim

forfeited where appellant "merely reasserts" his preferred conclusion but "does not address the district court's findings").

What little argument Vista does provide shows that it misunderstands the payment transfer formula and the role that the statewide average premium plays in those calculations. HHS does not "use[] statewide average premiums … as part of how it *estimated the varying degree of risk*." Br. 5 (emphasis added); *see* Br. 15 (similar). Rather, the statewide average premium is a cost-scaling measure used at the final step of the calculations under the transfer formula, to convert actuarial risk scores into dollar amounts (*i.e.*, the monetary charge or payment due from or to a particular insurer).[11]

Vista's assertion that HHS's use of the statewide average premium "added a factor not included in the statutory factors in section 18063" is incorrect. Br. 5; *see* Br. 33 (similar). Congress in creating the risk-adjustment program required HHS to "assess a charge" or "provide a payment" based on whether a plan's actuarial risk was below or above the average actuarial risk across all plans, 42 U.S.C. § 18063(a)(1)-(2), but the statute does not specify how to calculate the dollar amount of any such charge or payment. In determining how to translate actuarial risk into dollar charges and payments, Congress thus necessarily left a programmatic gap for HHS to fill. Indeed,

[11] Vista is thus incorrect to state that, at the third step of HHS's analysis, "the plan's risk score is multiplied by a statewide-average premium to arrive at *the final risk score*." Br. 5 (emphasis added). The third step does not yield another "risk score," but rather, produces the amount of the payment or charge. *See supra* pp. 6-7.

even Vista acknowledges that HHS "may certainly" consider premiums "in calculating the *amount of payments* to assess and distribute under section 18063." Br. 34. Though Vista appears to favor an approach that uses a plan's own premium rather than the statewide average premium as the cost-scaling factor, *cf.* Br. 5, Vista fails to meaningfully dispute that HHS acted lawfully in choosing otherwise.

III. THE DISTRICT COURT PROPERLY ENTERED SUMMARY JUDGMENT ON VISTA'S REMAINING CLAIMS

The district court properly rejected the balance of Vista's claims, and this Court should affirm the judgment on the existing record.

A. Review Of Vista's Remaining Claims Was Properly Limited To The Agency Record.

"When a party seeks review of agency action under the APA, the district judge sits as an appellate tribunal," and the "'entire case' on review is a question of law." *American Bioscience, Inc. v. Thompson*, 269 F.3d 1077, 1083 (D.C. Cir. 2001). Therefore, "[t]he focal point for judicial review should be the administrative record already in existence, not some new record made initially in the reviewing court." *Luminant Generation Co. v. EPA*, 714 F.3d 841, 850 (5th Cir. 2013) (quoting *Camp v. Pitts*, 411 U.S. 138, 142 (1973) (per curiam)).

That principle applies to all claims brought in seeking judicial review of agency action, including constitutional claims. The APA encompasses review of claims that a challenged agency action is "contrary to constitutional right, power, privilege, or immunity," 5 U.S.C. § 706(2)(B), and provides with respect to all claims that courts

must evaluate agency action upon "the whole record or those parts of it cited by a party," *id.* § 706. As the district court recognized, then, "there is no exception to the principle of record review where an APA claim is based on a violation of constitutional rights." ROA.2466 (citing *Robinson v. Veneman*, 124 F. App'x 893, 895 (5th Cir. 2005) (per curiam)).

Vista asserts on appeal that the district court "erred in basing its decision on the HHS's existing rule making record." Br. 14, 28. That argument is waived because Vista itself urged in district court that its claims should be adjudicated on the existing administrative record. *See* ROA.154 (joint scheduling motion) ("This case seeks review of agency action on an administrative record under [APA] standards …. The Parties further agree that this APA case is appropriately resolved by submission of an administrative record followed by cross-motions for summary judgment."). Indeed, Vista alleged in its amended complaint that there was "no adequate administrative remedy for [its] complaints" and that Vista therefore should not be expected to undertake further evidentiary proceedings before HHS. ROA.185. Having obtained the procedural relief that it sought in district court, Vista cannot now reverse course and argue that the district court erred in giving Vista what it asked for. *Cf. In re Coastal Plains, Inc.*, 179 F.3d 197, 205-06 (5th Cir. 1999) (discussing and applying the "common law doctrine by which a party who has assumed one position in his pleadings may be estopped from assuming an inconsistent position" later in the litigation (quotation marks omitted)).

