No. 21-1140

In the Supreme Court of the United States

UNITEDHEALTHCARE INSURANCE COMPANY, ET AL.,
Petitioners,

v.

XAVIER BECERRA, IN HIS OFFICIAL CAPACITY AS SECRETARY OF HEALTH AND HUMAN SERVICES, ET AL.,
Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE DISTRICT OF COLUMBIA CIRCUIT

REPLY BRIEF FOR PETITIONER

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INTRODUCTION

The government's response does not seriously dispute the reasons this petition warrants review. It offers no defense of the blatant statutory error at the heart of the D.C. Circuit's decision—the court's ruling that the statutory overpayment provision does not cross-reference or even implicate the Medicare statute's actuarial-equivalence provision. It largely ignores the amici from across the healthcare industry—including physicians who treat Medicare Advantage (MA) patients—explaining that the decision "will severely damage the [MA] program to the detriment of the millions of Americans who depend on it for high-quality, low cost care." AHIP Br. 1; *see* Chamber Br. 21. And it fails to identify any plausible way the questions presented will reach this Court again; indeed, the *government itself* has taken the position that the one alternative route the response proposes (False Claims Act litigation) is unavailable. The petition should be granted.

ARGUMENT

I. The Decision Below Is Manifestly Wrong

A. The Government Does Not Defend The Blatant Statutory Error At The Heart Of The D.C. Circuit's Decision

1. The central question in this APA challenge is whether the Medicare Act's actuarial-equivalence requirement applies to the statutory overpayment provision and, thus, to CMS's Overpayment Rule. The D.C. Circuit's response to that question was unequivocal: "[W]e hold that the actuarial-equivalence requirement does not pertain to the statutory overpayment-refund obligation or the

Overpayment Rule challenged here . . . ." Pet. App. 6a. In the court's view, the Overpayment Rule does not "even *implicate*" the actuarial-equivalence requirement. *Id.* at 52a (emphasis added).

That holding was based on the court's mistaken conclusion that there is no statutory connection between the actuarial-equivalence and overpayment provisions. The supposed absence of any "cross reference or other language" connecting these provisions was the key to the court's decision. *Id.* at 34a. The court stressed the absence of any such textual connection no fewer than eight times. *Id.* at 3a, 6a, 31a, 33a, 34a, 36a, 39a-40a, 52a; *see* Addendum (collecting these references). As the court held, the statute "speaks not at all to whether the actuarial-equivalence requirement in section 1395w-23(a)(1)(C)(i) bears on section 1320a-7k(d)'s requirement to refund overpayments." Pet. App. 36a.

While the government's response attempts to make this case appear as complicated as possible, that straightforward statutory ruling is the crux of the decision below. And it is demonstrably wrong.

2. As UnitedHealth explained, Congress in fact explicitly linked the actuarial-equivalence and overpayment provisions. Pet. 18-21. The government's response denies none of that. Nor does it deny that the D.C. Circuit used ellipses and selective paraphrasing to erase the explicit statutory cross-reference to "subchapter XVIII" and the language "under such subchapter." Pet. App. 23a-24a, 33a, 39a. Instead, the government acknowledges that there *is* a statutory "cross-reference." BIO 18.

That crucial statutory error alone warrants this Court's review, because it tainted the entire decision.

The court summarily rejected UnitedHealth's argument that the Overpayment Rule violated the Act's "same methodology" mandate for the "same reasons" it rejected its actuarial-equivalence requirement—i.e., its flawed statutory ruling. Pet. App. 50a; *see id.* at 6a. Likewise, because the court concluded that the Overpayment Rule does not "even *implicate*" actuarial equivalence, the court summarily dismissed UnitedHealth's argument that CMS had arbitrarily refused to explain its departure from its prior position. *Id.* at 52a (emphasis added).

And although the D.C. Court purported to hold that the Rule does not violate actuarial equivalence anyway, that ruling—which is itself flawed, *see infra* at 8-9—was both predetermined and infected by the court's threshold statutory error, too. Pet. 27.

