NO. 21-1140

In the
Supreme Court of the United States

UNITEDHEALTHCARE INSURANCE CO., *et al.*,

Petitioners,

v.

XAVIER BECERRA, SECRETARY OF HEALTH AND HUMAN SERVICES, *et al.*,

Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the D.C. Circuit

BRIEF OF THE CHAMBER OF COMMERCE OF THE UNITED STATES OF AMERICA AS *AMICUS CURIAE* IN SUPPORT OF THE PETITION

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INTEREST OF *AMICUS CURIAE*[1]

The Chamber of Commerce of the United States of America ("Chamber") is the world's largest business federation. It represents approximately 300,000 direct members and indirectly represents the interests of more than 3 million companies and professional organizations of every size, in every industry sector, and from every region of the country. An important function of the Chamber is to represent the interests of its members in matters before Congress, the Executive Branch, and the courts. To that end, the Chamber regularly files *amicus* briefs in cases, like this one, that raise issues of concern to the nation's business community.

This case is important to the Chamber for multiple reasons. First, the Chamber and its members have a strong interest in proper judicial review of administrative agency decisions, especially in cases like this one that involve private-sector participation in major federal programs in which the agency regulator is not neutral but competes with the private parties that it regulates. The decision below disregarded fundamental principles of judicial review and improperly tipped the scales in favor of the agency. Second, many of the Chamber's members partner with the federal government in healthcare

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[1] The parties received timely notice of this brief under Rule 37.2(a). Petitioners and respondents have consented to the filing of this brief. Pursuant to Rule 37.6, *amicus curiae* states that no counsel for any party authored this brief in whole or in part and that no entity or person, aside from *amicus curiae*, its members, or its counsel, made any monetary contribution intended to fund the preparation or submission of this brief.

and other critical sectors of the economy. These business relationships are often governed by statutes that include financial incentives, guarantees, and risk-sharing arrangements that Congress crafted to induce private-sector participation in the federal program and to protect against abuse by self-interested regulators. These statutory commitments can be effective, however, only if the federal government conducts itself as a reliable business partner and if courts hold the government to its obligations. The decision below does just the opposite. If allowed to stand, the decision will chill the business community from working with the federal government in the future and will make it more difficult and expensive for the government to accomplish important policy objectives.

INTRODUCTION AND SUMMARY OF THE ARGUMENT

This case is important not only because it concerns the administration of one of the nation's largest government programs. This case is about more than that: it is about holding the government to account when it reneges on its statutory obligations. Since the creation of the Medicare Advantage ("MA") program nearly a quarter-century ago, Congress has induced private-sector participation in the program by guaranteeing insurers that they will be compensated fairly and equitably for the risks they assume in delivering quality coverage to Medicare enrollees. This guarantee is explicitly embodied in the Medicare Act's comparative payment model, which requires the Centers for Medicare and Medicaid Services ("CMS") to compensate MA plans in a manner that ensures

"actuarial equivalence" with traditional Medicare. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). Reinforcing this requirement, Congress also required CMS to compute the cost of insuring a given MA or traditional Medicare beneficiary using the "same methodology." 42 U.S.C. § 1395w-23(b)(4)(D).

In reliance on these express promises, private insurers have partnered with the federal government to make Medicare Advantage a model of success. Over the past two decades, millions of Americans have chosen MA plans over traditional Medicare because MA plans offer more choice, more benefits, and built-in caps on out-of-pocket costs. In 2014, however, CMS pulled an about-face and, backtracking on its longstanding policy, adopted the Overpayment Rule. *See* 79 Fed. Reg. 29,844, 29,918–25 (May 23, 2014). The purported purpose of the rule was to "clarify" the meaning of "overpayment" in the Medicare statute. *Id.*; *see* 42 U.S.C. § 1320a-7k(d)(1).