Even if Vista had not waived its current argument, its assertions are without merit. As noted, the APA contemplates review on "the whole [agency] record" for statutory and constitutional claims alike. 5 U.S.C. § 706. And though Vista now asserts that the existing record is inadequate for resolving "challenges to the [risk] adjustment transfer rules *as applied* to Vista," Br. 15, Vista's opening brief fails to identify any reason why that is true for any of Vista's constitutional claims. Thus, there is no need for any future development of the record, whether in district court or on agency remand.

As noted (*supra* p. 17), the district court did perceive a factual gap with respect to Vista's purported "procedural due process" claim related to its 2018 risk-adjustment charges. The court noted that "[t]he record before the court does not include the result of [Vista's October 14, 2019 request for] reconsideration or any evidence of whether it took place." ROA.2503. Rather than invite further submissions from the parties about the status of Vista's claim for reconsideration, the district court stated that it would "remand the issue to HHS for proceedings consistent with [45 C.F.R. §] 156.1220." ROA.2503. That regulation permits insurers to request reconsideration based on "a processing error by HHS," an "incorrect application of the relevant methodology," or "HHS's mathematical error" with respect to the amount of a risk-adjustment payment or charge for a given benefit year. *See* 45 C.F.R. § 156.1220(a)(1)(ii).

As Vista was previously notified, however, and as HHS has since reiterated (*see* MJN ex. B), HHS considered Vista's request for reconsideration prior to the district court's ruling and denied that request on multiple grounds. Vista has not challenged HHS's November 12, 2019 decision letter, nor has it argued that there was any constitutional deficiency in that determination. Vista also has not clearly pressed or preserved any procedural due process claim independent of its (erroneous) assertion that it did not receive the process required by 45 C.F.R. § 156.1220, and in any event, such an independent constitutional claim would be meritless for the reasons explained in the government's briefing below, *see* ROA.2202-03. There are accordingly no further proceedings required on agency remand, and Vista has forfeited any due process claim that could have conceivably remained.

Vista's opening brief implies an expectation that further evidentiary proceedings will occur on remand before the agency. As explained, that expectation is incorrect. If Vista were correct, however, it would mean that this Court would lack jurisdiction over this appeal. *See Adkins v. Silverman*, 899 F.3d 395, 400 (5th Cir. 2018); *BNSF Ry. Co. v. American Train Dispatchers Ass'n*, 426 F. App'x 265, 266 (5th Cir. 2011) (per curiam); *Memorial Hosp. Sys. v. Heckler*, 769 F.2d 1043, 1044 (5th Cir. 1985). Vista cannot both claim that it is entitled to a remand to the agency and also bring an interlocutory appeal to this Court.

B. The District Court Properly Dismissed The Regulatory Takings Claim.

1. Finally, the district court properly dismissed Vista's regulatory-takings claim. Federal Rule of Civil Procedure 56 contemplates that a court should not enter summary judgment *sua sponte* unless the nonmoving party had "notice and a reasonable time to respond" to that ground. Fed. R. Civ. P. 56(f); *see D'Onofrio v. Vacation Publ'ns, Inc.*, 888 F.3d 197, 210-11 (5th Cir. 2018). Here, the district court's ruling on Vista's takings claim was not *sua sponte*, but invited by Vista itself. Though Vista at first stated that the takings claim "is not appropriate for summary judgment at this stage," ROA.2428, it immediately recognized that "[s]ome cases … that do not involve disputed facts[] are ripe for summary judgment," ROA.2428. Vista then went on to assert that so long as the government "do[es] not dispute" certain facts alleged by Vista, "the takings claim may be ripe for summary judgment." ROA.2428-29.[12]

The government did not dispute Vista's factual allegations. Instead, the government responded with arguments why, as a matter of law, those allegations were insufficient under binding precedent to establish an unconstitutional taking. ROA.2470. The district court then credited those arguments and entered judgment in the government's favor.

[12] These alleged facts are "that the [risk-adjustment charges] would take 50% of Vista's gross receipts for 2017 and 57% of Vista's gross receipts for 2018" and that the charges "caused Vista's shut down," ROA.2428.

