IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF MARYLAND
Northern Division

EVERGREEN HEALTH COOPERATIVE INC. Plaintiff, v. UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, *et al.*, Defendants.	)	Civ. No. 16-cv-2039

MEMORANDUM OF LAW IN SUPPORT OF EVERGREEN HEALTH'S MOTION FOR PRELIMINARY INJUNCTION

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INTRODUCTION

Two important goals of the Affordable Care Act ("ACA") are to promote innovation in the delivery of health care and increase competition in state health insurance markets to help make health coverage more accessible and affordable for all. Evergreen Health Cooperative Inc. ("Evergreen Health") was founded in Baltimore in 2012 as a non-profit health insurance company dedicated to helping achieve those goals in the State of Maryland. Evergreen Health has been described by a top official of the Department of Health and Human Services ("HHS") as delivering "exactly . . . the kind of competition and the kind of innovation that unique small companies can provide" in achieving the ACA's objectives. Less than three years after enrolling its first member, Evergreen Health is already providing services and improving health outcomes for close to 40,000 Marylanders.

Unfortunately, Evergreen Health's successes – as well as the broader goals of the ACA which Evergreen Health embodies – are now seriously threatened by the actions of HHS's Centers for Medicare & Medicaid Services ("CMS") in implementing the ACA's "Risk Adjustment" Program. The Risk Adjustment Program is intended to collect from and make payments to health plans within state health insurance markets based on the relative risk of the populations they serve. With little experience or expertise in state insurance markets, CMS has treated the first few years of the Risk Adjustment Program as an experimental stage, during which time it has promulgated rules and policies that are not fully formed and have no precedent in the United States health care system. The program has been the subject of criticism, including by CMS's own former chief actuary, but the agency recently announced that sorely needed "improvements" to the program will not take effect for several years. Ironically, the risk adjustment payments are intended to be part of a larger effort of "premium stabilization" that is

particularly focused on the first three years of ACA implementation. Instead of mitigating uncertainties in premium pricing, the program is having exactly the opposite effect.

On June 30, 2016, CMS announced that Evergreen Health would have to pay $24,210,834.04 in risk adjustment payments for 2015 – representing nearly 28.4 percent of all of Evergreen Health's premium revenue for 2015. *See* Decl. of Peter Beilenson, Ex. 3 (hereinafter "Beilenson Decl.") (Att. A). Evergreen Health will be required to make payment in full by August 15, 2016. CMS will then transfer these funds to one of Evergreen Health's competitors, for whom the $24 million will compromise less than 0.5 percent of its own premium revenue. Evergreen Health seeks to enjoin that payment as being completely inconsistent with the text and intent of the ACA, in three ways. First, the risk adjustment methodology that CMS developed fails to adequately assess relative actuarial risk. Second, the collection of the payment is not in accord with the purpose of the premium stabilization program, because it is not offset by payments that CMS owes to Evergreen Health. And third, CMS's operation and administration of the risk adjustment program has usurped authority that the statute intended to remain with state insurance commissioners.

Absent a preliminary injunction, CMS's Risk Adjustment Program will lead to disruptive and destabilizing results in Maryland and cause irreparable injury to Evergreen Health, its members and Maryland consumers. We respectfully request that this Court enjoin CMS from collecting the 2015 risk adjustment payments that it alleges are owed by Evergreen Health.

BACKGROUND

A. The Affordable Care Act

The ACA made sweeping changes to private health insurance markets nationwide through a series of programs and reforms that became effective on a rolling basis from its enactment on March 23, 2010 through January 1, 2014. The ACA sought to increase

competition in health insurance markets and to expand health insurance coverage to millions of uninsured Americans. To achieve these goals, it established new Health Insurance Marketplaces, also known as "Health Benefit Exchanges," through which insurers can sell individual and small group plans. States may run their own Exchanges, which Maryland has chosen to do. Otherwise, the Federal Government will run the Exchange in the State. *See* ACA §§ 1311, 1312, 1313, 1321, 42 U.S.C. §§ 13031, 18032, 18033, 18041. Health insurers can and do continue to sell individual and small group plans outside of the Exchange. However, plans sold through the Exchange must meet certain criteria; the plans that meet these requirements are known as "Qualified Health Plans." *See* ACA § 1301, 42 U.S.C. § 18021.

The ACA also included "guaranteed issue" and "community rating" provisions, which prohibit insurance companies from denying coverage or setting premium rates based on medical history or health status, including preexisting health conditions, effective January 1, 2014. ACA § 1201(2)(A); 42 U.S.C. §§ 300gg-1 - 300gg-5. In addition, the ACA imposed an "individual mandate" requiring all Americans, with limited exceptions, to have health care coverage (or face a tax penalty). 26 U.S.C. § 5000A. The ACA offered tax credits and cost sharing subsidies to help low-income individuals purchase Qualified Health Plans through the Exchanges. ACA §§ 1401-1402, 26 U.S.C. § 36B, 42 U.S.C. § 18071.

In the first several years of full ACA implementation, which began on January 1, 2014, health insurers faced significant challenges and uncertainty in setting premiums. Because of the guaranteed issue and community rating provisions, health insurers could no longer engage in medical underwriting. Moreover, insurers did not have any way to accurately predict the number and cost of the millions of previously uninsured individuals who would be enrolling in plans starting in 2014.

Congress recognized that this uncertainty could lead insurers to increase premiums and cause instability in the market, and thus the ACA included three inter-related "premium stabilization programs," often referred to as the "Three Rs": reinsurance, risk corridors, and risk adjustment. ACA §§ 1341-1343, 42 U.S.C. §§ 18061-18063. Reinsurance and risk corridors operate only during the first three years of full implementation of the ACA. This case is primarily about the third program, risk adjustment, which is a permanent program. All three programs target specific uncertainties in health insurance markets and, as CMS has explained, are designed "to assist insurers through the transition period, and to create a stable, competitive and fair market for health insurance,"[1] particularly during the first few years of full ACA implementation.

B. Evergreen Health

Started in 2012, Evergreen Health is the first new health insurer to enter Maryland's individual and small group market in decades. Evergreen Health was co-founded by Peter Beilenson, MD, a longtime public health leader in Maryland. From 1992 to 2005, Dr. Beilenson served as the Baltimore City Health Commissioner, during which time he led efforts to expand health clinics and improve immunization in Baltimore City Public Schools, abate lead paint in the city's housing stock, and combat and treat substance use disorders, among many other things. Dr. Beilenson subsequently led the Howard County Health Department from 2007 to 2012, where he launched and administered "Healthy Howard," which provided thousands of uninsured low-income Howard County residents with a primary care-focused model of health care. Dr.

[1] CMS, *The Three Rs: An Overview* (Oct. 1, 2015), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2015-Fact-sheets-items/2015-10-01.html.

Beilenson is now the President and Chief Executive Officer ("CEO") of Evergreen Health. Beilenson Decl. ¶1.

Evergreen Health's organizing purpose is to offer a new and different kind of private health care coverage for Marylanders, based in part on Dr. Beilenson's experience in Baltimore City and the successful Healthy Howard program. Evergreen Health combines traditional health insurance with patient-centered primary care and integrated health coaching and care coordination. Under this model, in addition to covering benefits through a network of third party providers, Evergreen Health's affiliated company, Evergreen Health Care (also a non-profit), offers all of Evergreen Health's members the option to receive care from one of four "Evergreen Health Care Primary Care Offices" located in Baltimore City, Greenbelt, White Marsh, and Columbia. These Primary Care Offices offer: treatment and preventive care (medical and behavioral), patient monitoring, care coordination, and wellness planning to encourage healthy behaviors. The caseload for providers at the Primary Care Offices is approximately half the national average, and the providers are thus able to spend approximately twice as much time with patients compared to other primary care offices. The Primary Care Offices also offer patients better access to their health care providers and health information, through a 24/7 telephone line for urgent health concerns and an online portal to allow patients to efficiently schedule appointments, access test results, and communicate securely with their health care providers. Beilenson Decl. ¶ 15.

Evergreen Health began selling plans in Maryland, both through and outside of the Maryland Health Benefit Exchange, on October 1, 2013, with coverage effective January 1, 2014. Unfortunately, major technical problems with Maryland's online Exchange contributed to a slower-than-expected enrollment in Evergreen Health. By the end of 2014, Evergreen Health

had 11,694 members (408 members in individual market plans; 11,286 members in small group plans). As the online Exchange began to improve, and as consumers came to learn about Evergreen Health, its enrollment expanded dramatically. By the end of 2015, Evergreen Health's enrollment had nearly tripled, to 29,680 members. Evergreen Health's premium revenue increased from $12,298,714 in 2014, to $85,781,847 in 2015.

As of April 30, 2016, Evergreen Health had 38,510 members: 11,210 members in the individual market; 24,186 members in the small group market; and 3,114 members in the large group market. Of these, 15,887 members are enrolled in Qualified Health Plans: 8,531 in individual market Qualified Health Plans and 7,356 in small group market Qualified Health Plans. Over 7,000 of Evergreen Health's members have chosen to receive patient-centered, coordinated primary care through an Evergreen Health Care Primary Care Office. Beilenson Decl. ¶ 30.

Evergreen Health is widely recognized as the type of health coverage that holds the promise of improving quality of care while driving down costs. CMS Acting Administrator Andy Slavitt has stated that Evergreen Health "is exactly the kind of example of the kind of competition and the kind of innovation that unique small companies can provide . . . . "[2] Similarly, Maryland Insurance Commissioner Al Redmer, Jr. has cited Evergreen Health as a new, innovative health care model that improves competition and patient care in the state's health insurance markets.[3] As the Baltimore Sun Editorial Board recently explained:

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[2] *Healthcare CO-OPS: A Review of Financial Oversight and Controls: Hearing Before the S. Comm. on Fin.,* 114th Cong. (Jan. 21, 2016) (statement of Andy Slavitt), *available at* http://www.finance.senate.gov/hearings/healthcare-co-ops-a-review-of-the-financial-andoversight-controls.

[3] *Review of Obamacare Consumer Operated and Oriented Plans (CO-OPs): Hearing Before the H. Oversight & Government Reform Comm.,* 114th Cong. (Feb. 25, 2016) (statement of Al (continued…)

> The ACA has been successful at reducing the number of uninsured in this country, but it has fared less well at fostering innovative approaches to delivering health care. Evergreen Health is a notable exception to the rule. It provides the elements of traditional insurance but also a heavy emphasis on evidence-based, patient-centered primary care and health and wellness coaching. It runs its own network of primary care offices where doctors' limited caseloads allow them to spend far longer with patients than is typical, offering the opportunity for more prevention and better coordination of care.