The Overpayment Rule vitiates the "actuarial equivalence" and "same methodology" requirements through the back door by imposing on MA plans a level of stringency for diagnostic coding—the identification of patients' medical conditions—that CMS does not impose on traditional Medicare. As UnitedHealth and other commenters explained during the notice-and-comment process, because CMS calculates payments to MA plans by extrapolating from data from traditional Medicare, determining whether an MA plan has received an "overpayment" requires accounting for the error rate in CMS's traditional Medicare data so as to achieve actuarial parity. *See* Pet. 13 (citing C.A.D.C. App. 64). Otherwise, an

alleged "overpayment" might well be an *underpayment*. Indeed, CMS had recognized the importance of accounting for this data mismatch in prior rulemakings. *See* Pet. 10–12. But in the Overpayment Rule, CMS abandoned that common-sense approach with hardly a word of explanation and imposed massive new burdens—potentially amounting to billions of dollars—on the private companies that make the MA program possible.

The district court correctly found that this betrayal of the government's statutory commitments violated the plain meaning of the Medicare Act and that CMS had acted arbitrarily and capriciously in failing to explain its flip-flop. The D.C. Circuit's decision to the contrary is not persuasive and does not reflect accepted standards for judicial review of agency action. Instead, the panel essentially abdicated its judicial role—disregarding the plain text of the statute linking the provisions at issue, inventing rationales the agency never considered, relying on evidence outside the administrative record, and giving the agency a free pass for its unjustified policy reversal. That abdication, which cannot be squared with the Administrative Procedure Act, is especially concerning in a case like this one, where the agency is not a neutral regulator but has a direct pecuniary interest in shirking its obligations to private businesses; indeed, the agency operates a competing government program.

The ramifications of the D.C. Circuit's decision for the Medicare program, and for all who participate in it, would be compelling reasons on their own for this Court's review. But the consequences of the decision

go far beyond Medicare. The government frequently relies on public-private partnerships, in health care and many other sectors, to harness the power of private-sector competition and innovation and to advance important policy objectives. Left uncorrected, the D.C. Circuit's decision will undermine the integrity of public-private partnerships across the board and will deter businesses from partnering with the government in a wide variety of contexts. The Court should grant the petition and should reaffirm that the government must honor its statutory obligations to its business partners.

ARGUMENT

I. The D.C. Circuit's Decision Violates Bedrock Principles of Judicial Review of Agency Action

A. At Each Step of Its Reasoning, the Panel Flouted Basic Standards of Judicial Review

The D.C. Circuit not only reached the wrong result; along the way, it disregarded principles of judicial review that this Court has long recognized as essential for policing administrative overreach.

1. The principal issue in this case is whether the Overpayment Rule comports with the Medicare Act's "actuarial equivalence" requirement. The D.C. Circuit held that the Overpayment Rule is not even subject to the actuarial-equivalence requirement because, according to the panel, there is no "cross-reference" to that requirement in the provision of the Medicare Act regulating "overpayments." *See* App. 34a (citing 42 U.S.C. § 1320a-7k(d)). As the petition explains, that

holding is an evident and inexplicable misreading of the statute. *See* Pet. 17–22. The statute defines an "overpayment" as "any funds that [an MA plan] receives or retains under subchapter XVIII . . . to which the [MA plan] . . . is not entitled under such subchapter." 42 U.S.C. § 1320a-7k(d)(4)(B). Subchapter XVIII, in turn, includes the actuarial-equivalence requirement. *See* 42 U.S.C. § 1395w-23(a)(1)(C)(i). And the funds to which an MA plan is "entitled" can be determined only by applying that core requirement.

But the D.C. Circuit's counterintuitive interpretation is fatally flawed for an even more basic reason: CMS never advanced it in the rulemaking process or even after the fact in litigation. *See* 79 Fed. Reg. at 29,918–25; C.A.D.C. Gov't Br., C.A.D.C. Gov't Reply Br. A vital principle of judicial review of agency action is that it must be based on the agency's position at the time of the action. *See SEC v. Chenery Corp.*, 318 U.S. 80 (1943). Agency action "cannot be upheld unless the grounds upon which the agency acted in exercising its powers were those upon which its action be sustained." *Id.* at 95. To ensure accountability, courts must "[c]onsider[ ] only contemporaneous explanations for agency action"; allowing "belated justifications . . . forc[es] both litigants and courts to chase a moving target." *Dep't of Homeland Sec. v. Regents of Univ. of Cal.*, 140 S. Ct. 1891, 1909 (2020). And ultimately, a "judicial judgment cannot be made to do service for an administrative judgment." *Gonzales v. Thomas*, 547 U.S. 183, 186, 187 (2006) (per curiam) (quoting *Chenery*, 318 U.S. at 88) (granting certiorari and vacating Ninth Circuit decision for *Chenery* violation where "no special circumstance . . .

might have justified the Ninth Circuit's determination of the matter in the first instance").