3. Instead of defending the D.C. Circuit's statutory ruling, the government invents an alternative rationale. BIO 18-20. The government's arguments are wrong, *see infra* at 4-8, but the more important point is that they were not the basis of the decision below. The D.C. Circuit held that the overpayment provision does not "cross-reference," "speak[] . . . at all too," or "even implicate," the actuarial-equivalence provision. Pet. App. 34a, 36a, 52a. If the Court denies review in this case, that indefensible statutory ruling will be the final say on this core issue—fundamentally re-writing the Medicare statute and gutting the comparative payment model that drives the MA program. AHIP Br. 10-14; Physicians Br. 8-12; Chamber Br. 17-20.

All this is reason enough to grant review.

B. The Government's Alternative Arguments Are Equally Flawed And Would Gut The MA Payment Model

1. While not defending the D.C. Circuit's statutory holding, the government argues that the actuarial-equivalence requirement applies only to the "design of the risk-adjustment model as a whole," but somehow has nothing to say about payment accuracy after that initial stage. BIO 16-17.[1] That argument defies the text, logic, and history of the statute.

The government attempts to brush off the overpayment provision's explicit cross-reference as too *broad* to establish that actuarial equivalence "governs the payment to which an insurer is 'entitled.'" BIO 18. That is wrong. A cross-reference is a cross-reference—and is entitled to effect. *See Cyan, Inc. v. Beaver Cnty. Emps. Ret. Fund*, 138 S. Ct. 1061, 1070 (2018). And here, the cross-reference unambiguously connects the actuarial-equivalence and overpayment provisions of the statute.

The subchapter expressly cross-referenced in the overpayment provision includes a subsection titled "Payments to Medicare [Advantage] Organizations," which, in turn, includes the actuarial-equivalence mandate at issue here: The Secretary "*shall* adjust" the "payment amount" for "such risk factors . . . so as to *ensure actuarial equivalence*." 42 U.S.C. § 1395w-23(a)(1)(C)(i) (emphasis added). Thus, the statute not only expressly connects the overpayment and actuarial-equivalence provisions, but the latter is also

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[1] Contrary to its assertion (BIO 22), below the government consistently argued that the Overpayment Rule *satisfied* actuarial equivalence, not that actuarial equivalence was inapplicable. Pet. 21-22.

the *only* way to determine the amount of the payment to which an MA plan is "entitled" (as required by the overpayment provision). Pet. 20.

The government's bare assertion that actuarial equivalence applies only to the "establish[ment]" and "design" of the risk-adjustment model is flatly wrong. BIO 15-16. The statute requires that payment adjustments ensure equivalence, and the Overpayment Rule clearly effectuates an "adjust[ment]" to the "payment amount." 42 U.S.C. § 1395w-23(a)(1)(C)(i). By contrast, the "[e]stablishment" of the risk-adjustment model is addressed in a different part of that subsection. *Id.* § 1395w-23(a)(3). Nor does the government's proposed reading make any sense: Under its view, Congress required actuarial equivalence between traditional Medicare and MA populations to determine MA *payments*, only to allow CMS to *claw back* payments through a definition of overpayment that disregards actuarial equivalence. Pet. 22.[2]

The government also suggests that Congress left all this to the Secretary's "discretion." BIO 21-22. But while Congress gave the Secretary leeway to determine what *risk factors* to consider, it mandated that "the Secretary *shall adjust the payment amount* . . . so as to ensure actuarial equivalence." 42 U.S.C. § 1395w-23(a)(1)(C)(i) (emphasis added). And that mandate is critical, given that CMS—which acts as *both* a contractee *and* competitor of MA plans—has

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[2] The government's reading is also contradicted by CMS's own adoption of a fee-for-service (FFS) adjuster in addressing the same question of what constitutes an "overpayment" in the context of auditing payments, not model design. Pet. 10-11.

a financial incentive to skew the assumptions in its favor to limit its own payments. Chamber Br. 10-13.

2. The government's response also begs the question. The government simply asserts that all payments related to unsupported codes are "overpayments," and then mischaracterizes UnitedHealth's position as wanting payment for "known overpayments." BIO 15, 21. But that is *the* contested question: Given that CMS assumes the validity of all its codes—including unsupported codes—in determining the health and costliness of the *traditional Medicare population*, can it declare every payment to an MA plan based on an equivalent unsupported code an overpayment? Pet. 24.