Editorial, *Can Evergreen Health Force Obamacare to Live up to Its Promises*, BALT. SUN, June 18, 2016.

C. Implementation of the ACA's "Premium Stabilization" Programs

Evergreen Health's success is threatened by the way in which CMS has implemented two of the "Three Rs" that are intended to stabilize premiums in the health insurance marketplace: risk adjustment and risk corridors.

1. Risk Adjustment Program

CMS has described the intent of the risk adjustment program as "protecting consumers' access to a range of robust coverage options by reducing the incentive for insurance companies to seek only to insure healthy individuals." CMS, *The Three Rs*, *supra* note 1. The program does this by "requir[ing] insurance companies with healthier consumers in a state to pay charges that help offset some of the costs of those insurance companies with sicker consumers in that state." *Id.* Specifically, Section 1343(a)(1) of the ACA requires States to charge issuers in the individual and small group markets a risk adjustment assessment if the "actuarial risk" of their enrollees is less than the average actuarial risk in the State:

> each State shall assess a charge on health plans and health insurance issuers [in the individual or small group market within

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Redmer, Jr.), *available at* https://oversight.house.gov/wp-content/uploads/2016/02/2016-02-25-Written-Testimony-Redmer-MIA.pdf.

> the state] . . . 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).

The statute refers to these as "low actuarial risk plans."

Section 1343(a)(2) requires States to make risk adjustment payments to issuers in the individual and small group markets if the "actuarial risk" of their enrollees is greater than the average actuarial risk in the State:

> each State shall provide a payment to health plans and health insurance issuers [in the individual or small group market within the state] . . . 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).

The statute refers to these as "high actuarial risk plans."

Section 1343(b) requires the Secretary of Health and Human Services ("HHS"), "in consultation with the States," to develop "criteria and methods" to implement the Risk Adjustment Program. These "criteria and methods" "may" be "similar to" those used in Medicare Part C (Medicare managed care, also known as Medicare Advantage) or Medicare Part D (the Medicare prescription drug benefit).

On March 23, 2012, CMS finalized regulations establishing the framework for implementation of the Section 1343 risk adjustment program. 77 Fed. Reg. 17,220 (Mar. 23, 2012). While Section 1343 provided that "each State shall" assess or make risk adjustment payments, CMS through its regulations took control of the program: CMS operates and administers the Risk Adjustment Program, unless a state with a state-based exchange elects to

operate its own "alternative" risk adjustment methodology that comports with federal standards and is federally approved. 45 C.F.R. § 153.310. States that do not operate their own exchange are ineligible to create their own "alternative" risk adjustment programs. *Id.*

Later in 2012, CMS published its proposed methodology for calculating risk adjustment assessments and payments. 77 Fed. Reg. 73,118 (Dec. 7, 2012). Key features of CMS's model included the following:

First, it proposed uses a "concurrent data model," *i.e.*, it uses data provided by the issuers from the year for which the adjustment assessment or charge applies. *Id.* at 73,125. This means that plans would not know whether they would be receiving or making a payment until after the year was over.

Second, unlike the risk adjustment programs in Medicare or any other governmental program, CMS proposed that the program would operate as a "transfer" of funds from the low actuarial risk plans to high actuarial risk plans (with CMS as the conduit). In order for this to work, CMS based the payment on the average statewide premium payment rather than a plan's actual premiums. This means that plans with lower than average premiums would unduly benefit if they were to receive risk adjustment payments, but also that these plans would unduly be penalized if they were determined to be "low actuarial risk."

Third, while the calculation of the risk adjustment assessments and payments is complex, the primary input is the actuarial "risk score" for each enrollee. A high risk score assumes that the individual has more complex health needs that are likely to result in higher health care costs. A low risk score assumes that the individual has low health care needs and will incur fewer health care costs. *See id.* at 73,125-49

The risk score starts with a coefficient (*i.e.*, a numeric value) for each individual based on age and gender (except for the infant model; all infants start with the same age and gender coefficient). This demographic-based coefficient is supplemented if the enrollee has been assigned one or more hierarchal condition categories ("HCCs") that correspond with a certain condition or diagnosis. Examples of HCCs include "HIV/AIDS"; "Diabetes without Chronic Complications"; "Asthma"; and "Drug Dependency." Each of these HCCs has a coefficient that is added to the age/gender coefficient. The HCC coefficient may also be adjusted based on disease interaction and severity. *Id*. at 73,128-38.

Individuals are associated with HCCs only when a health care provider diagnoses a condition or recognizes a diagnosis during the time in which the individual is enrolled in the plan in the applicable calendar year, properly codes that diagnosis, and transmits that information to the plan issuer. *See id*. at 73,129 (explaining that the model uses "current year diagnoses"). For example, an individual will receive a diabetes HCC only when he/she visits a physician, during a month in which he/she is enrolled in the plan in the applicable calendar year, and the physician records and transmits a diabetes diagnosis to the issuer. The risk score for members who have not been assigned an HCC in that calendar year is simply the age/gender coefficient value. They thus have a lower risk score than members of a similar age/gender that have an HCC recorded, even if the plan has other clear evidence that the enrollee has an HCC condition.

Fourth, CMS's model proposed to use only HCC codes and not prescription drug data to identify patients' diagnoses. *Id.* at 73,128. CMS had indicated that it was proposing to exclude prescription drug information because it was concerned that it "could create adverse incentives to modify discretionary prescribing." 77 Fed. Reg. at 73,128. A number of entities disagreed with this aspect of CMS's proposal and filed comments on the proposed rule explaining that using

prescription drug data would result in a more accurate risk adjustment methodology, particularly for the first few years of ACA implementation. Commenters also proposed solutions in response to CMS's concern that the use of prescription drug utilization data could incentivize over-prescribing behavior. Suggested solutions included limiting prescription drug data to drugs that are not discretionary (e.g., insulin, anti-rejection drugs, cancer chemotherapies), or limiting prescription drug claims to certain high-impact drugs that treat select conditions.[4]

In March 2013, CMS finalized the methodology that it would use to calculate risk adjustment payments, largely as it had been proposed (hereafter, "the Government's Risk Adjustment Methodology"). *See* 78 Fed. Reg. 15,410, 15,419-52 (Mar. 11, 2013). In the final rule CMS did not respond to comments regarding the exclusion of prescription drugs or repeat its concern that including them would create adverse incentives for providers. Instead, it stated only that "HHS is finalizing its proposal to exclude prescription drugs for the initial HHS risk adjustment models, but will consider how prescription drugs could be included in future HHS risk adjustment models." 78 Fed. Reg. at 15,419. Under the final rule, plans must submit the data, including HCC codes, to CMS by a specific deadline – for 2014 data, the deadline was May 15, 2015; for 2015 data the deadline was May 2, 2016. CMS then calculates the risk scores for each plan and the risk adjustment assessment or risk adjustment payment for the plan.

Major problems began to emerge with the Government's Risk Adjustment Methodology in its first year of operation. Small insurers nationwide were receiving crippling risk adjustment

[4] *See, e.g.*, Or. Dep't of Consumer and Business Services, *Comment to CMS-9964-P, Patient Protection and Affordable Care Act: Benefit and Payment Parameters for 2014*, at *1-2 (Jan. 3, 2013), available at: https://www.regulations.gov/document?D=CMS-2012-0152-0174; *DC-BlueCross BlueShield, Comments on the Proposed Rule: "Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2014" [CMS-9964-P]*, at *49 (Dec. 28, 2012), available at: https://www.regulations.gov/document?D=CMS-2012-0152-0270.

assessments, to the benefit of large insurers. For example, a small insurer in Alabama was assessed a payment equaling 25 percent of its premium revenue, and an insurer in Florida received a $97 million assessment, equaling close to 40 percent of its premium revenue.[5]

Evergreen Health itself was assessed a "default" risk adjustment payment in 2014 of $2,752,054, when errors in the data submitted to CMS were discovered, which could not be corrected until after the deadline closed. Beilenson Decl. ¶ 37. However, in light of what was happening to other plans, Evergreen Health joined with a nationwide coalition of new and growing health plans to advocate for change in the Government's Risk Adjustment Methodology. The coalition is known as CHOICES.

Uncertain as to why new plans were receiving such disproportionate assessments, the CHOICES coalition asked Rick S. Foster, who served as CMS's Chief Actuary for nearly two decades, to review the Government's Risk Adjustment Methodology. In October 2015, CHOICES published Mr. Foster's report, detailing a number of serious technical problems with the Government's Risk Adjustment Methodology (hereinafter, "the Foster Report").[6] Among other things, the Foster Report explains that the methodology: fails to account for the time lag in identifying HCC diagnoses, which disproportionately impacts the risk score of partial year enrollees; fails to allow plans to consider prescription drug data in identifying HCC diagnoses;

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[5] Amy Goldstein, *Critics say ACA 'risk strategies are having reverse Robin Hood effect*, WASH. POST, Jan. 13, 2016, available at https://www.washingtonpost.com/national/health-science/critics-say-aca-risk-strategies-are-having-reverse-robinhood-effect/2016/01/13/e41cf574-b48f-11e5-a842-0feb51d1d124_story.html.

[6] Leavitt Partners & Rick S. Foster, *Technical Issues with ACA Risk Adjustment and Risk Corridor Programs, and Financial Impact on New, Fast-Growing, and Efficient Health Plans* (Nov. 4, 2015), *available at* http://www.choicescoalition.org/documents/CHOICES%20White%20Paper%20on%20Risk%20Adjustment.pdf and http://nashco.org/wp-content/uploads/2015/11/CHOICES-White-Paper-on-Risk-Adjustment-Issues.pdf.

and inappropriately calculates assessments based on average statewide premiums, which disadvantages plans with premiums below the state average. The Foster Report identified several ways to correct the methodology, including:

- Use prescription drug data to identify HCC diagnoses.
- Apply a "credibility-based" adjustment to account for the proportion of members who had not previously been enrollees with the insurer.
- Place an upper bound on the amount of a plan's premium revenue that will be transferred through risk adjustment.
- Use plans' own premiums, instead of the statewide average premium, to calculate the risk adjustment transfer amounts.