The D.C. Circuit paid no heed to that principle. All along, the government assumed that the actuarial-equivalence requirement applied and argued only that "the Overpayment Rule is consistent with" that requirement. C.A.D.C. Gov't Br. 27; C.A.D.C. Gov't Reply Br. 3. The government never took the position that the Overpayment Rule and the actuarial-equivalence mandate inhabited parallel universes. The D.C. Circuit appears to have simply invented that theory out of thin air. It thus improperly substituted its judgment for that of the agency and sprung an unfair surprise on regulated parties, who had no opportunity to confront that novel rationale in the administrative process. That error by itself, in a case of this magnitude, warrants this Court's review and reversal.

2. In the alternative, the D.C. Circuit held that even if the Overpayment Rule is subject to the actuarial-equivalence requirement, UnitedHealth did not show that errors in CMS's traditional Medicare data are significant enough to matter. This holding likewise flouted ordinary standards of judicial review. Most egregiously, the court permitted CMS to rely on an October 2018 study—published four years after the rulemaking and, coincidentally or otherwise, *during this litigation*—that purported to conclude that auditing of CMS data was unnecessary. *See* App. 22a–23a, 47a. A "fundamental principle[ ]" of judicial review of agency action is that it must be limited to the "'administrative record already in existence, not some new record made initially in the reviewing

court.'" *Fla. Power & Light Co. v. Lorion*, 470 U.S. 729, 743 (1985) (quoting *Camp v. Pitts*, 411 U.S. 138, 142 (1973) (per curiam)). The panel violated that basic principle by reaching outside the administrative record and taking into account CMS's belated, self-serving study.[2]

The court also misstated UnitedHealth's burden of proof. To be sure, the party challenging agency action bears the burden of identifying a problem with the challenged action. App. 29a (citing *Abington Crest Nursing & Rehab. Ctr. v. Sebelius*, 575 F.3d 717, 722 (D.C. Cir. 2009)). But here, the problem UnitedHealth identified was CMS's failure to compare relative error rates in defining an "overpayment." *See* C.A.D.C. Appellee Br. 13–14. That clearly satisfied UnitedHealth's burden, because CMS undisputedly made no such comparison. Moreover, it was undisputed that CMS data "must contain errors." App. 61a (internal quotation marks omitted); C.A.D.C. App. 689. Given CMS's far greater access to that data, the onus should have been on CMS to show—at the time of the rulemaking—that any errors were *not* significant. By artificially ratcheting up the challenger's burden of proof, the court tilted the scales in favor of the agency.

3. As a direct result of these statutory interpretation errors and departures from standard judicial review principles, the D.C. Circuit improperly

[2] Upon reviewing the raw data underlying the study, UnitedHealth's actuarial expert sharply disagreed with CMS's conclusion. *See* C.A.D.C. App. 770–89. But even apart from the study's flaws, it should never have factored into the court's analysis in the first place.

excused CMS's arbitrary and capricious failure to explain its change in policy. Before issuing the Overpayment Rule, CMS had acknowledged the importance of comparing coding practices to ensure actuarial equivalence between traditional Medicare and Medicare Advantage. For example, in the context of its regular auditing of MA plans, CMS had previously agreed to apply an "adjuster" mechanism to account for coding errors in traditional Medicare. *See* Pet. 10–11. CMS also applies a "coding intensity adjuster" that lowers payments to MA plans on the rationale that MA plans have a greater incentive to identify all relevant diagnostic codes. *See* Pet. 11–12.

