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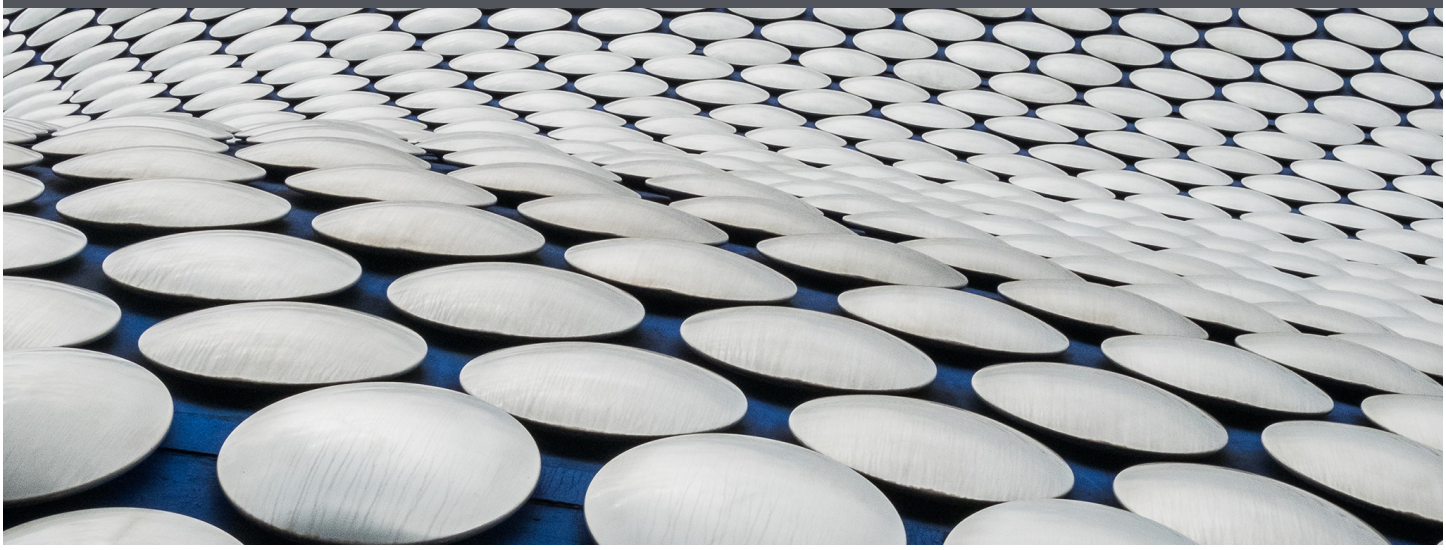

MARCH 30, 2022 • NO. 2

Another Defunct Small Health Insurer Fails in Challenge to ACA Risk Adjustment Rules

The Fifth Circuit Court of Appeals recently rejected a slew of claims by Vista Health Plan, Inc. ("Vista") seeking to invalidate the 2017 and 2018 regulations governing the risk adjustment program that applies to individual and small group health insurance policies under the Affordable Care Act ("ACA")–the latest in a series of failed attempts by small issuers to challenge the ACA risk adjustment program. This repeated pattern should give smaller health insurance issuers pause as they consider the potential unpredictable impacts of the ACA risk adjustment rules on their operations and perhaps also may spur the United States Department of Health and Human Services ("HHS") to consider whether it has regulatory tools to better support smaller health insurers bringing new competition to marketplaces.

Vista had been a small, startup health insurance company in Texas, until it was driven out of business by being forced to pay risk adjustment charges that exceeded 50 percent of its premium revenue. Although the ACA risk adjustment program has the laudable goal of reducing incentives by issuers to dodge sicker enrollees, it has been heavily criticized for disproportionately penalizing smaller, startup insurance companies while transferring large windfalls to some of the country's largest health insurance carriers.

RISK ADJUSTMENT PROGRAM

The ACA prohibits health insurance issuers from either charging higher premiums or denying coverage based on an individual's health status (often referred to as community rating and guaranteed issue).[1] However, these requirements create a risk that a health insurance issuer will be subject to adverse selection in its insured population. As a result, there could be an incentive for issuers to try to avoid covering sicker consumers. To counteract this incentive, Congress directed the HHS to establish a permanent risk adjustment program, which was designed to redistribute and balance out actuarial risk among issuers by shifting funds from issuers with healthier members to issuers with sicker members. HHS employs a three-step risk adjustment methodology. First, HHS computes an actuarial risk score for each individual enrollee by using demographic and diagnostic data to determine the predicted cost of insuring that enrollee.[2] Second, those risk scores are aggregated to determine the plan's average risk score.[3] Third, a plan's risk score is multiplied by the statewide average premium to determine what an issuer will pay as a charge or receive as a payment under that particular plan.[4]

Other small health insurers like Vista have unsuccessfully sued to challenge the risk adjustment program on grounds that HHS arbitrarily and capriciously applies statewide average premiums as opposed to the insurer's own self-determined premium in assessing risk adjustment charges.[5]

VISTA'S APPEAL

After HHS issued its Final Rules for risk adjustment for the 2017 and 2018 plan years, Vista was assessed risk-adjustment charges that consumed most of its premium revenue, causing it to cease operations. In response, Vista sued HHS challenging the 2017 and 2018 risk adjustment rules. Vista's various claims were based on the fact that HHS's 2017 and 2018 plan year rules had been vacated by the district court in the *N.M. Health Connections v. U.S. Dep't of Health & Hum. Servs.* case but then subsequently reissued several months later without notice and comment. The district court granted summary judgment for HHS and Vista appealed.