Throughout 2015 and 2016, insurers – and several insurance commissioners who were worried about the destabilizing effects of the risk adjustment assessments on competition in their States – continued to appeal to CMS to change the methodology. Issuers of adversely affected plans met repeatedly with Administrator Slavitt and others in CMS and HHS leadership and staff. *See, e.g.*, Beilenson Decl. ¶ 41. Plans and state regulators also testified before Congress on the subject. For example, in February of 2016, Maryland Insurance Commissioner Redmer testified before the House Committee on Oversight and Government Reform outlining the threat to "new innovative health insurance plans" from "the adverse and perhaps fatal financial impact caused by the technical shortcomings of the current risk adjustment and risk corridor programs." Al Redmer, Jr., Test., Feb 25, 2016 (Att. B). Commissioner Redmer explained:

> The risk adjustment formula is of concern to state regulators because it has proven to place newer carriers at a distinct disadvantage. . . . New carriers have very limited information on the health status or previous claims history of the applicants. Therefore, the carrier's population may appear healthier than it actually is if some diagnoses are not captured which may result in improper risk adjustment payments. . . .

> The [National Association of Insurance Commissioners ("NAIC")] has urged CMS to review the formula and work with carriers and state regulators to make adjustments for 2015 and 2016 to ensure it is providing appropriate protection for all carriers, and not wait until 2017 or 2018 to enact reforms. There are several immediate solutions that would provide financial relief while technical corrections are developed. Among these are exempting new and fast-growing plans from risk adjustment for the first 3-5 years or limiting the amount a carrier pays for risk adjustment to 2% of the carrier's premium revenue in the year for which the risk adjustment payment is assessed.

Id.

In March 2016, CMS released a 130-page "discussion paper" that attempted to justify its methodology in advance of a meeting with insurers and other stakeholders about risk adjustment. CMS, *Discussion Paper: March 31, 2016, HHS-Operated Risk Adjustment Methodology Meeting* (Mar. 24, 2016). In this paper, CMS also acknowledged significant problems with its current methodology. CMS explained that its methodology

> may be inaccurate when a plan's enrollees differ substantially from the market as a whole with respect to characteristics that are not adjusted for in the risk adjustment model. . . . Specifically, if the risk adjustment methodology does not fully capture risk for partial year enrollment, then if the plan had higher than average enrollment duration, the plan risk score might be too high, and similarly, if the plan had lower than average enrollment duration, the plan risk score might be too low.

Id. at 36. CMS also acknowledged that using prescription drug data "may capture the existence of some conditions (diagnoses associated with drug treatment) that are missing in diagnoses entered on claims"; provide "a more complete picture of the severity of illness"; and may be "a more complete reflection of health conditions for patients whose chronic conditions do not require frequent patient visits." *Id.* at 40-41.

On May 11, 2016, CMS published an interim final rule regarding special enrollment periods in the Exchanges. 81 Fed. Reg. 29,146, (May 11, 2016). At the end of the preamble,

CMS added a brief discussion of risk adjustment, in which it acknowledged that some new and rapidly growing issuers "owed substantial risk adjustment charges that they did not anticipate." *Id.* at 29, 152. It further "recognize[d] that States are the primary regulators of their insurance markets" and "encourage[d] States to examine whether any local approaches, under State legal authority, are warranted to help ease this transition to new health insurance markets." *Id*. Despite this invitation to state insurance commissioners, CMS still would not accept Commissioner Redmer's proposal to cap risk adjustment assessments in Maryland at 2 percent of premium revenue. *See* Sara Hansard, State Officials: CMS Inflexible on Risk Adjustment Changes, BNA, May 27, 2016, *available at* http://www.bna.com/state-officialscms-inflexible-n57982073275/ (quoting Commissioner Redmer as stating that CMS will not allow him "any flexibility" in remedying the risk adjustment problem).

Finally, on June 8, 2016, CMS announced it would be "improving" and "maturing" the risk adjustment methodology through two changes. First, for 2017 and beyond, the Government's Risk Adjustment Methodology will include an adjustment for partial year enrollees to "more accurately account[] for the costs of short term enrollees in ACA-compliant risk pool[s]." Second, for 2018 and beyond, CMS will incorporate prescription drug utilization data into the Government's Risk Adjustment Methodology.[7]

2. Risk Corridors Program

According to CMS, "[t]he goal of the risk corridors program is to support the Marketplaces by providing insurers with additional protection against uncertainty in claims costs during the first three years of the Marketplace." CMS, *The Three Rs*, *supra* note 1. It does this

[7] CMS, *Strengthening the Marketplace - Actions to Improve the Risk Pool* (June 8, 2016), *available at* https://www.cms.gov/Newsroom/MediaReleaseDatabase/Fact-sheets/2016-Fact-sheets-items/2016-06-08.html.

by having the Federal government share risk in a health plan's losses and gains. "Issuers whose premiums exceed claims and other costs by more than a certain amount pay into the program, and insurers whose claims exceed premiums by a certain amount receive payments for their shortfall." *Id.*

Specifically, Section 1342 of the Act directs the Secretary of HHS, for the first three years of full ACA implementation, to make risk corridors payments to any Qualified Health Plan that, for the applicable year, had health care costs that were more than three percent greater than a target amount based on aggregate premiums charged by the plan in the applicable year:

> (b) PAYMENT METHODOLOGY. —
> (1) Payments out. — The Secretary shall provide under the program established under subsection (a) that if —
> (A) a participating plan's allowable costs for any plan year are more than 103 percent but not more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to 50 percent of the target amount in excess of 103 percent of the target amount; and
> (B) a participating plan's allowable costs for any plan year are more than 108 percent of the target amount, the Secretary shall pay to the plan an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of allowable costs in excess of 108 percent of the target amount.
> (2) Payments In.—The Secretary shall provide under the program established under subsection (a) that if—
> (A) a participating plan's allowable costs for any plan year are less than 97 percent but not less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to 50 percent of the excess of 97 percent of the target amount over the allowable costs; and
> (B) a participating plan's allowable costs for any plan year are less than 92 percent of the target amount, the plan shall pay to the Secretary an amount equal to the sum of 2.5 percent of the target amount plus 80 percent of the excess of 92 percent of the target amount over the allowable costs.

Subsection 1342(c) defines allowable costs as "an amount equal to the total costs (other than administrative costs) of the plan in providing benefits covered by the plan," and defines "target amount" as "an amount equal to the total premiums (including any premium subsidies under any governmental program), reduced by the administrative costs of the plan."

In other words, if a plan's allowable costs are more than three percent above the total of the plan's premium revenue less the plan's administrative costs, the plan is entitled to a payment equal to 50 percent or more of the plan's costs over that three percent threshold. A risk adjustment payment made by a health plan is one of the costs included in the calculation of a plan's allowable costs for purposes of determining eligibility for, and calculating the amount of, a risk corridors payment. ACA § 1343(c)(1)(B); 45 C.F.R. §153.530(b)(1).

In December of 2014, Congress enacted an appropriations rider that limited funding available for CMS to make risk corridor payments to plans that had sustained losses in operating their Qualified Health Plans. Pub. L. No. 113-235, div. G, title II, 128 Stat. 2130 (2014). CMS has taken the position that the only funding available to it to make risk corridors payments is the money it collects through the Risk Corridors Program from plans that make a profit. In October 2015, the Government announced that it owed $2.87 billion to plans with costs in excess of their premium revenue, but collected only $362 million in risk corridors payments (12.6 percent of the amount owed).[8] On October 1, 2015, the Government formally notified Evergreen Health that it would pay out only 12.6 percent of the amount due to it in risk corridors payments. Beilenson

[8] *See* CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf; *see also* CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/RC_Obligation_Guidance_11-19-15.pdf.

Decl., Ex. 4. This meant that Evergreen Health received only $505,163 of the $4,178,290 in risk corridors payment to which it is entitled for 2014. However, CMS acknowledged that it was still under a legal obligation to pay the $3,673,127 balance owed under the statute.

In addition, CMS has indicated that it will not pay any of its 2015 risk corridors obligations, unless and until it receives sufficient funding under the risk corridors program to satisfy its $2.5 billion debt to all Qualified Health Plans for 2014, which is an extremely unlikely event, given the amounts that it continues to owe for 2014, and the fact that it will no longer collect risk corridor payments from plans after 2016. Evergreen Health's outside actuary (Milliman USA) calculated that CMS will owe Evergreen Health approximately $16 million in 2015 risk corridors payments, assuming a $22 million risk adjustment assessment. If the $24 million risk adjustment assessment stands, the risk corridors payment for 2015 will be even greater than $16 million.

D. Evergreen Health's Risk Adjustment Assessment for 2015

In February of 2016, Evergreen Health's outside actuary its projected risk adjustment liability for 2015 to be between $4 million and $12 million, with the most likely outcome being the midpoint of $7.5 million, representing close to 10 percent of Evergreen Health's $86 million in premium revenue for 2015. By May 2016, the Maryland Insurance Administration ("MIA") and Evergreen Health had more information about Evergreen Health's risk scores and its competitors' risk scores, and it became clear that Evergreen Health's risk adjustment liability for 2015 would likely exceed $20 million.

On June 15, 2016, the MIA sent Evergreen Health a letter regarding the "severe stress" that the risk adjustment payment will put "on the Company's ability to remain solvent," and outlining the actions the MIA is "taking at this time, and the actions we could be required to take in the near future." Letter from Vincent P. O'Grady, Assoc. Comm'r, MIA, to Peter Beilenson,

Pres. and CEO, Evergreen Health Cooperative, Inc. (June 15, 2016) (Beilenson Decl., Ex. 5). Among other things, the MIA asked Evergreen Health "to provide the Administration with a formal plan for remaining solvent despite the sizable expected payment to CMS"; stated that it would "be conducting a targeted examination of the Company" in July 2016; and warned that the MIA "may have no choice other than to place the Company into receivership" if it "is not able to demonstrate a clear path forward that maintains appropriate risk-based capital (RBC) levels, maintains appropriate liquidity ratios, and otherwise demonstrates that its subscribers will not be harmed by the Company's financial situation." *Id.*

In order to minimize the chance of receivership and stay in business, Evergreen Health worked around the clock to secure loans that would enable Evergreen Health to maintain adequate reserves. Specifically, Evergreen Health sought a five-year, fully guaranteed loan from a commercial bank, commencing in August of 2016. This loan will be in compliance with MIA rules to allow it to qualify as a surplus note financing. Evergreen Health is seeking $17 million and has calculated that it must raise a minimum of $11 million to avoid the potential of receivership. As of June 27, 2016, there is $6.5 million in guaranteed funds committed and several other pending requests totaling an additional $10 million in guarantees. Evergreen Health will continue to seek potential funders to obtain sufficient funds to remain solvent.