A fundamental rule of administrative law is that an agency cannot turn on a dime for reasons only it knows; instead, the agency must demonstrate "awareness" that it is shifting its approach and articulate "good reasons" for doing so. *FCC v. Fox Television Stations, Inc.*, 556 U.S. 502, 515 (2009); *see* Pet. 30–31. In deciding to issue the Overpayment Rule, CMS failed to offer any coherent explanation for abandoning its prior position. CMS simply recited the empty truism that CMS has "always . . . require[d] that any reported diagnosis be substantiated" by underlying data. App. 82a (internal quotation marks omitted) (citing 79 Fed. Reg. at 29,921–22). As the district court pointed out, this was a transparent dodge; the issue was not whether diagnosis codes must be supported by underlying data, but why an unsupported code should now automatically be treated as evidence of "overpayment." *See* App. 82a–83a.

"The reasoned explanation requirement of administrative law . . . is meant to ensure that agencies offer genuine explanations for important decisions, reasons that can be scrutinized by courts and the interested public." *Dep't of Commerce v. New York*, 139 S. Ct. 2551, 2575–76 (2019). Here, CMS's purported explanation was inscrutable. Yet the D.C. Circuit let the agency get away with it, asserting in conclusory fashion that CMS's response "reiterated Medicare Advantage insurers' longstanding obligations" and was "therefore reasonable." *See* App. 52a. The reasoned explanation requirement is too important to countenance such rubber-stamping.

B. The Panel's Abdication of Proper Judicial Review Is Especially Problematic Because CMS Is a Self-Interested Party, Not a Neutral Regulator

The panel's failure to adhere to basic principles of judicial review of agency action would have been bad enough in an ordinary case. But that abdication is especially inexcusable in a case like this one, where the agency is a self-interested party rather than a neutral regulator. Because CMS is responsible for paying MA plans, it has a clear financial incentive to promulgate regulations that minimize those payments. The risk that CMS will tilt the playing field is heightened by the fact that CMS also operates a competing program, in the form of traditional Medicare—which, it so happens, has fast been losing ground to MA plans as more and more Americans opt for the flexibility and freedom of Medicare Advantage. In short, CMS wears two hats: rival and referee.

Against that backdrop, if anything, the D.C. Circuit should have given the Overpayment Rule a harder look. Yet the panel did just the opposite.

The principle that "one should not be a judge in his own cause" is deeply rooted in the Anglo-American legal tradition. *See, e.g.*, John Locke, Two Treatises of Government 275 (Peter Laslett ed. 1988); *Dr. Bonham's Case*, 77 Eng. Rep. 646, 652 (C.P. 1610). As Madison put it, "[n]o man is allowed to be a judge in his own cause; because his interest would certainly bias his judgment, and, not improbably, corrupt his integrity." The Federalist No. 10 (George W. Carey & James McClellan eds. 2001).

Self-interested adjudication often raises due process concerns. For example, the Due Process Clause forbids a judge or an administrative official from presiding over an adjudicatory proceeding when she has a substantial financial interest in the outcome. *E.g.*, *Tumey v. Ohio*, 273 U.S. 510 (1927) (criminal proceeding); *Ward v. Village of Monroeville*, 409 U.S. 57 (1972) (criminal proceeding); *Gibson v. Berryhill*, 411 U.S. 564 (1973) (administrative proceeding); *Aetna Life Ins. Co. v. Lavoie*, 475 U.S. 813 (1986) (civil proceeding). Applying similar logic, courts have recognized in a variety of contexts that where a government entity has a direct financial interest in its own regulatory action, judges must be careful to scrutinize the action rigorously.