Similarly, the government mistakenly claims that the Overpayment Rule merely enforces a "longstanding obligation." BIO 33; *see id.* at 20. Not so. Before the 2014 Rule, CMS had never established that every unsupported code in an MA plan's data results in an overpayment. On the contrary, since 2012 CMS's formal audit methodology for MA plans had treated an MA plan's unsupported codes as overpayments *only if* the resulting payment impact exceeded the rate of unsupported codes in CMS's traditional Medicare data—ensuring actuarial equivalence. Pet. 10-11. This explains why UnitedHealth and others strongly objected to the Overpayment Rule—which sought to impose a *new* obligation flouting actuarial-equivalence. *Id.* at 13.[3]

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[3] The only source the government cites addressing the deletion of unsupported codes is a *guidance* document that lacks the force of law and was issued in mid-2013—just a few months before the 2014 Rule. BIO 4-5 (citing C.A. App. 410). It is, therefore, neither an "obligation" nor "longstanding."

The government likewise mischaracterizes UnitedHealth's argument as seeking to retain "mistaken or fraudulent payment[s]." *E.g.*, BIO 18. As the district court recognized, that is a strawman. Pet. App. 82a-83a; Pet. 26-27. UnitedHealth simply argues that whether payments are in fact inaccurate must be determined in a manner that ensures *actuarial equivalence*—i.e., based on the same assumptions that CMS applies to the traditional Medicare data that it uses to set MA payment rates. It is also simply not the case that an unsupported code is always wrong. AHIP Br. 3.

The government does not dispute that actuarial equivalence requires payments to be determined based on "a given set of actuarial assumptions." *Stephens v. U.S. Airways Grp., Inc.*, 644 F.3d 437, 440 (D.C. Cir. 2011), *cert. denied*, 566 U.S. 921 (2012). So if CMS sets MA rates based on the assumption that all codes in its traditional Medicare data are valid (even though that data indisputably includes unsupported codes), then MA plans must be paid based on that same assumption.

And importantly, UnitedHealth is not seeking payment for nonexistent conditions. CMS's payment model distributes the actual costs of insuring the traditional Medicare population's actual conditions across all its diagnosis codes, including unsupported codes. Pet. 8-9. As the government has admitted, its own payment model therefore attributes some actual costs to unsupported conditions. D.D.C. Dkt. 60 at 7-8; *see* Pet. 19; Physicians Br. 13-15. By denying MA plans payment for all unsupported codes, the Overpayment Rule deprives plans of payment for legitimate costs attributable to real conditions—and

confers on CMS a windfall to the tune of billions of dollars.

The government complains that it is burdensome to adjust MA payments so they are calculated based on the same assumptions about the validity of diagnosis codes. The short answer is that Congress required CMS to do so by mandating actuarial equivalence. *Supra* at 4-5. In any event, CMS has done it before, and the government all but admits (BIO 20-21 & n.2) that it could achieve this result by statistical sampling—a technique CMS regularly uses in auditing MA plans. Pet. 10-11.

3. Like the D.C. Circuit's opinion, the government's alternative defenses of the result below are infected by the underlying presumption that actuarial equivalence is fundamentally unrelated to payment accuracy. BIO 22-27; Pet. 27-29. But the government offers no response to the chart in the petition illustrating the basic actuarial-equivalence problem with the Overpayment Rule. Pet. 24. The assumptions underlying CMS's front-end calculation of MA rates and its back-end enforcement of rates under the Rule are incompatible. And as amici explain, ensuring that MA plans are paid in a manner that is actuarially equivalent to traditional Medicare is critical to the viability of the MA program. AHIP Br. 5, 9-16; Physicians Br. 12-20; Chamber Br. 17-21.