On June 30, 2016, CMS assessed Evergreen Health $24,210,834 in risk adjustment payments for the 2015 calendar year, representing 28.4 percent of Evergreen Health's $86 million in premium revenue for 2015. To collect the risk adjustment assessment, CMS will deduct between $2 million and $3 million from payments that it would otherwise make to Evergreen Health on July 15, 2016. The remainder of the payment is due by check by August 15, 2016. Beilenson Decl. ¶ 48.

Evergreen Health has been notified that its independent audit firm – Baker Tilly Virchow Krause, LLP – will issue a "qualified opinion" on the 2015 statutory audit because the severity of the risk adjustment assessment will cause a going concern issue. In essence, this opinion means that, absent the anticipated additional capital, the company will not be able to survive for the next twelve months. Beilenson Decl. ¶ 59.

All of the approximately $24 million in risk adjustment payments assessed against Evergreen Health by the Government will be transferred to CareFirst BlueCross BlueShield ("CareFirst"), for which the payment will represent less than 0.5 percent of over $5 billion in annual premium revenue in Maryland. *See* Beilenson Decl. ¶ 46.

While the immediate threat of receivership appears to have been averted due to the last-minute loans that Evergreen Health may be able to obtain, payment of the assessment will seriously damage Evergreen Health's financial health and its competitive position.

ARGUMENT

A preliminary injunction is intended to "protect the status quo and to prevent irreparable harm during the pendency of the lawsuit ultimately to preserve the court's ability to render a meaningful judgment on the merits." *In re Microsoft Corp. Antitrust Litig.*, 333 F.3d 517, 525 (4th Cir. 2003). To obtain a preliminary injunction, a movant must establish that 1) there is a likelihood of success on the merits, 2) the movant will face irreparable harm in the absence of preliminary relief, 3) the balance of equities favors preliminary relief, and 4) an injunction is in the public interest. *See, e.g.*, *Winter v. Nat. Res. Def. Council, Inc.*, 555 U.S. 7, 20 (2008).

As set forth below, Evergreen Health's request that the Government be enjoined from collecting $24 million in risk adjustment payments – over 28 percent of its total premium revenue for 2015 – satisfies each of the four criteria for a preliminary injunction. Evergreen

Health is likely to succeed on the merits of its claim that the Government's untested and experimental Risk Adjustment Program is rife with errors that fail to capture the true actuarial risk of Evergreen Health's population, as compared to more established plans. Evergreen Health is also likely to succeed on its alternative claims that the Government is unlawfully collecting the risk adjustment payment while refusing to pay the associated risk corridor payments, and that the Government's usurpation of authority belonging to the state insurance commissioner is contrary to the text of the ACA. Collecting the entirety of the risk adjustment payment from Evergreen Health by August 15th will cause imminent, irreparable injury to the company, its members and consumers in Maryland. Because of the structure and operation of the insurance market in Maryland, and the limitations of the Administrative Procedure Act's ("APA") waiver of sovereign immunity, these injuries cannot be repaired even if Evergreen Health's risk adjustment payment is later refunded after a trial on the merits.

A. Evergreen Health is Likely to Succeed on the Merits on At Least One of Its Three Claims.

Under the APA, courts reviewing agency action must set aside any action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with the law." 5 U.S.C. § 706(2)(A). Similarly, Courts must reject agency action that is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." *Id.* § 706(2)(A).

Evergreen Health's Complaint sets forth three independent claims, each demonstrating that the Government's implementation of the Risk Adjustment Program cannot survive APA review. While Evergreen Health believes that all three claims are likely to succeed on the merits, the Court need only agree that Evergreen Health will prevail on any one of the three to grant a preliminary injunction.

1. The Government's Risk Adjustment Methodology is Arbitrary, Capricious, and Contrary to Section 1343.

Section 1343 of the ACA requires that a plan be assessed a risk adjustment charge if, and only if, the "actuarial risk of the enrollees" in the plan is less than the average "actuarial risk" of all enrollees in non-grandfathered individual and small group plans in the State. ACA § 1343(a)(1), 42 U.S.C. § 18063(a)(1). The Government's Risk Adjustment Methodology is arbitrary and capricious, and contrary to this statutory mandate.

The most glaring problems with the Government's Risk Adjustment Methodology are that it entirely fails to consider prescription drug data or the impact of partial year enrollment on obtaining HCC diagnoses. These have long been recognized as two major flaws in the methodology and, last month, the Government finally proposed to address them – but not until 2017 and 2018, well after the three-year "transition" period, which the ACA has recognized is the most volatile period for health insurers and the one most in need of premium stabilization. *See* §§ 1341, 1342 (authorizing the reinsurance and risk corridors programs for a three year transitional period); CMS, *The Three Rs*, *supra* note 1 (explaining that the ACA introduced the Three Rs "to assist insurers through the transition period"). These two flaws exacerbate another problem with the methodology, which is the informational advantage accorded to preexisting insurers' over new market entrants and rapidly growing plans. Finally, the Government's Risk Adjustment Methodology unreasonably inflates risk adjustment assessments for plans with premiums below the statewide average premium.

Each of these problems independently supports a finding that the Government's Risk Adjustment Methodology is arbitrary, capricious, and/or contrary to law. Collectively, these shortcomings result in a methodology that yields risk adjustment assessments and payments that have no rational relationship to the actuarial risk of plans' enrollees.

a) The Government's Risk Adjustment Methodology Fails to Consider Critical Factors and Information Relating to the Actuarial Risk of Plans' Enrollees.

The Government's Risk Adjustment Methodology fails to consider critical facts relevant to the actuarial risk of health plans' enrollees.

First, the Government's Risk Adjustment Methodology fails to account for difficulties in identifying HCC diagnoses for partial year enrollees. New and rapidly growing health plans have a disproportionately high percentages of consumers who are enrolled only for some part of the calendar year, not the entire calendar year. For example, in 2015, 57.2 percent of Evergreen Health's members enrolled on or after April 1, 2015; 38.9 percent enrolled on or after September 1, 2015; and 26.5 percent enrolled on or after December 1, 2015. Beilenson Decl. ¶ 32.

When a large percentage of a plan's enrollees are only enrolled for part of the calendar year, there is a greater likelihood they have not visited a health care provider in that calendar year while covered by their current plan, and thus the issuer does not have their HCC diagnosis information. Because new and rapidly growing plans have a higher percentage of partial year enrollees, a higher percentage of their enrollees with chronic conditions will lack a recorded HCC diagnosis, compared to enrollees with similar conditions in plans issued by longstanding issuers. This problem is particularly acute in the small group market, which makes up the overwhelming majority of Evergreen Health's premium revenue, Beilenson Decl. ¶ 32. In the individual market, the plan year coincides with the calendar year. Individuals generally enroll for the entire upcoming calendar year during an "open enrollment" period beginning in the fall of the prior year (unless they enroll through a "special enrollment period" during the calendar year). However, enrollment in the small group market can occur at any time, and the vast majority of small group employers have plan years beginning on dates other than the start of the calendar year. For example, consider a small employer that switches from Plan X to Plan Y on July 1,

2015, mid-way through the calendar year. If an employee with diabetes visits a physician in the first six months of 2015, but not in the second half of the year, he or she will have an HCC for purposes of calculating Plan X's risk adjustment assessment, but that very same enrollee will not have an HCC – and thus will have the same risk score as a healthy enrollee – for purposes of calculating Plan Y's risk adjustment assessment. All other things being equal, Plan Y will end up paying part of its premiums to Plan X for that enrollee, because under the Government's formula, Plan X is viewed as having greater risk.

The Government's Risk Adjustment Methodology did not include any measure to address this predictable issue of partial year enrollment. As explained in the Declaration of David V. Axene, an actuarial expert with over four decades of experience in the health care field, the failure to consider partial year enrollment makes it impossible for the Government's Risk Adjustment Methodology to accurately capture the "actuarial risk" of enrollees in Evergreen Health's plans. *See* Decl. of David V. Axene ¶ 30-34 (hereinafter "Axene Decl.") (Att. C). Approximately 34 percent of Evergreen Health's members in 2015 enrolled in the last quarter of the calendar year, with over 26 percent enrolling in the final month of the year. Beilenson Decl., Ex. 1; Axene Decl., ¶ 30. There was a much lower likelihood that these individuals would visit a health care professional, and thus have an HCC diagnosis, before the end of calendar year 2015, compared to individuals who enrolled earlier in the calendar year. Axene Decl. ¶ 30. Indeed, just 49.9 percent of the individuals who enrolled in Evergreen Health in the final quarter of 2015 had a non-pharmacy medical claim, compared to 71.3 percent of individuals who enrolled in Evergreen Health in the first quarter of 2015. Axene Decl. ¶ 32.

Mr. Axene is not the only actuarial expert with this opinion. For example, Wakely Consulting, in establishing a risk adjustment methodology for Massachusetts, made a 91 percent

adjustment for individuals enrolling in plans in the last month of the year, a 55 percent adjustment for individuals enrolling in the second-to-last month of the year, and a 45 percent adjustment for individuals enrolling in the third-to-last month of the year. Axene Decl. ¶ 31. No such adjustment exists in the Government's Risk Adjustment Methodology.

Even CMS has acknowledged that, because "partial year enrollment is not accurately accounted for," the Government's Risk Adjustment Methodology may be "inaccurate" if a plan has a disproportionately high percentage of partial year enrollees, as Evergreen Health did in 2015. CMS, *Discussion Paper*, at 36. "Specifically, if the risk adjustment methodology does not fully capture risk for partial year enrollment, then if the plan had higher than average enrollment duration, the plan risk score might be too high, and similarly, if the plan had lower than average enrollment duration, the plan risk score might be too low." *Id.*

Second, the Government's Risk Adjustment Methodology fails to allow plans to identify HCC diagnoses based on prescription drug data, even though such data is "one of the simplest, most effective, and most reliable indicators of health status." Foster Rep. at 3. The American Academy of Actuaries has concluded that "risk-adjustment models that use only pharmacy claims have proven to be surprisingly powerful predictors of future medical costs – the [Society of Actuaries ("SOA")] risk-assessment study found that, in terms of predictive power, pharmacy only models rival models that use both diagnosis data and pharmacy data." Axene Decl. ¶ 15. As explained in the Axene Declaration, prescription drug data is an effective and reliable indicator of health status, and it is particularly useful in a concurrent risk adjustment model, where the information a plan has about enrollees' diagnoses may not otherwise be complete. *Id.* ¶__; Foster Rep. at 3. Because prescriptions are filled regularly, new market entrants, such as

Evergreen Health, are more likely to have information regarding an enrollee's prescriptions than they are to have an HCC associated with an enrollee. Foster Rep. at 3.