For instance, that common-sense principle is a fixture of jurisprudence interpreting the Contracts Clause. As this Court has explained, "[w]hen the State is a party to the contract, 'complete deference to a legislative assessment of reasonableness and

necessity is not appropriate because the State's self-interest is at stake.'" *Energy Rsrvs. Grp., Inc. v. Kan. Power & Light Co.*, 459 U.S. 400, 412 n.14 (1983) (quoting *United States Trust Co. v. New Jersey*, 431 U.S. 1, 26 (1977)); *see also, e.g.*, *Sullivan v. Nassau Cnty. Interim Fin. Auth.*, 959 F.3d 54, 65–66 (2d Cir. 2020), *cert. denied*, 141 S. Ct. 1063 (2021) ("[W]hen the state impairs a public contract . . . we must examine the record for indicia of self-serving, privately motivated, action"); *RUI One Corp. v. City of Berkeley*, 371 F.3d 1137, 1151–52 (9th Cir. 2004) ("Courts . . . apply a decreased deference for self-interested government acts" when "inquir[ing] into the government's legislative judgment that the ordinance is reasonable and of appropriate character.").

For much the same reason, courts are properly reluctant to defer to federal agencies' interpretations of contracts or statutes that affect their obligations to private parties. *See, e.g.*, *S. Cal. Edison Co. v. United States*, 226 F.3d 1349, 1357 (Fed. Cir. 2000) ("When a party enters into a contract with the government, that party should reasonably expect to be on equal legal footing with the government should a dispute over the contract arise"); *Transohio Sav. Bank v. Dir., Off. of Thrift Supervision*, 967 F.2d 598, 614 (D.C. Cir. 1992) (abrogated in part on other grounds) ("This Court has expressed concern about deferring to an agency interpretation of an agreement to which the agency is a party and we think the same concern applies to an agency interpretation of a statute that will affect agreements to which the agency is party") (citation omitted); *Amalgamated Sugar Co. v. Vilsack*, 563 F.3d 822, 825, 831, 834 (9th Cir. 2009) (rejecting *Chevron* deference where the agency had a financial interest in

a particular statutory interpretation). Where an agency "interprets or administers a statute in a way that furthers its own administrative or financial interests," the agency interpretation "must be subject to greater scrutiny to ensure that it is consistent with Congressional intent and the underlying purpose of the statute." *Amalgamated Sugar Co.*, 563 F.3d at 834. The insight behind this approach is that "deference might lead a court to endorse self-serving views that an agency might offer in a post-hoc reinterpretation" of its commitments. *Nat'l Fuel Gas Supply Corp. v. FERC*, 811 F.2d 1563, 1571 (D.C. Cir. 1987); *see also Scenic Am., Inc. v. Dep't of Transp.*, 138 S. Ct. 2, 3 (2017) (statement of Gorsuch, J., joined by Roberts, C.J., and Alito, J., respecting the denial of certiorari) (questioning whether *Chevron* deference should apply to "disputes where the contending parties are at least usually a little self-interested").

Here, the government argued on appeal that CMS's decision "warrants deference" and, in fact, that "[d]eference is particularly appropriate given the technical and predictive nature" of the issue. C.A.D.C. Gov't Br. 30–31 (citing *Chevron* cases). The D.C. Circuit did not invoke *Chevron* deference by name. But the panel stated that the actuarial equivalence requirement did not "unambiguously" apply to the Overpayment Rule, App. 4a, which certainly sounds like the language of *Chevron*, and in any event, the panel's indulgence of CMS went beyond mere deference: the panel not only gave extra weight to the agency's asserted rationales, but went out of its way to invent new rationales that the agency never considered. *See supra* 5–9. This was an exercise not in judicial review, but in judicial rescue.

II. The D.C. Circuit's Decision Undercuts Fundamental Premises of Medicare Advantage and Other Public-Private Partnerships

A. The D.C. Circuit's Decision Undermines the Integrity of Public-Private Partnerships Across Vitally Important Sectors of the National Economy

Although this case involves the Medicare Act and the health insurance industry, the D.C. Circuit's decision—if allowed to stand—will have far-reaching consequences for the many arenas in which American businesses, large and small, partner with the federal government to provide vital goods and services. The government frequently relies on public-private partnerships to advance important policy objectives. A notable recent example is the government's partnerships with companies in the pharmaceutical and healthcare industries, through initiatives such as Operation Warp Speed, to combat the COVID-19 pandemic. These efforts are ongoing. Indeed, the government has explained that "a public-private partnership with 21 national pharmacy partners" is "a key component" of the government's strategy "to expand equitable access to vaccines for the American public."[3]