Instead, the government—again like the D.C. Circuit—attempts to flip the burden onto UnitedHealth to prove that this lack of actuarial equivalence will cause systematic underpayment of MA plans. BIO 24-26. This is another red herring. *Any* underpayment as a result of failing to ensure actuarial equivalence violates the statute; UnitedHealth does not have to show that plans would

be *systematically* underpaid—though, as the district court found and amici explain, they will be. Pet. App. 72a; AHIP Br.10-12; Physicians Br. 5-6, 13-15.[4]

C. Like The D.C. Circuit, The Government Papers Over CMS's Glaring And Unexplained Flip In Positions

The government's attempt to defend the D.C. Circuit's ruling on UnitedHealth's "arbitrary and capricious" challenge also fails. BIO 30-32. Most notably, the government does not deny that, in excusing CMS's failure to explain its change in position, the D.C. Circuit relied on its flawed statutory ruling. Pet. App. 52a; Pet. 30. For that reason alone, this ruling cannot stand.

In any event, the government's attempt to explain CMS's "about-face" (Chamber Br. 3) is baseless. It primarily relies on a revisionist account of CMS's decision in 2012—in response to comments by the American Academy of Actuaries—that a "fee-for-service adjuster" was required to account for the coding errors in determining overpayments. Pet. 10-11. The government now says that CMS's adoption of this adjuster had nothing to do with actuarial equivalence. BIO 30-33. That is clearly incorrect. As the district court explained: CMS "recognized [in 2012] that actuarial equivalence, mandated by

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[4] The 2018 CMS study cited by the government (BIO 32) post-dates the Overpayment Rule by four years and is outside the administrative record. Pet. App. 22a-23a; 52a n.1; *see id.* at 95a-96a. As a matter of black-letter law, it therefore cannot support the Rule. *See Florida Power & Light Co. v. Lorion*, 470 U.S. 729, 743-44 (1985). In any event, the study's findings are deeply flawed. AHIP Br. 20; Chamber Br. 8 n.2; Pet. App. 100a-02a (district court questioning study).

statute, required an FFS Adjuster for purposes of defining overpayments because of dissimilar data for RADV audits"—and that CMS thereafter "provide[d] no legitimate reason for abandoning that statutory mandate in the context of the 2014 Overpayment Rule." Pet. App. 84a; *see* C.A. App. 397-98.

The government also argues that a "[c]ontract-level [RADV] audit[]" is different from the error-correction mechanism of the Overpayment Rule. BIO 30 (citation omitted). But CMS never offered that argument in contemporaneously explaining its Rule. In any event, this post-hoc distinction fails to answer UnitedHealth's core point: before the Overpayment Rule, CMS recognized that to determine whether a plan has been overpaid, the statute's actuarial-equivalence requirement mandated an adjuster that took account of unsupported codes in CMS's own data to level the assumptions used to calculate payments. But then CMS abandoned that understanding—and any adjuster—in the Overpayment Rule without ever acknowledging its change in position. Pet. App. 84a.[5]

That is a classic violation of one of the most important checks on arbitrary agency action.

II. This Court's Review Is Necessary

In seeking to stave off review of this egregiously flawed decision, the government relies on the absence

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[5] For similar reasons, the government's reference to OIG audits of UnitedHealth plans is wholly misleading. BIO 7. The "payment impacts" that OIG calculated due to unsupported diagnosis codes were *prior to* assessment of "the potential impact of error rates [in traditional Medicare] data on MA payments" (C.A. App. 474, 484)—which OIG acknowledged *that CMS rules required* before assessing whether MA payments based on unsupported codes were in fact overpayments.

of a circuit conflict—while maintaining that there is no "reason to believe that the decision below will prevent further percolation." BIO 27. Once again, the government's position is not credible.

1. The government does not dispute that the statute of limitations will prevent anyone else from challenging the Overpayment Rule. Pet. 37. So it is clear that an APA suit like this will not arise again.

The government instead argues that MA plans can raise the questions presented in defending against False Claims Act (FCA) liability. BIO 27, 30. But this argument is disingenuous—because the government has repeatedly argued (including in the very cases it cites) that defendants *cannot* raise actuarial equivalence as a defense in FCA actions. Chamber Br. 22; U.S. Partial Summ. J. Mot. 16, *United States ex rel. Poehling v. UnitedHealth Grp.*, No. CV 16-08697, (C.D. Cal. May 22, 2018), Dkt. 234-1, 2018 WL 3104971. Thus, under the government's position, the issues here could *not* "percolate" through FCA litigation. And even if the government were wrong about that, "the draconian nature of the FCA makes further percolation unlikely." Chamber Br. 22.[6]

Thus, in all likelihood, this is the only opportunity the Court will have to review these issues. Pet. 17; AHIP Br. 4-5; Chamber Br. 21-22; Agilon Br. 18.