On appeal, Vista raised several arguments, all to no avail. First, Vista argued that the district court erred in determining that HHS's re-adoption of the 2017 and 2018 risk adjustment transfer rules was impermissibly retroactive.[6] The court found that the differences between the initially vacated and later reissued 2017 and 2018 Final Rules were immaterial because HHS only added an "explanation regarding the use of statewide average premium and the budget neutral nature of the program."[7] The court concluded that because 2017 and 2018 rules were virtually identical to their earlier versions, their issue did not "create an impermissible retroactive effect."[8]

Vista argued that the district court erred in ruling that HHS's "last minute" reissue of the 2017 Final Rule was harmless because Vista had detrimentally relied on the absence of the 2017 Final Rule to provide insurance at lower premiums during the year, which resulted in heavier rate adjustment transfer charges once the rule was reissued.[9] The court rejected this argument, reasoning that the 2017 Final Rule adopted the same methodology as prior rules on which Vista would have relied. The court also noted that HHS issued the 2017 Final Rule in order to "protect the settled expectations of issuers that ha[d] structured their pricing and offering decisions in reliance on the previously promulgated 2017 benefit year methodology."[10] The court concluded that "the very language of the rule thus belies Vista's detrimental reliance argument."[11]

Vista also contended that the district court erred in granting summary judgment and dismissing Vista's claims that the risk adjustment rules violated the Constitution's Equal Protection clause, constituted a regulatory taking under the Fifth Amendment, and were arbitrary-and-capricious.[12] Vista claimed that the court erroneously "bas[ed] its decision on the HHS's existing rule making record" instead of relying on an agency adjudication record in which Vista could challenge its particular risk adjustment assessment.[13] Vista contended that "[w]ithout…agency adjudication, there is no agency record upon which the court can resolve Vista's challenges."[14] The court, however, rejected this argument because Vista failed to provide any authority to support this assertion.[15]

Vista also argued that the district court erred in concluding that HHS is entitled to *Chevron* deference in its interpretation and implementation of the risk adjustment program under 42 U.S.C. § 18063. The court deemed this argument to be abandoned, however, because Vista failed to cite to or analyze any case law, statute, or regulation in support of this contention.[16]

Next, Vista contended that the district court erred in ruling *sua sponte* on Vista's regulatory taking claim because the court failed to "address[] the factual basis for" its claim that the risk adjustment fees took over 50 percent of Vista's premium revenue, which ultimately forced it to go out of business.[17] The court rejected this argument because Vista failed to provide this evidence at the district court stage, and therefore could not raise it on appeal.[18]

Finally, Vista contended that the rules had a disparate impact on small insurance companies, therefore violating their constitutional right to equal protection.[19] The Fifth Circuit rejected this argument because Vista failed to provide any legal authority to support this claim.[20] The Fifth Circuit affirmed the district court's decision,

which held that "small insurers are not an inherently suspect class, and the risk-adjustment program does not trammel fundamental rights."

Vista's case, like several earlier cases, presented a recurring fact pattern: a small, startup health insurance company was forced out of business by a surprise risk adjustment bill that consumed an enormous percentage of its premium revenue. This again led to unsuccessful administrative law challenges to the program.

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1. *King v. Burwell,* 576 U.S. 473, 479-84 (2015) (summarizing the background and purpose of the ACA).
2. *78 Fed. Reg. 15 , 410 ,* 15,419 (Mar. 11, 2013).
3. *Id.* at 15,432
4. *Id.* at 15,430-34.
5. *N.M. Health Connections v. U.S. Dep't of Health & Hum. Servs.,* 946 F.3d 1138, 1148-50 (10th Cir. 2019); *Evergreen Health Coop., Inc. v. U.S. Dep't of Health & Human Servs.,* No. 16-2039 (D. Md. Jan. 31, 2017); *Minuteman Health, Inc. v. U.S. Dep't of Health & Hum. Servs.,* 291 F. Supp. 3d 174, 198-205 (D. Mass. 2018).
6. *Vista Health Plan v. United States HHS,* 2022 U.S. App. LEXIS 7003, *15-16, __ F.4th __, 2022 WL 807554 (5th Cir. 2022).
7. *Id.*
8. *Id.*
9. *Id.* at *20.
10. *Id.* at *22.
11. *Id.*
12. *Id.* at *22-23.
13. *Id.* at *23.
14. *Id.* at *24
15. *Id.* at *25.
16. *Id.*
17. *Id.* at *26-27
18. *Id.*
19. *Id.* at *9.
20. *Id.*