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[3] Press Release, White House, *FACT SHEET: President Biden Announces Increased Vaccine Supply, Initial Launch of the Federal Retail Pharmacy Program, and Expansion of FEMA Reimbursement to States* (Feb. 2, 2021), https://www.whitehouse.gov/briefing-room/statements-releases/2021/02/02/fact-sheet-president-biden-announces-increased-vaccine-supply-

The federal government also depends on the participation of private-sector companies for other important policy goals such as promoting affordable housing and developing the nation's infrastructure. The Department of Housing and Urban Development has stated that "most HUD programs are structurally public-private partnerships" or "have some public-private aspects."[4] HUD favors these partnerships because they "enable government to share risks with the private sector, leverage investments for far greater effect, take advantage of efficiencies outside government, and employ broader knowledge and skills."[5] Private companies play a similarly central role in the infrastructure sector. The Department of Homeland Security has made "[p]ublic-private partnerships" the "foundation for effective critical infrastructure and resilience strategies."[6] Such coordination is crucial for safeguarding and strengthening the nation's transportation, communication, and energy infrastructure because "neither government nor the private sector . . . has the

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initial-launch-of-the-federal-retail-pharmacy-program-and-expansion-of-fema-reimbursement-to-states/.

[4] Office of Policy & Rsch., U.S. Dep't of Hous. & Urban Dev., *The Evolution of HUD's Public-Private Partnerships: A HUD 50th Anniversary Publication* 1 (2015), https://www.huduser.gov/hud50th/HUD2-048-Public-Private_Partnership_508.pdf.

[5] *Id.* at 2.

[6] Cybersecurity & Infrastructure Sec. Agency, *Critical Infrastructure Partnerships and Information Sharing*, https://www.cisa.gov/critical-infrastructure-partnerships-and-information-sharing (last visited Mar. 7, 2022).

knowledge, authority, or resources to do it alone."[7] Public-private partnerships are also expected to play a major role in the implementation of the recently enacted trillion-dollar Infrastructure Investment and Jobs Act.[8] The Chamber believes that the use of public-private partnerships is essential to modernizing America's infrastructure.[9]

These partnerships do not materialize simply because the government asks for help. When private companies agree to administer government-funded programs, they make substantial investments of time, money, and resources to comply with congressional mandates and regulatory requirements. They assume a certain level of risk in exchange for compensation guarantees and legal protections that are commensurate with that risk. To put their livelihoods (and lenders' and shareholders' capital) on the line, businesses must have confidence that the government will honor its statutory obligations. Those protections may be even more important when private companies are invited to compete with a government-run alternative. For such competition to work, the rules need to be fair, clear in advance, and not subject to

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[7] *Id.*

[8] *See* Sarah Kline, Bipartisan Policy Ctr., *Five Reasons Public-Private Partnerships Could See Big Growth Under the Bipartisan Infrastructure Bill* (Nov. 16, 2021) https://bipartisanpolicy.org/blog/five-reasons-public-private-partnerships-could-see-big-growth-under-the-bipartisan-infrastructure-bill/.

[9] *See* U.S. Chamber of Commerce, *How Should We Rebuild Our Infrastructure? The U.S. Chamber Will Offer Up a Plan* (Jan. 17, 2018), https://www.uschamber.com/infrastructure/how-should-we-rebuild-our-infrastructure-the-us-chamber-will-offer-plan.

arbitrary change through post-hoc regulatory maneuvers.