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[6] The government elsewhere suggests that UnitedHealth should challenge CMS's annual rate adjustments. BIO 26-27. But the challenge here is to the *Overpayment Rule*, which impacts the whole payment scheme. The APA is the proper vehicle for that challenge—which likely explains why the government never actually contends that the questions presented could be litigated through an annual rate challenge.

2. In any case, certiorari is necessary here and now. The government does not address or distinguish any of the prior instances in which this Court granted certiorari without a conflict. Pet. 36-37. Like those cases, this petition seeks review of a decision that will have massive implications for an important government program—and here, a multi-billion-dollar component of the U.S. economy.

As amici explain, a wait-and-see approach could be disastrous for the MA program. The Overpayment Rule "fundamentally changes how Medicare Advantage organizations are compensated." AHIP Br. 4; *see* Physicians Br. 12-13. And the D.C. Circuit's decision upholding the Rule—which relieves CMS of *any* obligation to ensure MA plans are fairly compensated for the risks they undertake—compounds that disruption. AHIP Br. 10-11; Physicians Br. 19-20. As stakeholders from across the healthcare system explain, that decision will gut the innovative payment model that has made the MA program a wild success, jeopardize the provision of healthcare services under the MA program, and ultimately undermine the healthcare relied upon by tens of millions of Americans. Physicians Br. 6-7; AHIP Br. 5; Chamber Br. 21; Agilon Br. 17.

With the stakes so high, the D.C. Circuit's deeply flawed decision cannot be the final say.

CONCLUSION

The petition should be granted.

Respectfully submitted,

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ADDENDUM

Addendum

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Excerpts of Court of Appeals' Decision

Decision Text	Pet. App.
"[A]ctuarial equivalence does not apply to the Overpayment Rule or the statutory overpayment-refund obligation under which it was promulgated."	Pet. App. 3a.
"Reference to actuarial equivalence appears in a different statutory subchapter from the requirement to refund overpayments, and neither provision cross-references the other."	Pet. App. 3a
"[N]othing in the Medicare statute's text, structure, or logic applies actuarial equivalence to its separate overpayment-refund obligation, and thus the Overpayment Rule does not violate actuarial equivalence."	Pet. App. 6a
"[N]othing in the Medicare statute's text, structure, or logic makes the actuarial equivalence requirement in section 1395w-23(a)(1)(C)(i) applicable to the overpayment-refund obligation in section 1320a-7k(d) or to the Overpayment Rule promulgated under that section."	Pet. App. 31a

Decision Text	Pet. App.
"No part of the Medicare statute or the Overpayment Rule supports UnitedHealth's challenge. The statute's actuarial-equivalence requirement does not apply to the separate statutory obligation on insurers to refund overpayments they erroneously elicit from CMS; nor, by the same token, does actuarial equivalence apply to the Overpayment Rule that implements that statutory obligation and, in relevant part, essentially parrots it."	Pet. App. 33a
"Nothing in the text of either the actuarial-equivalence requirement in section 1395w-23(a)(1)(C)(i) or the overpayment-refund obligation in section 1320a-7k(d) applies the former to the latter. There is no cross-reference or other language suggestive of overlap . . . ."	Pet. App. 34a
"Here, the Medicare statute is similarly silent, as it speaks not at all to whether the actuarial-equivalence requirement in section 1395w-23(a)(1)(C)(i) bears on section 1320a-7k(d)'s requirement to refund overpayments."	Pet. App. 36a

Decision Text	Pet. App.
"[I]n the absence of any textual or structural connection between the two provisions, we decline to hold that the actuarial-equivalence requirement in section 1395w-23(a)(1)(C)(i) applies to the overpayment-refund obligation in section 1320a-7k(d) or the Overpayment Rule CMS promulgated to comply with that provision."	Pet. App. 39a-40a
"Because, as discussed above, the Overpayment Rule does not violate, or even implicate, actuarial equivalence, CMS had no obligation to consider an FFS Adjuster or similar correction in the overpayment-refund context."	Pet. App. 52a