Vista now claims (Br. 35-39) that it was not placed on sufficient notice. That argument cannot be squared with Vista's prior assertion that its "takings claim may be ripe for summary judgment." ROA.2428-29; *see, e.g.*, *O'Hara v. General Motors Corp.*, 508 F.3d 753, 763-64 (5th Cir. 2007) (rejecting claim of error where plaintiffs "placed the[] [relevant] claims at issue by raising them in their … reply brief").

Even assuming *arguendo* that the district court erred in interpreting Vista's assertions, Vista is not entitled to any relief. This Court "review[s] for harmless error a district court's improper entry of summary judgment *sua sponte* without notice." *Paske v. Fitzgerald*, 785 F.3d 977, 986 (5th Cir. 2015) (quoting *Atkins v. Salazar*, 677 F.3d 667, 678 (5th Cir. 2011) (per curiam)). A district court's grant of summary judgment is harmless "if the nonmovant has no additional evidence" or if the nonmovant's additional evidence would not "present[] a genuine issue of material fact." *Id.* (quotation marks omitted).

Vista gains no ground in asserting that it "most certainly would have provided additional evidence and briefing on the regulatory takings claim had Vista been afforded the opportunity to do so," Br. 37; *see* Br. 15 (similar). It is Vista's burden to show that it was prejudiced by the entry of summary judgment, *see Leatherman v. Tarrant Cty. Narcotics Intelligence & Coordination Unit*, 28 F.3d 1388, 1399 (5th Cir. 1994), and Vista fails to explain what any such additional evidence would entail or why it would be relevant under governing legal principles. *See, e.g.*, *Tolbert ex rel. Tolbert v. National Union Fire Ins. Co. of Pittsburgh*, 657 F.3d 262, 270-72 (5th Cir. 2011) (noting

that a plaintiff must "offer[] … reasoning as to the relevance" of additional evidence). Accordingly, any error here was harmless. *See, e.g.*, *Delaval v. PTech Drilling Tubulars, LLC*, 824 F.3d 476, 481 (5th Cir. 2016) (affirming *sua sponte* entry of summary judgment as harmless where the plaintiff failed to "describe[] in briefing on appeal any additional evidence that should have been considered"); *United States v. Holmes*, 693 F. App'x 299, 304 (5th Cir. 2017) (same where the plaintiffs "d[id] not identify any new evidence they would advance if given the chance"); *Markel Am. Ins. Co. v. Verbeek*, 657 F. App'x 305, 311 (5th Cir. 2016) (per curiam); *Tolbert*, 657 F.3d at 270-72.

2. Vista's takings claim fails on the merits for multiple reasons. First, the Takings Clause is implicated only where a government-imposed obligation "operate[s] upon or alter[s] an identified property interest." *Koontz v. St. Johns River Water Mgmt. Dist.*, 570 U.S. 595, 613 (2013) (quotation marks omitted); *see Degan v. Board of Trs. of Dallas Police & Fire Pension Sys.*, 956 F.3d 813, 814-15 (5th Cir. 2020) (dismissing takings claim where the plaintiff had no "property interest" in particular financial arrangement). Here, HHS's actions do not burden any specific interest in property. Instead, they impose an unrestricted monetary assessment against insurers whose plans have lower-than-average risk in order to provide funds to those with higher-than-average risk. "Because [the risk-adjustment statute] merely requires [Vista] to pay money—and thus does not infringe a specific, identifiable property interest—the Takings Clause does not apply here." *West Virginia CWP Fund v. Stacy*, 671 F.3d 378, 386 (4th Cir. 2011); *see McCarthy v. City of Cleveland*, 626 F.3d 280, 285 (6th Cir.

2010) (observing that "all circuits that have addressed the issue have uniformly found that a taking does not occur when the statute in question imposes a monetary assessment that does not affect a specific interest in property").[13]

Second, even assuming it could identify a property interest in "undifferentiated, fungible money," *West Virginia*, 671 F.3d at 386, Vista has failed to state a valid regulatory takings claim. "[W]hen a regulation impedes the use of property without depriving the owner of all economically beneficial use," the analysis whether a taking has occurred is "based on 'a complex of factors.'" *Murr v. Wisconsin*, 137 S. Ct. 1933, 1943 (2017). These *Penn Central* factors include: "(1) the economic impact of the regulation on the claimant; (2) the extent to which the regulation has interfered with distinct investment-backed expectations; and (3) the character of the governmental action." *Id.*; *see Penn Central Transp. Co. v. New York City*, 438 U.S. 104, 124 (1978)). This analysis seeks to balance an individual's "right to retain the interests … of private property ownership" with "the government's well-established power to adjust rights for the public good." *Murr*, 137 S. Ct. at 1943 (brackets and quotation marks omitted).