Failure to adhere to this basic bargain will have predictable consequences. As this Court has recognized in a related context, if the federal government failed to act as "'a reliable contracting partner'" that honors its commitments, then "contracting would become more cumbersome and expensive for the Government, and willing partners more scarce." *Salazar v. Ramah Navajo Chapter*, 567 U.S. 182, 191–92 (2012) (quoting *United States v. Winstar Corp.*, 518 U.S. 839, 883 (1996) (plurality opinion)). That is because "would-be contractors would bargain warily—if at all—and only at a premium large enough to account for the risk of nonpayment." *Id.* Just as private parties "must turn square corners when . . . deal[ing] with the Government," it is "also true, particularly when so much is at stake, that the [g]overnment should turn square corners in dealing with the people." *Regents of Univ. of Cal.*, 140 S. Ct. at 1909 (internal quotation marks omitted). If the government reneges on its statutory commitments and gives itself an unfair edge in the market, private businesses will decline to participate or will be forced to raise their prices for participating in Medicare Advantage and other programs that depend on private-sector collaboration.

B. The D.C. Circuit's Decision Jeopardizes the Successful and Highly Popular Medicare Advantage Program

Medicare Advantage is by many measures a model of success for public-private partnerships. Unlike traditional Medicare, Medicare Advantage

allows enrollees to select coverage from a wide variety of plans administered by private insurance companies. By harnessing the efficiencies generated by private-sector competition, Medicare Advantage has managed to deliver higher quality care at lower cost. Studies show that MA plans outperform traditional Medicare "on nearly all clinical quality and most patient experience measures."[10] Meanwhile, in 2021, MA plans delivered basic Medicare benefits at an estimated 87% of the cost of the traditional Medicare program.[11]

More than 26 million Americans—over 40% of those eligible for Medicare[12]—have chosen to receive their Medicare benefits through Medicare Advantage.[13] Enrollment has nearly doubled over the

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[10] Justin W. Timbie et al., *Medicare Advantage and Fee-for-Service Performance on Clinical Quality and Patient Experience Measures: Comparisons from Three Large States*, 52 Health Servs. Rsch. 2038, 2058 (2017), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC5682140/pdf/HESR-52-2038.pdf.

[11] AHIP, *Americans Agree on Protecting Medicare Advantage for the People It Serves* (June 2, 2021) https://www.ahip.org/news/articles/americans-agree-on-protecting-medicare-advantage-for-the-people-it-serves.

[12] Coal. for Medicare Choices, *What Is Medicare Advantage?*, https://medicarechoices.org/medicare-advantage-101/ (last visited Mar. 8, 2022).

[13] Meredith Freed et al., KFF, *Medicare Advantage in 2021: Enrollment Update and Key Trends* (June 21, 2021), https://www.kff.org/medicare/issue-brief/medicare-advantage-in-2021-enrollment-update-and-key-trends/.

past decade.[14] More than 90% of Americans with Medicare Advantage report being satisfied with their coverage, and the majority (56%) are very satisfied.[15] In surveys, three out of four Americans say that it is important for the federal government to protect funding for Medicare Advantage.[16] The MA program also enjoys broad bipartisan support in Congress. More than 400 members of Congress recently signed letters affirming their strong support.[17] In sum, given the success and popularity of Medicare Advantage, it has become a centerpiece of the U.S. health care system.

The D.C. Circuit's decision jeopardizes all of that success. The "actuarial equivalence" and "same methodology" requirements are critical guarantees for health insurance companies that have agreed to participate in Medicare Advantage. By ensuring that MA plans are adequately compensated for the risks they assume in providing insurance, these commitments enable MA plans to provide quality coverage to a wide range of enrollees, including those

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[14] KFF, *A Dozen Facts About Medicare Advantage in 2019* (June 6, 2019), https://www.kff.org/medicare/issue-brief/a-dozen-facts-about-medicare-advantage-in-2019/.

[15] Coal. for Medicare Choices, *Medicare Advantage Polling Report* (Jan. 16, 2020), https://medicarechoices.org/medicare-advantage-polling-report/.

[16] *Id.*

[17] Press Release, *AHIP Thanks Congress for the Record-Setting Bipartisan Support for Medicare Advantage* (Feb. 5, 2020), https://www.ahip.org/news/press-releases/ahip-thanks-congress-for-the-record-setting-bipartisan-support-for-medicare-advantage.

with serious health conditions that require costlier care. The D.C. Circuit's decision nullifies those important guarantees. By allowing CMS to renege on the basic premises of the MA partnership and to rewrite the terms of its longstanding payment model, the decision seriously undermines the reliance interests of private companies that have built their businesses around that model.