CMS has acknowledged that its methodology would be improved by allowing prescription drug data to be used in identifying HCC diagnoses. CMS has explained that "drug utilization data may capture the existence of some conditions (diagnoses associated with drug treatment) that are missing in diagnoses entered on claims," and thus may be "a more complete reflection of health conditions for patients whose chronic conditions do not require frequent patient visits." CMS, *Discussion Paper*, at 40-41. Further, prescription drug data provides "a more complete picture of the severity of illness." *Id.*

For example, if a diabetic individual enrolls in an Evergreen Health Plan in October, but does not see a physician for the last three months of the calendar year, he or she may still fill insulin prescriptions during those last three months of the year, the cost of which are billed to Evergreen Health. The Government's Risk Adjustment Methodology arbitrarily refuses to consider this type of prescription drug data in determining an enrollee's risk, instead relying solely on HCC coding.[9]

CMS's failure to use prescription drug data "directly and negatively impacts the new players in the marketplace," because such data "is available more quickly than most other claims information and can readily show what types of health care conditions are present in the population." Axene Decl. ¶ 14. As the Axene Declaration demonstrates, if the Government's

[9] The focus on using HCC codes only is particularly problematic in light of the Government's own experience in Medicare Advantage, in which it has routinely discovered through audits that the codes submitted by plans are unsupported by medical records. *See* Government Accountability Office, *Medicare Advantage: Fundamental Improvements Needed in CMS's Effort to Recover Substantial Amounts of Improper Payments* at 11-12 & n.6 (Apr. 2016) (reporting that 10 of 32 contracts audited had reported unsupported diagnosis between 30 and 40 percent of the time, and 10 of the 32 contracts had rates at or above 40 percent).

Risk Adjustment Methodology used prescription drug data, not only would Evergreen Health have avoided the devastating $24 million assessment, it might even have been owed a risk adjustment payment. Specifically, the Axene Declaration shows that, based on prescription drug data, Evergreen Health's actuarial risk was actually above average when compared to a typical under-65 population of health insurance enrollees. Axene Decl. ¶ 22.

Third, the Government's Risk Adjustment Methodology fails to account for the information advantage longstanding health insurance issuers have over new market entrants. *See* Foster Rep. at 2-4. Because longstanding insurers serve many enrollees who have been enrolled in one of their plans in a previous year, they are able to utilize diagnosis data collected from previous years to target outreach to specific high-risk enrollees, and ensure that they visit a physician to get appropriately coded during the current calendar year (e.g., through targeted reminders and incentives to visit a primary care physician before the end of the calendar year). *See* Foster Rep. at 2-4. In contrast, new market entrants and rapidly growing plans serve a much smaller percentage of repeat customers, and thus have less information about their enrollees. For example, in 2015, 72 percent of Evergreen Health's enrollees had not previously been enrolled in an Evergreen Health plan. Beilenson Decl. ¶ 31. Because of this informational advantage, longstanding issuers are able to record HCC diagnoses for a higher percentage of their enrollees with chronic conditions, as compared to new market entrants who do not have the historic data necessary to target outreach to their enrollees with similar conditions.

In 2010, the American Academy of Actuaries explained that diagnosis code-based risk adjustment models are not sufficiently reliable when they are first implemented, and thus should be phased in over time:

> when a risk-adjustment system is first put into place, complete data on health-based information may not be available for many plan

> enrollees, and health plan diagnosis data may not be fully coded. Therefore, it may be appropriate to phase in implementation of a risk-adjustment payment system over a period of time. During the initial years, demographic and other non-health based information can be used, with claims-based risk-adjustment models phasing in over time. The Medicare Advantage program has taken this approach.

Axene Decl. ¶ 29.

CMS ignored well-known concerns about the lack of adequate diagnosis information for this type of code-based risk adjustment methodology and declined to include any measure to address the informational imbalance between new plans and established issuers in the Government's Risk Adjustment methodology. CMS's failure to account for this information imbalance artificially increases the risk profile of established plans and correspondingly deflates that of new market entrants such as Evergreen Health. There are several ways CMS could have addressed this imbalance, including by applying a "credibility-based" adjustment to a plan's aggregate risk adjustment score to account for the proportion of members who had not previously been enrollees with the insurer, as proposed by the Foster Report.

The failure of the Government's Risk Adjustment Methodology to give new market entrants like Evergreen Health a fair chance to identify high-risk diagnoses is exacerbated by the fact that, according to leading employer benefits consulting firm Oliver Wyman, the methodology "tends to result in overpayments for individuals with high risk scores, and underpayments for those with low risk scores," which "is particularly significant for smaller share players and new market entrants." Axene Decl. ¶ 37. The negative impacts on Evergreen Health are further exacerbated by the methodology's failure to account for effective primary care coordination, *see* Axene Decl. ¶ 39-42, which is the founding principle and focus of Evergreen Health, *see generally* Beilenson Decl.

These problems with the Government's Risk Adjustment Methodology independently and together paint a false picture of which plans are "low actuarial risk" and which plans are "high actuarial risk," as the statute requires. Where, as here, a federal policy or implementing regulation is inconsistent with a clear statutory instruction, that policy or regulation must be struck down as arbitrary, capricious, and contrary to law under the APA. *Cf., e.g.*, *Los Angeles Haven Hospice, Inc. v. Sebelius*, 638 F.3d 644, 660-61 (9th Cir. 2011) (striking down HHS hospice cap regulation under the APA because the regulatory method for counting Medicare beneficiaries was inconsistent with the statutory instruction about how to count Medicare beneficiaries in calculating the cap); *Russell-Murray Hospice, Inc. v. Sebelius*, 724 F. Supp. 2d 43, 57-59 (D.D.C. 2010) (same); *Conservation L. Found. v. Evans*, 209 F. Supp. 2d 1, 12-13 (D.D.C. 2001) (striking down Secretary of Commerce's policies as failing to comply with Congress's statutory instruction that the Secretary should take action to "minimize bycatch").

Agency action is "arbitrary" and "capricious" within the meaning of the APA when it "'entirely fail[s] to consider an important aspect of the problem'" that Congress instructed it to address. *Conservation L. Found.*, 209 F. Supp. 2d at 12-13 (quoting *Motor Vehicle Mfg. Ass'n v. State Farm Mutual Ins.*, 463 U.S. 29, 43 (1983)); *accord Ohio River Valley Envtl. Coal., Inc. v. Kempthorne*, 473 F.3d 94, 103 (4th Cir. 2006) (finding a rule arbitrary and capricious because it "avoided the question" of the cumulative impact of its regulation, and so "ignored an important aspect of the problem"). In this case, Congress sought to create a program that measured "actuarial risk" for "all" enrollees in "all" non-grandfathered individual and small group market plans, including new market entrants. ACA § 1343(c). It certainly did not intend to create a program that favored existing insurers, which would have been completely contrary to its goal of promoting competition and expanding choices for consumers.

In the "discussion paper" issued in March 2016, CMS indicated that including prescription drugs, or devising solutions to deal with partial year enrollment or information imbalance among plans, would be complex. *See* Discussion Paper at 43 ("[a]dding drug data . . . introduces operational complexities"; using separate models to account for partial year enrollment "would add to the complexity of the HHS risk adjustment methodology"). Complexity does not absolve CMS from its responsibility to adhere to the statutory mandate. In *Los Angeles Haven Hospice, Inc. v. Sebelius*, an HHS regulation calculated a cap on Medicare hospice reimbursement differently than specified in the statute because the manner specified in the statute "would be difficult," whereas HHS's regulation "will achieve the intent of the statute without being burdensome." 638 F.3d at 651. The Ninth Circuit struck down HHS's regulation as inconsistent with the text of the statute, explaining that HHS does not have the authority to substitute Congress's clear intent for "an alternative that [it] considers more convenient and less burdensome." *Id.* at 660; *see also Miller v. AT & T Corp.*, 250 F.3d 820, 833 (4th Cir. 2001) ("If the Secretary's regulations implementing [a statute] subvert congressional intent to a degree that renders the regulations arbitrary, we are obliged to declare them inconsistent with the statute."). Similarly, in this case, Congress required the Secretary to accurately measure plans' "actuarial risk", and HHS does not have the authority to substitute Congress's clear intent for "an alternative that [it] considers more convenient and less burdensome."

As explained above, CMS's failure to allow plans to use prescription drug data, as well as CMS's failure to account for partial year enrollment and the informational imbalance between new and longstanding plans, prevents the Government's Risk Adjustment Methodology from accurately capturing "actuarial risk," as required by Section 1343. CMS arbitrarily refused to allow plans to use reliable information (prescription drug data) to capture actuarial information

about enrollees. CMS similarly arbitrarily failed to consider important aspects of the insurance market – *i.e.*, that many individuals are enrolled in plans for only part of the year and the information advantage held by longstanding plans – in developing its risk adjustment methodology.

Last month, CMS finally recognized that it was a mistake to preclude plans from using prescription drug data and to fail to account for partial year enrollment. The agency now proposes to allow plans to use prescription drug data to identify HCC diagnoses and to add variables to its methodology that reflect the predicted risk of enrollees with different enrollment durations. CMS, *Strengthening the Marketplace*, *supra* note 7. However, CMS has refused to make these methodological changes until 2017 and 2018, which comes too late for Evergreen Health and many other issuers irreparably harmed by CMS's arbitrary and capricious methodology in the meantime.

In creating the temporary risk corridors and reinsurance programs to run only from 2014 through 2016, Congress recognized the critical importance of market and premium stability in the first three years of full implementation of the ACA, when costs would be particularly unpredictable and insurers would be at heightened risk of financial instability. *See* CMS, *The Three Rs*, *supra* note 1 ("The Act introduced three programs – risk adjustment, reinsurance, and risk corridors – to assist insurers through the transition period."). Yet CMS leadership, instead of promptly fixing methodological errors in the risk adjustment methodology, views the first few years of ACA implementation as a "learning and experiment stage," during which time the agency will take a wait-and-see approach.[10] In CMS's opinion, it is more important to "maintain

[10] *See* CMS, *Remarks of CMS Acting Administrator Andy Slavitt at the Marketplace Innovation Conference* (June 9, 2016), *available at* https://blog.cms.gov/2016/06/09/remarks-of-cms-acting-administrator-andy-slavitt-at-the-marketplace-innovation-conference/.

model stability . . . in the initial years of risk adjustment" than to get that model right. 79 Fed. Reg. 13,744, 13,817 (Mar. 11, 2014).