[13] As the Sixth Circuit observed, this Court's decision in *U.S. Fidelity & Guaranty Co. v. McKeithen*, 226 F.3d 412 (5th Cir. 2000), is not to the contrary. In finding a taking in *McKeithen*, this Court concluded that any requirement for an "identifiable property interest" was satisfied because the case involved assessments specifically against a particular "fund of reserves" that had been "set aside from the premiums collected under specific insurance policies." *Id.* at 420. The same is not true for amounts due under the ACA risk-adjustment program.

Application of that test—which Vista does not discuss in its brief (*cf.* Br. 38-39)—shows that the district court correctly dismissed Vista's claim. Though Vista alleges that the risk-adjustment charges had a substantial economic impact on its business, *see* Br. 37 (arguing that "Vista remained solvent" but for its regulatory debts), the Constitution does not guarantee that any particular business will be profitable.

Other *Penn Central* factors weigh decisively against Vista's takings claim. Vista could have no reasonable investment-backed expectation against paying risk-adjustment charges; when it chose to enter the market in 2016, the risk-adjustment program had long since been enacted and, indeed, had been operational for several years. Indeed, as Vista has acknowledged, its own advisers warned that its business model would result in risk-adjustment charges. ROA.2435-36.

The character of the risk-adjustment program also makes clear that it is not a taking. The program is part of a broader set of ACA reforms that seek to provide health insurance coverage to millions of previously uninsured Americans and, in the process, expand the size of private insurance markets. *Cf.* Br. 3, 5 (agreeing that the ACA "expanded healthcare coverage" and provided insurers numerous "incentive[s] to participate"). The risk-adjustment program, in particular, protects insurance markets by more equitably allocating risk among insurers and mitigating the impact of adverse selection. Such public programs "adjusting the benefits and burdens of economic life to promote the common good" are not takings. *Penn Central*, 438 U.S. at 124.

That is particularly true where, as here, participation in the relevant market was a voluntary choice by plaintiff. "Governmental regulation that affects a group's property interests 'does not constitute a taking of property where the regulated group is not required to participate in the regulated industry.'" *Burditt v. U.S. Dep't of HHS*, 934 F.2d 1362, 1376 (5th Cir. 1991). Vista entered the insurance market in Texas with full awareness of the ACA's rules—including the risk-adjustment program—and nothing had obliged it to do so. *See, e.g.*, *National Lifeline Ass'n v. FCC*, 983 F.3d 498, 515 (D.C. Cir. 2020) (finding no regulatory taking where petitioners "voluntarily elect[ed] to participate" in the government program and "[were] not required to offer" the relevant service).

As the district court recognized, ROA.2501, Vista's claim is "irreconcilable" with *Connolly v. Pension Benefit Guaranty Corp.*, 475 U.S. 211 (1986). There, the Court evaluated an ERISA provision that required employers withdrawing from a multiemployer pension plan to pay their share of the plan's unfunded liabilities attributable to the withdrawing employer. *Id.* at 215-17. The petitioners asserted, *inter alia*, that this withdrawal liability violated the Takings Clause by "requiring an uncompensated transfer." *Id.* at 221. But the Supreme Court emphasized that "it cannot be said that the Taking Clause is violated whenever legislation requires one person to use his or her assets for the benefit of another." *Id.* at 223. The Court proceeded to reject the notion that the challenged ERISA provision "interfered with reasonable investment-backed expectations," explaining that "[p]rudent employers"

had "more than sufficient notice not only that pension plans were currently regulated, but also that withdrawal itself might trigger additional financial obligations." *Id.* at 226-27. So too here: Vista chose to participate in a heavily regulated market governed by programs and rules designed to "adjust[] the benefits and burdens of economic life to promote the common good." *Id.* at 225. Vista may in retrospect be disappointed with how its business model fared in that market, but its failure to achieve greater success does not mean that it has suffered an uncompensated taking.