Worse yet, the unfairness and costs to MA plans are exacerbated by the threat of False Claims Act (FCA) liability. The Medicare statute provides that "[a]ny overpayment retained by a person after the deadline for reporting and returning the overpayment . . . is an obligation" for purposes of the FCA. 42 U.S.C. § 1320a-7k(d)(3). And the FCA provides for treble damages plus penalties when a company "knowingly and improperly avoids or decreases an obligation to pay or transmit money or property to the Government." 31 U.S.C. § 3729(a)(1)(G). The Rule expands FCA exposure—specifically and only for MA plans—by treating every unsupported diagnostic code as conclusive evidence of an "overpayment," regardless of the error rate in CMS's benchmark data. As a result, MA plans will be deemed to owe more "obligation[s] to pay or transmit money or property to the Government" enforceable through *qui tam* actions as well as government enforcement.[18]

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[18] The Overpayment Rule overreached in another respect by imposing a negligence standard—and an accompanying "reasonable diligence" requirement—as the test for when a company will be deemed to have "identified" an "overpayment" as defined by the Rule. App. 85a. The Rule thus would have vastly expanded FCA liability: by lowering the standard for

Ultimately, this disruption of the MA program will harm health care providers and patients, especially the most vulnerable Americans. *See* Pet. 35–36. If MA plans are underpaid, they will not be able to pay providers as much, and the quality and availability of care will suffer. Furthermore, unlike traditional Medicare plans, MA plans have built-in caps on out-of-pocket costs and thus are often a more affordable option for low-income Americans. Forty percent of MA enrollees make less than $25,000 a year.[19] But MA plans that are tailored to low-income beneficiaries have less pricing flexibility than other plans and may be especially hard hit by the shortfall of CMS funding. *See* Pet. 36. All in all, the D.C. Circuit's decision is a major setback for Medicare Advantage and the millions of Americans who have benefited from its market-oriented model of choice, affordability, and efficiency.

C. Review Is Warranted Now

This Court need not and should not delay in granting review. For the reasons explained in the petition, including the applicable statute of limitations, this case will likely be the Court's only

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"identifying" an overpayment, the Rule would have penalized companies for not repaying alleged overpayments they did not know they had received. The district court correctly struck down this aspect of the Rule to ensure consistency with the FCA's scienter requirement, App. 85a–87a, and the government did not challenge that decision on appeal. Even with the scienter error fixed, the Rule still has the serious FCA impacts that are noted above.

[19] Coal. for Medicare Choices, *What is Medicare Advantage?*, *supra* note 12.

opportunity to address the questions presented. *See* Pet. 37–38. Additional percolation is also unlikely because of the difficulty of raising the unlawfulness of the Overpayment Rule on an as-applied basis in an enforcement action. As an initial matter, the government has argued that the Rule's invalidity cannot be raised as a defense at all in FCA actions. *See, e.g.*, Gov't Opp. to Mot. to Dismiss 18–20, *United States ex rel. Ormsby v. Sutter Health*, No. 15-cv-1062 (N.D. Cal. Aug. 27, 2019), Dkt. No. 82. And even if the government is wrong about that—as the Chamber believes—the draconian nature of the FCA makes further percolation unlikely. Few companies, even when they have done nothing wrong, can afford to roll the dice and litigate FCA cases to final judgment given the risk of treble damages, plus per-claim penalties, plus attorneys' fees. 31 U.S.C. §§ 3729(a), 3730(d)(1)–(2). "Faced with even a small chance of a devastating loss, defendants will be pressured into settling questionable claims." *AT&T Mobility LLC v. Concepcion*, 563 U.S. 333, 350 (2011).

This Court should therefore grant review now; protect the Medicare Advantage program—and the businesses, health care providers, and millions of patients who rely on it—from further destabilization; and vindicate the rights of all parties who do business with the federal government, as well as the interests of all those who benefit from that business.

CONCLUSION

The Court should grant the petition for certiorari.

Respectfully submitted,

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