There is no rational reason for CMS to decline to apply these corrections to the methodology for 2015 and 2016 or to "maintain model stability." Retroactive application of regulatory changes may be inappropriate where regulated entities have detrimentally relied on the original regulation. But that is not the situation here. There is no indication that health plans relied on the Government's Risk Adjustment Methodology when they developed their benefits packages, priced their premiums, and otherwise prepared to offer policies in 2015 and 2016. To the contrary, the risk profile of a plan's enrollees, which is supposed to determine the risk adjustment payment or liability, is generally beyond the plan's control. To the extent a plan acted to try to target certain types of people to enroll in their plans, that type of activity is exactly what the Risk Adjustment Program is intended to discourage.

b) The Government's Risk Adjustment Methodology Artificially Inflates Evergreen Health's Risk Adjustment Liability.

Although the statute requires only that a State "assess" low actuarial risk plans and "make payment to" high actuarial risk plan, the Government's Risk Adjustment Methodology creates a system where payments are "transferred" from one plan to another, via CMS. These so-called "transfer payments" are calculated after the end of the applicable calendar year, and are based not on a plan's actual premiums, but instead on statewide average premiums.

The structure of the program creates enormous uncertainty for insurers, which cannot reliably predict their liability until well after the end of the year, and is entirely unprecedented in the American health care system before the ACA. Axene Decl. ¶ 43. In the Medicare Advantage risk adjustment program, for example, plans are reimbursed at a higher level for having an actuarial riskier population through increases in the per enrollee rate CMS pays to the

plans. The rate the plan receives for a particular enrollee is adjusted up or down based on the enrollee's risk score. 42 C.F.R. § 422.308. Medicare Advantage plans do not get saddled with a large, unexpected risk adjustment assessment at the end of the year.

Evergreen Health's inflated risk adjustment liability is caused in part by CMS's misguided effort to "normalize" the risk scores by multiplying those risk scores by the statewide premium average. As the Axene Declaration explains, using the statewide average premium as the baseline means that plans premiums that are significantly lower (or higher) than the average will have exaggerated risk adjustment liability. Axene Decl. ¶ 43-44. This arbitrarily punishes plans with low premiums, including plans that have low premiums because they have low administrative costs. Axene Decl. ¶ 45-46.

2. CMS's Collection of Full Risk Adjustment Payments from Evergreen Health is Arbitrary, Capricious, and Contrary to the ACA.

Separate and apart from problems with how CMS has calculated the risk adjustment, its decision to collect it without offset is also arbitrary, capricious, and contrary to the ACA. CMS owes Evergreen Health $3,673,127 in risk corridor payments for 2014. In addition, much of the impact of the 2015 risk adjustment assessment would be mitigated if CMS were to pay Evergreen Health the risk corridors payment it owes for that year; as mentioned above, Milliman has calculated that CMS will owe Evergreen Health over $16 million in 2015 risk corridors payments, if the $24 million risk adjustment assessment stands. That is because the risk adjustment payment is one of the costs included in calculating risk corridors payments. Thus, if CMS honored is statutory obligation to make risk corridors payments, Evergreen Health would be able to recover at least 50 percent, and maybe more, of the cost of its risk adjustment payment. However, CMS has decided to collect the risk adjustment payment in full, without offsetting its own debt to Evergreen Health pursuant to the Risk Corridors Program.

As indicated by CMS's "Three R" moniker, reinsurance, risk adjustment and risk corridors are inter-related programs that work together to stabilize insurance premiums and prevent adverse selection. *See, e.g.*, 77 Fed. Reg. 41,931 (July 17, 2012). Because the purpose and function of the Three Rs are intertwined, Congress placed them in adjacent sections in their own subchapter of the ACA. 42 U.S.C. Sub-Chapter III, Part E. CMS has explained that the goal of the Three Rs is to spread the risk associated with high-cost enrollees to "mitigate the potential impact of adverse selection and provide stability for health insurance issuers in the individual and small group markets." 77 Fed. Reg. at 41,931. All three programs are necessary in the first few years of the ACA, when the risk of adverse selection is greatest, and when insurers have little to no information about the health risk of the new eligible population. Congress and CMS worried that "insurers may set premiums higher than necessary to offset the potential expense of high-cost enrollees" as a result of this information gap. *Id.* To blunt the impact of miscalculating the costs associated with the previously uninsured population, and to discourage spiraling premiums, Congress and CMS promised to share in insurer's gains and losses during the first three years of the ACA through the temporary Risk Corridors Program. *Id.*

The actual amount of payments and/or liability under each of the Three Rs is intertwined. The amount of risk corridors payments owed to a plan (if any) depends on the amount that its "allowable costs" exceed a "target amount," and the statute expressly specifies that "allowable costs shall [be] reduced by any risk adjustment or reinsurance payments received." ACA § 1343(c)(1)(B). Under CMS regulations, the inverse is true as well: a plan's "allowable costs" are increased by any risk adjustment or reinsurance payments made or accrued. § 153.530(b)(1).

CMS's insistence on collecting risk adjustment payments without honoring its related risk corridors obligations violates the structure and text of the ACA, and it is arbitrary and

capricious. First, CMS's position violates basic accounting principles of "offset," which allow "entities that owe each other money to apply their mutual debts against each other, thereby avoiding the absurdity of making A pay B when B owes A." *Citizens Bank of Md. v. Strumpf*, 516 U.S. 16, 18 (1995) (quoting *Studley v. Boylston Nat. Bank*, 229 U.S. 523, 528 (1913)); *Gardner v. Montgomery Cnty. Tchrs. Fed. Credit Union*, 864 F. Supp. 2d 410, 417 (D. Md. 2012). Under this doctrine, every creditor has the right to "apply the unappropriated moneys of his debtor, in his hands, in extinguishment of the debts due to him," *United States v. Munsey Trust Co. of Washington, D.C.*, 332 U.S. 234, 239 (1947). In the insurance context, the National Association of Insurance Commissioners ("NAIC") recognizes a valid right of offset when: 1) each of two parties owe the other determinable amounts, 2) the reporting party has the right to set off the amount owed, 3) the reporting party intends to set off, and 4) the right to setoff is enforceable at law. NAIC, *Statements of Statutory Accounting Principles ("SSAP") #64, Accounting Practices and Procedures Manual* (Mar. 2016).

There is no dispute that Evergreen Health is still owed $3,673,127 in risk corridors payments for calendar year 2014; indeed, CMS has publicly acknowledged that it is legally obligated to pay the remaining funds it owes plans such as Evergreen Health under the Risk Corridors Program. CMS, *Risk Corridors Payment Proration Rate for 2014* (Oct. 1, 2015); CMS, *Risk Corridors Payment and Charge Amounts for Benefit Year 2014* (Nov. 19, 2015). Further, CMS will not pay any of the 2015 risk corridors payments it owes Evergreen Health, unless and until it receives sufficient payments under the Risk Corridors Program to satisfy its $2.5 billion debt to all Qualified Health Plans nationwide for 2014. CMS has now assessed Evergreen Health a payment under the Risk Assessment Program totaling $24 million, and as a result, the two entities "owe each other mutual, mature, and liquidated debts." *See United States*

v. Peterson, 738 F. Supp. 2d 869, 873 (C.D. Ill. 2010). The 2014 risk corridors amount has been finalized and can be readily quantified, and CMS and Evergreen Health each stand in a debtor/creditor relationship with the other. The same will apply to the 2015 risk corridors payments, when CMS finalizes that calculation in October of 2016. *See Stanley v. United States*, 140 F.3d 1023, 1028-29 (Fed. Cir. 1998). Thus, CMS should deduct its risk corridors obligations to Evergreen Health from the risk adjustment payment it demands from Evergreen Health.

CMS's decision to continue to collect full risk adjustment payments from Evergreen Health has created results that are directly contradictory to the structure and goals of the ACA. Congress could not have intended that Evergreen Health should pay the entire risk adjustment assessment without the mitigating effect of the risk corridors payment. To the contrary, the ACA contemplates that the programs work in tandem. Under this common sense reading of the statute, the remaining $3.7 million that CMS owes Evergreen for the 2014 risk corridors payments, and the approximately $16 million that CMS owes to Evergreen Health in 2015 risk corridors payments, *see* Beilenson Decl. ¶ 53-54, should be offset against risk adjustment liability.

CMS itself has construed the ACA, through its regulations, as authorizing Qualified Health Plan issuers to offset or "net" payments owed to the federal Government against payments the federal Government owes to the issuers, and vice versa, including with respect to risk adjustment payments, risk corridors payments, reinsurance payments, cost sharing subsidies, and premium tax credits. 45 C.F.R. § 156.1215(b). CMS regulations state that the "determination of debt" owed by Qualified Health Plan issuers must be calculated "after HHS nets amounts owed by the Federal government under these programs." *Id.* § 156.1215(c). In the

preamble to the final rule, CMS anticipated that this "netting" process would occur under an "integrated monthly payment and collection cycle," and specifically rejected comments recommending that CMS delay calculating payments owed to a Qualified Health Plan issuer until the end of a calendar year. 79 Fed. Reg. at 13,817. In fact, CMS will be withholding premium tax credits and cost sharing subsidies due to Evergreen Health on July 15th in partial satisfaction of the risk adjustment payment at issue in this case. *See* Beilenson Decl. ¶ 48.

The purpose and structure of the ACA, and CMS's implementing regulations, leave no room for CMS to unilaterally collect payments under one of the Three Rs while refusing to honor obligations under the other. All three programs form the basis of the ACA's premium stabilization programs, and CMS must "give effect to the unambiguously expressed intent of Congress." *Chevron*, 467 U.S. at 842–43. It is arbitrary, capricious, and contrary to the ACA for the Government to pick and choose which provisions of the Three Rs premium stabilization programs it wishes to enforce.

If CMS cannot fulfill its risk corridors obligations because of the congressional appropriations riders, it is more consistent with the text and purpose of the ACA for CMS to either halt risk adjustment collections until the Risk Corridors Program is fully funded, or at least decrease risk adjustment collections for Evergreen Health by the $3.7 million the Government is statutorily required to pay in 2014 risk corridors payments, as well as the $16 million in risk corridors payments the Government will owe Evergreen Health for the same year (2015) for which CMS is demanding the risk adjustment payments.

3. CMS's Operation and Administration of the Risk Adjustment Program in Maryland is Arbitrary, Capricious, and Contrary to Law.

