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Federal District Court Vacates Part of CMS's ACA Risk Adjustment Methodology

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Health Care

Last week, in *New Mexico Health Connections v. United States Department of Health and Human Services (HHS)*, No. 16-cv-0878 (D.N.M.), the U.S. District Court for the District of New Mexico granted summary judgment for plaintiff-New Mexico Health Connections (NMHC) in a case challenging the Centers for Medicare & Medicaid Services' (CMS) methodology implementing the Affordable Care Act's (ACA) Risk Adjustment Program. In granting that motion, the court "set[] aside and vacate[d] the [CMS] action as to using a statewide average premium for the 2014, 2015, 2016, 2017, and 2018 [risk adjustment methodology] and remand[ed] the case to the agency for further proceedings."

Other district court decisions have upheld the risk adjustment formula. Given the divided decisions, CMS is likely to seek a stay of the decision pending appeal and/or, since the adjustment is applied on a state-by-state basis, take the position that the court's decision affects only New Mexico. Alternatively, it is possible that CMS could act quickly on remand to address the deficiencies identified by the court. Therefore, it is uncertain what impact the court's decision will have on CMS's application of its risk adjustment methodology.

Background

Because the ACA prohibits insurers from denying coverage or pricing insurance based on an individual's preexisting conditions, it is possible that some insurers will enroll a disproportionately expensive population, while receiving the same premium revenue as a plan with a more healthy and cheaper population. To minimize financial harm to insurers that find themselves in such a situation, and to discourage insurers from marketing their plans or engaging in other tactics to attract healthy enrollees (or avoid those likely to be unhealthy), the ACA's drafters created a Risk Adjustment Program for the private individual and small group health insurance markets. Unlike the ACA's reinsurance and risk corridor programs, which terminated after three years, the Risk Adjustment Program is permanent and ongoing.

The ACA contemplated that, under the Risk Adjustment Program, insurers covering a population with an actuarial risk above the average actuarial risk of all enrollees in all plans in the State would receive a risk adjustment payment from insurers covering a population with a below-average actuarial risk. 42 U.S.C. § 18063. The ACA gave the States the option to implement their own Risk Adjustment Programs. CMS regulations provided that the federal government would implement a Risk Adjustment Program for any State that declined to operate its own Exchange or declined to operate its own Risk Adjustment Program, 45 C.F.R.

§ 153.310(a). Only Massachusetts opted to create its own Risk Adjustment Program, which it has since ended; thus, the CMS's Adjustment Program applies in all States.

CMS implemented a methodology to calculate individual enrollees' risk scores, calculate a plan's average risk based on those individual risk scores, and convert plans' average actuarial risk into a dollar total of either risk adjustment payments or risk adjustment charges. The court in *New Mexico Health Connections* described CMS's methodology as follows:

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

(Citations omitted.)

Under CMS's methodology, plaintiff-NMHC ended up owing millions of dollars in risk adjustment payments to other insurers in the State, and sued to enjoin several features of the methodology.

The Court's Decision in *New Mexico Health Connections*

The court granted summary judgment in favor of NMHC on the ground that CMS's use of statewide average premiums in its risk adjustment methodology was arbitrary and capricious, and thus violated the federal Administrative Procedure Act (APA), because CMS had not articulated any reasons for using the statewide average, other than its mistaken assumption that the program had to be budget neutral.

NMHC argued that the use of average statewide premiums to calculate risk adjustment payments and charges artificially and unfairly increased the risk adjustment charges it was required to transfer to its competitors, because NMHC's premiums were below the statewide average, the calculation of which is driven by the generally high premiums charged by insurers with a dominant market share. NMHC explained that statewide average premium is unrelated to

the actuarial risk of the plans' enrollment on which risk adjustment charges are supposed to be based. CMS countered that the ACA did not bar the use of statewide average premiums, and using statewide average premiums was necessary to convert the plans' average actuarial risk score into a dollar total for risk adjustment charges and payments and to ensure that the Risk Adjustment Program was budget neutral. However, CMS conceded in the litigation that the statute did not require that risk adjustment be budget neutral.

The court rejected NMHC's argument that the risk adjustment transfer formula must be based solely on actuarial risk. Nevertheless, it struck down CMS's use of statewide average premiums in the formula as arbitrary and capricious because (1) the agency's "justifications for using the statewide average premium instead of a plan's own premium all assume that the ACA requires risk adjustment to be budget neutral, which is not correct"; and (2) CMS "gives no policy reason for requiring budget neutrality." As the court explained, "[CMS] could have justified its promulgation of budget neutral regulations if it determined that budget neutrality was a worthy policy goal," but the agency "never made such a determination in the record . . . and the Court considers only the reasons that the agency actually gave and not the reasons that the agency might have given when determining agency action was arbitrary and capricious."