CONCLUSION

The judgment of the district court should be affirmed.

Respectfully submitted,

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AUGUST 2021

CERTIFICATE OF SERVICE

I hereby certify that on August 9, 2021, I electronically filed the foregoing corrected brief with the Clerk of Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 12,330 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word in Garamond 14-point font, a proportionally spaced typeface.

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ADDENDUM

ADDENDUM CONTENTS

5 U.S.C. § 553. Rule making.

…

(b) General notice of proposed rule making shall be published in the Federal Register, unless persons subject thereto are named and either personally served or otherwise have actual notice thereof in accordance with law. The notice shall include—

(1) a statement of the time, place, and nature of public rule making proceedings;
(2) reference to the legal authority under which the rule is proposed; and
(3) either the terms or substance of the proposed rule or a description of the subjects and issues involved.

Except when notice or hearing is required by statute, this subsection does not apply—

(A) to interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice; or
(B) when the agency for good cause finds (and incorporates the finding and a brief statement of reasons therefor in the rules issued) that notice and public procedure thereon are impracticable, unnecessary, or contrary to the public interest.

…

5 U.S.C. § 706. Scope of review.

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.

42 U.S.C. § 18041. State flexibility in operation and enforcement of Exchanges and related requirements.

(a) ESTABLISHMENT OF STANDARDS

(1) In general

The Secretary shall, as soon as practicable after March 23, 2010, issue regulations setting standards for meeting the requirements under this title, and the amendments made by this title, with respect to—

(A) the establishment and operation of Exchanges (including SHOP Exchanges);

(B) the offering of qualified health plans through such Exchanges;

(C) the establishment of the reinsurance and risk adjustment programs under part E; and

(D) such other requirements as the Secretary determines appropriate.

The preceding sentence shall not apply to standards for requirements under subtitles A and C (and the amendments made by such subtitles) for which the Secretary issues regulations under the Public Health Service Act.

(2) Consultation

In issuing the regulations under paragraph (1), the Secretary shall consult with the National Association of Insurance Commissioners and its members and with health insurance issuers, consumer organizations, and such other individuals as the Secretary selects in a manner designed to ensure balanced representation among interested parties.

(b) STATE ACTION Each State that elects, at such time and in such manner as the Secretary may prescribe, to apply the requirements described in subsection (a) shall, not later than January 1, 2014, adopt and have in effect—

(1) the Federal standards established under subsection (a); or

(2) a State law or regulation that the Secretary determines implements the standards within the State.

(c) FAILURE TO ESTABLISH EXCHANGE OR IMPLEMENT REQUIREMENTS

(1) In general If—

(A) a State is not an electing State under subsection (b); or

(B) the Secretary determines, on or before January 1, 2013, that an electing State—

(i) will not have any required Exchange operational by January 1, 2014; or

(ii) has not taken the actions the Secretary determines necessary to implement—

(I) the other requirements set forth in the standards under subsection (a); or

(II) the requirements set forth in subtitles A and C and the amendments made by such subtitles;

the Secretary shall (directly or through agreement with a not-for-profit entity) establish and operate such Exchange within the State and the Secretary shall take such actions as are necessary to implement such other requirements.

(2) Enforcement authority

The provisions of section 2736(b) of the Public Health Services Act shall apply to the enforcement under paragraph (1) of requirements of subsection (a)(1) (without regard to any limitation on the application of those provisions to group health plans).

(d) NO INTERFERENCE WITH STATE REGULATORY AUTHORITY

Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title.

(e) PRESUMPTION FOR CERTAIN STATE-OPERATED EXCHANGES

(1) In general

In the case of a State operating an Exchange before January 1, 2010, and which has insured a percentage of its population not less than the percentage of the population projected to be covered nationally after the implementation of this Act, that seeks to operate an Exchange under this section, the Secretary shall presume that such Exchange meets the standards under this section unless the Secretary determines, after completion of the process established under paragraph (2), that the Exchange does not comply with such standards.

(2) Process

The Secretary shall establish a process to work with a State described in paragraph (1) to provide assistance necessary to assist the State's Exchange in coming into compliance with the standards for approval under this section.

42 U.S.C. § 18063. Risk adjustment.

(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. This subsection shall not apply to a grandfathered health plan or the issuer of a grandfathered health plan with respect to that plan.