For centuries, state governments controlled regulation of insurance in the United States. Even as the federal government has increased its involvement, States have maintained their role as the primary regulators of insurance markets, including health insurance markets.[11]

While the ACA represents a dramatic increase in federal involvement in health insurance markets, Congress did not seek to displace state insurance commissioners as the primary regulators of health insurance. *See, e.g.*, 81 Fed. Reg. at 29, 152 (CMS explaining "that States are the primary regulators of their insurance markets"). Rather, the ACA contemplates that many of its market reforms would be enforced primarily by States; the federal government has the authority to enforce those provisions only if the State fails to do so. *See* 42 U.S.C. §§ 300gg-22, 300gg-23, 300gg-61, 300gg-62; 45 C.F.R. §§ 150.201, 150.203. Further, the ACA included a provision entitled, "No Interference with State Regulatory Authority," which expressly provides that "[n]othing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." ACA § 1321(d). And the ACA sought to use state insurance regulators to implement critical provisions of the ACA. For example, the ACA requires that issuers of Qualified Health Plans be licensed by States and encourages States to establish their own Exchanges. ACA §§ 1302, 1311, 1321. As CMS has explained, States remain "the primary regulators of their insurance markets" under the ACA. 81 Fed. Reg. at 29152.

Consistent with Congress's intent to preserve the critical role of state insurance commissioners in regulating insurance markets, the ACA provided that States would operate and

[11] *See, e.g.*, NAIC, State Insurance Regulation, at 1 (2011), available at http://www.naic.org/documents/topics_white_paper_hist_ins_reg.pdf.

administer the Risk Adjustment Program. Specifically, the ACA provided that "each State shall provide" risk adjustment payments, and "each State shall assess" risk adjustment charges, subject to "criteria and methods" developed by CMS "to be used in carrying out the risk adjustment activities," developed "in consultation with States." § 1343.

While the ACA plainly provides that "each State shall" administer and operate the Risk Adjustment Program, CMS regulations give CMS the authority to administer and operate the Risk Adjustment Program in each State, which includes assessing and providing risk adjustment payments. 153.310. States that operate their own Exchanges, like Maryland, may develop their own "alternative" programs, if the State complies with a number of federal standards, 45 C.F.R. § 153.330, and obtains the federal Government's certification. § 153.310(d). States that do not operate their own Exchanges are completely prohibited from operating their own programs; the federal Government will operate the Risk Adjustment Program in those states. *Id.* § 153.310.

CMS's unilateral federalization of the Risk Adjustment Program is directly contrary to the plain text of the ACA. Section 1343 authorizes only the State, *not* the federal Government, to "assess" or "provide" a payment under the Risk Adjustment Program. The fact that CMS gave some States the option to run their own risk adjustment programs, after review and approval by the federal government, does not save CMS's regulations. Section 1343 simply does not give CMS the authority to operate a risk adjustment program in place of the State. While the ACA provides that the Secretary will "establish criteria and methods to be used in carrying out the risk adjustment activities under this section," that is quite different than actually operating the program and assessing and collecting the charges. For example, States operate the Medicaid program, while the Secretary has the authority to promulgate rules and regulations to govern that state-run program. Congress' intent was similar with respect to the ACA's Risk Adjustment

Program: States operate the program, and CMS promulgates rules and regulations to govern the state's operation of the program.

This congressional intent is made even clearer by comparing the risk adjustment provision in Section 1343 with the Exchange provisions in Sections 1311 and 1321. Subsection 1311(b) provides that "[e]ach State shall" establish an Exchange, but Section 1321 clarifies that States have the option to decline to run an Exchange, in which case the federal Government will establish Exchanges for the State. In contrast, the Section 1343 risk adjustment provision specifies that "each States shall" assess and provide risk adjustment payments, and no other provision of the ACA authorizes the federal Government to operate the Risk Adjustment Program. While States may be able to delegate operation to the federal Government, the statute does not give the Secretary of HHS the authority to seize complete control of the program and prevent state insurance commissioners from making determinations as to how the program should operate in his or her State.

CMS's failure to follow this statutory instruction directly harmed Evergreen Health. Maryland Insurance Commissioner Redmer has publicly expressed his opposition to the federal Government's administration of risk adjustment and has worked with CMS to try to minimize the harm caused to Maryland's insurers by risk adjustment assessments. Commissioner Redmer has publicly proposed capping "the amount a carrier pays for risk adjustment to 2% of the carrier's premium revenue," (Att. B), but CMS will not allow it. *See* Hansard, State Officials: CMS Inflexible on Risk Adjustment Changes, BNA.

In sum, CMS's decision to usurp state authority and to operate and administer the Risk Adjustment program in Maryland and other states is "not in accordance with" the ACA and is in "excess of" CMS's statutory authority, in violation of the APA. 5 U.S.C. §706(2)(A), (C). To

the extent CMS regulations authorize the federal Government to assess and collect risk adjustment payments, *see* 45 C.F.R. § 153.310, those regulations are inconsistent with the plain text of Section 1343. "Congress has directly spoken to the precise question at issue," *Chevron*, 467 U.S. at 842, and the plain language of the statute is unambiguous: States are responsible for assessing and administering the Risk Adjustment Program.

B. Evergreen Health Will Face Irreparable Harm Without Preliminary Relief

If it is required to make the assessed risk adjustment of $24 million by August 15th, Evergreen Health will immediately suffer injuries that cannot be remedied by later relief. This satisfies the second prong of the preliminary injunction inquiry. *Multi-Channel TV Cable Co. v. Charlottesville Quality Cable Operating Co.*, 22 F.3d 546, 551 (4th Cir. 1994).

While the APA provides Evergreen Health with a cause of action to challenge the Government's Risk Adjustment Methodology, it does not provide it with a complete remedy. Section 702 of the APA waives the Government's sovereign immunity only for claims "seeking relief other than monetary damages." 5 U.S.C. § 702. In construing the scope of that waiver, the Supreme Court has distinguished claims seeking the return of funds which the Government has wrongfully taken, from those seeking "money in compensation for the losses . . . suffered." *Bowen v. Massachusetts*, 487 U.S. 879, 895 (1988). Therefore, even though the APA authorizes the Court to order the Government to refund Evergreen Health its risk adjustment payment, it does not authorize it to compensate Evergreen Health for other losses suffered as a result of the Government's action. As the Sixth Circuit has explained, the APA does not waive immunity for recovery of "business losses, emotional distress, and tarnished business reputation," because these represent "traditional money damages" unconnected to a statutory entitlement. *Haines v. Fed. Motor Carrier Safety Admin.*, 814 F.3d 417, 425 (6th Cir. 2016).

As set forth below, the inability to obtain damages under the APA's limited waiver of immunity makes these injuries irreparable and justifies preliminary relief. *See, e.g., Hughes Network Sys., Inc. v. InterDigital Comm. Corp.*, 17 F.3d 691, 693 (4th Cir. 1994). In addition, Evergreen Health faces some injuries (such as loss of business reputation and goodwill) which would be irreparable even if money damages were available.

1. The Payment Will Irreparably Harm Evergreen Health's Financial Viability and Its Competitive Market Position.

Under Maryland law, Evergreen Health, like all insurers, is required to maintain minimum capital and surplus requirements. Specifically, Evergreen Health must maintain capital above the minimum risk-based capital ("RBC") level, as determined by formulas set forth in the RBC instructions written and adopted by the NAIC. Md. Ann. Code § 4-302. Insurers that fall below the minimum RBC levels will face regulatory consequences, including being placed under receivership, rehabilitation and/or liquidation. Md. Ann. Code §§ 4-305, 4-306.

Evergreen Health has approximately $26 million as of May 30 in its surplus account. Today, CMS assessed Evergreen Health $24 million in risk adjustment payments, to be paid in full by August 15 of this year. Beilenson Decl. ¶ 48. An assessment of this size would drop Evergreen Health's capital reserve amount to between $4 million and $5 million. In order to maintain its required minimum RBC level of 250 percent, Evergreen Health would need to raise at least $11 million in new financing to avoid receivership, if the full risk adjustment payment needs to be made by August 15. Md. Ann. Code § 4-308(b)(2). While 200 percent is the bare minimum a state requires, the administration will likely take action at any level below 250%. Indeed, as a result of the risk adjustment assessment, Evergreen Health's independent auditors have informed the company that they will be issuing a qualified opinion identifying a risk to Evergreen Health's status as a going concern. *See* Beilenson Decl. ¶ 59.

Receivership would have devastating consequences for Evergreen Health that would effectively end the company's viability as an ongoing concern. Insurance brokers would not recommend that their clients do business with an insurer under receivership, and thus Evergreen Health would stop receiving referrals from brokers for group plans, which represent approximately 80 percent of Evergreen Health's business. Beilenson Decl. ¶ 61.

Evergreen Health may be able to forestall this result only through last minute efforts to secure a loan of between $11 and $17 million, enough to keep it above the mandatory RBC control level. Beilenson Decl. ¶ 57, 63. While Evergreen Health believes it will be able to survive, it is close enough to the required RBC level that the MIA has asked Evergreen Health to present a formal plan to the MIA on how Evergreen Health "plans to maintain solvency through December 31, 2017, including the actual payment of the 2015 risk-adjustment amount in 2016 and the projected payment of the 2016 risk-adjustment amount in 2017." Beilenson Decl., Ex. 5. In addition, the letter stated that the MIA would be conducting a financial examination of Evergreen Health in July and warned of the possibility of receivership. *Id.* If Evergreen Health cannot demonstrate financial viability through 2017, the Commissioner has the right to place Evergreen Health under receivership, rehabilitation or liquidation at any time. *Id.; see also* Md. Ann. Code § 4-308(a).

Because it believes it may be able to secure the loan, Evergreen Health believes it will be able to avoid receivership. However, the loan comes at a cost (interest payments) to Evergreen Health which it will not be able to recover from the federal Government.

More importantly, even with this loan, Evergreen Health will be right on the edge of its RBC requirements if the company has to make the risk adjustment payment. Consequently, because the RBC level is tied to enrollment, Evergreen Health will need to closely monitor

enrollment in order to ensure it continues to remain above its RBC requirements. This may mean that certain business will not be accepted and certain brokers may not continue to place their trust in Evergreen. Beilenson Decl. ¶ 63, 64. Evergreen Health will also need to continuously monitor its financial condition, avoid discretionary expenditures that are critical to future success, and most likely leave certain employee openings unfilled, until it can rebuild its financial reserves. Evergreen Health's goal was to increase enrollment up to between 53,000 and 55,000 by the end of 2016. Instead, it will need to keep enrollment close to its current level of approximately 40,000 and should not exceed 45,000 by the end of the year. Beilenson Decl. ¶ 63.