While the court rejected CMS's arguments for using the statewide average premium, it left open the door for CMS, on remand in a future rulemaking, to justify a decision to make the program budget neutral:

> there may be excellent policy reasons for making the risk adjustment plan budget neutral. For example, HHS may not have the funding to make up the shortfall between the risk adjustment charges and credits. Budget neutrality may also be a rational policy decision, so that HHS may allocate discretionary funds to other programs that more desperately need that funding. The problem with invoking those policy rationales here, however, is that HHS never articulates any public policy decision to operate risk adjustment in a budget neutral way; HHS' only decision is to comply with a supposed statutory requirement.

The court rejected NMHC's other attacks on CMS's risk adjustment methodology:

- NMHC argued that CMS's formula under-predicted costs for enrollees without hierarchical condition codes (HCCs). The court held that CMS considered this possibility and provided a reasoned basis for its decision that costs of non-HCC enrollees did not need to be counted in the methodology.
- NMHC argued that CMS's formula under-predicted costs for partial year enrollees for whom it is harder to capture HCCs because of the limited time they are enrolled in the plan. NMHC asserted that CMS could have addressed this issue, at least in part, by allowing plans to consider prescription drug data in identifying enrollees with health conditions. The court held that CMS "rationally considered and addressed concerns regarding partial year enrollment" by allowing partial year enrollees to be treated as having an HCC for the entirety of their enrollment period, even if the HCC was not discovered until several months into his or her enrollment in the plan. The court also held

that CMS had articulated a reasonable basis for not considering prescription drug data (i.e., distorting incentives for providers to prescribe drugs).

- NMHC argued that CMS's formula effectively eliminated bronze level plans, which the ACA intended to create, by making it impossible for them to be profitable. Specifically, NMHC argued that, because bronze plans have low premiums and "attract a healthier population, the use of the state average premium and the underestimation bias against healthier enrollees particularly hammer these products." The court rejected this argument on several grounds, including because, according to the court, nothing in the ACA requires that CMS ensure that bronze plans be profitable.

Minuteman Health v. HHS

Several weeks before the decision in *New Mexico Health Connections*, a federal district court in Massachusetts ruled in CMS's favor in a similar challenge to the risk adjustment methodology. *See Minuteman Health, Inc. v. HHS*, 2018 WL 627381 (D. Mass. Jan. 30, 2018).

Unlike the court in *New Mexico Health Connections*, the court in *Minuteman Health* held that CMS's use of the statewide average premium was not arbitrary, capricious, or contrary to law. First, the court held that the statute required CMS to establish a method to convert plans' actuarial risk scores into a dollar charge or payment, and using statewide average premiums was a reasonable exercise of its discretion in establishing such a method. In so holding, the court explained that CMS decided to use statewide average premiums "because it concluded that such an approach would result in balanced transfers, was a 'straightforward and predictable benchmark,' and would best compensate plans for liability differences due to risk selection, as opposed to other cost factors." According to the court, "[t]hose articulated reasons have a clearly rational connection to HHS's choice." Second, the court held that, while the ACA did not require the Risk Adjustment Program to be budget neutral, it was not arbitrary and capricious for CMS to implement it in a budget neutral manner. The court explained that "there is no evidence that there was any significant comment on the [budget neutrality] topic that [CMS] was required to address in 2014," and, in any invent, "HHS considered the effects of non-budget-neutral methodologies and rationally chose to operate a budget-neutral program."

The court also rejected Minuteman Health's additional challenges to CMS's methodology, which mirrored NMHC's challenges to the methodology (i.e., under-predicted costs of non-HCC enrollees; failed to account for risk associated with partial year enrollees, including by failing to use prescription drug data; unfairly impacted bronze plans).

Implications and Next Steps

As described above, the court in New Mexico "set[] aside and vacate[d] the [CMS] action as to using a statewide average premium for the 2014, 2015, 2016, 2017, and 2018 [risk adjustment methodology] and remand[ed] the case to the agency for further proceedings."

Although the injunction appears to be nationwide, because risk adjustment is implemented on a state-by-state basis, and the methodology has been upheld by federal district courts in other states, it is possible that CMS will take the position that it applies only in New Mexico, or seek a stay of the injunction pending appeal. It is also possible that CMS would not appeal, but would immediately act on remand to develop policy reasons justifying its budget neutral approach and

the use of the statewide average premium. Thus, the immediate impact of the decision is not apparent.

If you have any questions concerning the material discussed in this client alert, please contact the following members of our firm:

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