Curtailing its sale of plans will irreparably harm Evergreen Health in a number of ways. Evergreen Health's "limited market" status will hurt its reputation with brokers and consumers, who will have limited visibility of Evergreen Health in the market, and who may have concerns about Evergreen Health's long-term viability. This will damage Evergreen Health's ability to compete both in the short-term and over the long-term, even after it is able to admit new enrollees. These types of injuries are irreparable. *Cf. Stulhbarg Intern. Sales Co., Inc. v. John D. Brush and Co., Inc.*, 240 F.3d 832, 841 (9th Cir. 2001) (finding irreparable harm where, without an injunction, business was deprived an opportunity to expand business and "stood to lose its newfound customers and accompanying goodwill and revenue"); *John B. Hull, Inc. v. Waterbury Petroleum Prod., Inc.*, 588 F.2d 24, 28-29 (2d Cir. 1978) (affirming that irreparable harm can be found where "plaintiff is deprived totally of the opportunity to sell an entire line of merchandise and may incur injury to its goodwill and reputation as a dependable distributor which offers a full line of goods").

Evergreen Health's injuries will be exacerbated by the fact that, while Evergreen Health is sidelined, its competitors will continue to gain market share and create goodwill with consumers and brokers. *See Multi-Channel TV*, 22 F.3d at 551-52 (affirming a finding of irreparable harm where there is a threat of "permanent loss of customers and the potential loss of goodwill"); *Rex Medical L.P. v. Angiotech Pharm. (US), Inc.*, 754 F. Supp. 2d 616, 623 (S.D.N.Y. 2010) (finding that the disruption to plaintiff's distribution of its product constituted irreparable harm because, during plaintiff's "absence from the market, its customers will resort to competing products to fill their needs, and, even after [plaintiff's] return, customers may nonetheless refuse to return to [plaintiff], because of [its] lack of dependability in supplying its product"). Evergreen Health already faces substantial challenges as a small, new market entrant competing against large, longstanding insurers like CareFirst. Essentially taking Evergreen Health's products off the market, even if only for a few months, will irreparably exacerbate that challenge.

Finally, any unexpected event – for example, higher than projected costs in a given month – could put Evergreen Health below the RBC requirements, which would result in the company being put into receivership. This existential risk represents the prototypical irreparable harm for which courts will provide preliminary relief. *See Hughes*, 17 F.3d at 693 (finding that irreparable can exist "where the moving party's business cannot survive absent a preliminary injunction"); *Transport Ass'n of Am., Inc*. 840 F. Supp. 2d at 336 ((explaining that irreparable injury will be found where "movant makes a strong showing that the economic loss would significantly damage its business . . . or demonstrates that the loss would cause extreme hardship to the business, or even threaten destruction of the business") (internal quotations and citations omitted)).

2. The Payment Will Require Evergreen Health to Raise Premiums for 2017, Putting It At a Competitive Disadvantage.

In order to build up its capital reserve, and to protect against the impact of another large assessment in 2016, Evergreen Health will have to raise its premiums for the 2017 calendar year, if it is forced to make the risk adjustment payment to CMS on August 15. Evergreen Health has already started to recalculate its premiums to support an amendment to its rate filing, which will need to be submitted to the MIA by early July 2016. Evergreen Health expects that it will need to increase its 2017 premiums by approximately 15 percent over its original rate submissions. Once these premium rates have been approved (in August or September of this year), Evergreen Health will have little opportunity to subsequently lower the rates, even if this Court later strikes down the Government's Risk Adjustment Methodology on the merits.

In addition to harming members, an increase in premiums will place Evergreen Health at a competitive disadvantage with other insurers who are able to keep premiums at the market average or lower, because they fared better under the Risk Adjustment Program or are comparatively better equipped to absorb the financial impact. Even if money damages were available under the APA, this is the type of injury that courts have found to be irreparable and supportive of a preliminary injunction. *See PRE Holding Inc. v. Monaghan Med. Corp*., Civ. A. No. 3:09CV458-HEH, 2009 WL 3874171 (E.D. Va. Nov. 17, 2009); *Multi-Channel TV*, 22 F.3d at 551-52 (affirming a finding of irreparable harm where there is a threat of permanent loss of customers to a competitor).

3. The Payment Will Prevent Evergreen Health from Launching New Products and Improving the Benefits It Provides to Its Members.

Evergreen Health had planned to launch several new programs in 2016 and 2017 to improve the health care products its offers its members. If it is required to make the risk

adjustment payment by August 15th, it will no longer have the available funds to implement these programs, causing irreparable injury.

First, Evergreen Health, in collaboration with the Baltimore start-up b.well, planned to release a mobile application for all members. The mobile application would allow members to search for doctors in their network, obtain their medical history, communicate with their physicians, and manage all other aspects of their care. It also would have allowed teleconferencing between members and providers. Research has shown that increase in patient engagement through online portals and applications result in better health outcomes and health savings in the short- and long-term. Beilenson Decl. ¶ 65.

In addition, Evergreen Health's affiliate's planned to open new Primary Care Offices in 2017 to serve current and future members living in Montgomery County, Frederick County, and the Eastern Shore. Evergreen Health's affiliate had also planned to open a second office in Baltimore City and to hire additional care coordinators to serve all its open offices.

Evergreen Health's inability to launch the mobile application, open additional primary care offices, and hire more care coordinators results in direct, irreparable harm to Evergreen Health and its members. Evergreen Health's members will not benefit from these services, which will make their health care more expensive for Evergreen Health in both the short- and long-term. In addition, Evergreen Health's plans will be less appealing to potential and existing enrollees without these features, which will hurt Evergreen Health's ability to compete, even after it is able to re-open enrollment. Even if the APA provided for recovery of money damages, this harm to Evergreen Health is irreparable, as money damages later in the litigation will be unable to restore Evergreen Health to the competitive position in which it would have been in the absence of the arbitrary and capricious risk adjustment assessment. *See Stulhbarg Intern. Sales*,

240 F.3d at 841 (finding irreparable harm where, without an injunction, business was deprived an opportunity to expand business and "stood to lose its newfound customers and accompanying goodwill and revenue.").

Finally, Evergreen Health had planned to expand into Medicaid managed care in 2017, which it will not have the financial capacity to do if the risk adjustment assessment is collected. The Primary Care Offices already serve hundreds of Medicaid managed care enrollees, through contracts Evergreen Health's affiliate has with Medicaid managed care organizations. Many low-income consumers cycle in and out of Medicaid eligibility; in one year they may be eligible for Medicaid, and in the next year they are not, and instead must access subsidized coverage through the Exchange. The contracts between the Primary Care Offices and the Medicaid managed care organizations allow individuals who churn between Medicaid and coverage under Evergreen Health to retain their primary care doctor. Because of its existing work with the Medicaid population, and its focus on increased access to primary care, Evergreen Health would be a natural fit for the Medicaid managed care market, and had planned to expand into that market in 2017.

C. A Preliminary Injunction is in the Public Interest and the Balance of Hardships Favors Granting a Preliminary Injunction.

Evergreen Health exemplifies the type of health care that the ACA intended to encourage. Evergreen Health's model focuses on encouraging targeted, quality primary care for its members. Evergreen Health believes that it will be able to improve health outcomes and contain costs by investing heavily in primary and preventive care. As described above, Evergreen Health's model has been widely praised, including by CMS Acting Administrator Slavitt, Maryland Insurance Commissioner Redmer, and the Baltimore Sun, among many others. As a result of its innovative model and its strong and experienced leadership, Evergreen Health has

been able to expand enrollment quickly, increasing from 11,694 members at the end of 2014, to 38,510 members by April of 2016. Beilenson Decl. ¶ 25, 30. Evergreen Health turned a profit for the first five months in 2016, before the assessment of the increased risk adjustment, and it was projected to continue to turn a profit throughout 2017. *See* Beilenson Decl. ¶ 36.

Evergreen Health also adds much-needed competition to the Maryland health insurance markets. Including Evergreen Health, Maryland only has six health insurance issuers. Am. Med. Assoc., *Competition in Health Insurance: A Comprehensive Study of U.S. Markets* (2015). The market is dominated by one company. In 2015, CareFirst had 48 percent of the health insurance market in the State, more than the next two largest issuers combined. Evergreen Health is the first new insurer to enter the individual and small group market in Maryland in decades.

By allowing Evergreen Health to remain in a financial position where it can continue to expand, a preliminary injunction would improve competition and innovation in Maryland's health insurance markets, which is in the best interest of the public. *See, e.g., Direx Israel, Ltd v. Breakthrough Med. Corp.*, 952 F.2d 802, 820 (4th Cir. 1991) (recognizing that increased competition in the market is in the public interest); *Ball Memorial Hosp., Inc. v. Mutual Hosp. Ins., Inc.*, 784 F.2d 1325, 1333 (7th Cir. 1986) (recognizing a public interest from competition in the health care market, and resulting decrease in health care costs to consumers): *Calvin Klein Cosmetics Corp. v. Lenox Labs., Inc.*, 815 F.2d 500, 505 (8th Cir. 1987) (finding a "strong public interest in lowest possible prices . . ., in avoiding monopolies and in encouraging, not stifling, competition"). Moreover, it would enable Evergreen Health to expand the benefits provided to its members (mobile app, more Primary Care Offices and care coordinators) and to expand its primary care-focused model to more residents of Maryland.

There is no compelling hardship or public interest that weighs against granting preliminary relief. A preliminary injunction here would simply prevent the federal Government from collecting approximately $24 million from Evergreen Health until the Court has an opportunity to hear this case on the merits. While there may be some public interest in these funds going to the Government immediately, it pales in comparison to the harm that Evergreen Health, its members, and Maryland consumers will suffer if the risk adjustment assessment is collected. The fact that the approximately $24 million will be directly transferred by the Government to CareFirst further minimizes any public interest in allowing that transaction to move forward. Beilenson Decl. ¶ 46. CareFirst already dominates the health insurance market in Maryland, and the $24 million represents less than 0.5 percent of its over $5 billion in premium revenues in 2015.[12]

CONCLUSION

For the foregoing reasons, the Court should grant Evergreen Health's motion for preliminary injunction.

[12] NAIC, 2014 Market Share Reports, at 59 (2015), *available at* http://www.naic.org/prod_serv/MSR-HB-15.pdf.

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June 30, 2016