Hogan Lovells US LLP
Columbia Square
555 Thirteenth Street, NW
Washington, DC 20004
T +1 202 637 5600
F +1 202 637 5910
www.hoganlovells.com

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BY CM/ECF

Catherine O'Hagan Wolfe
Clerk of Court
U.S. Court of Appeals for the Second Circuit
40 Foley Square
New York, NY 10007

Re: ***UnitedHealthcare of New York, Inc. et al. v. Lacewell*, No. 18-2583**

Dear Ms. Wolfe:

We write on behalf of Plaintiffs-Appellants in response to the Court's August 7, 2019 order directing the parties to file letter briefs responding to the United States' brief as *amicus curiae*, filed on behalf of the U.S. Department of Health and Human Services (HHS). Plaintiffs agree with that brief in its entirety. Moreover, because the United States' brief unequivocally embraces Plaintiffs' view of the relevant federal statutory and regulatory guidance, it should now be beyond dispute that (1) the contested New York regulation is "preempted, because it prevents the application of the [Affordable Care Act's] risk-adjustment program as implemented by HHS"; and, accordingly, (2) "the judgment of the district court should be reversed." U.S. Br. 12, 17; *compare* Pls.' Br. 30-42.

As Plaintiffs have explained, the plain text of the Affordable Care Act (ACA) and its implementing regulations unambiguously establish that New York's regulation cannot stand. The United States agrees. Its brief observes that, under the ACA's statutory and regulatory scheme, any "reductions to the risk-adjustment transfers calculated by HHS cannot occur without HHS's approval." U.S. Br. 10; *compare* Pls.' Br. 34-38. It further observes that, "[u]ntil recently," HHS regulations did not permit States to request any modification of federal risk adjustment methodology when HHS was administering risk adjustment in the State (as it was in New York). U.S. Br. 5. While a 2018 "state-flexibility regulation" does mean that States like New York are now permitted to seek approval for prospective reductions, a State still "may not modify charge or payment amounts determined under the HHS risk-adjustment methodology—either in advance or on the back end—without obtaining HHS approval under the procedure set out in the state-flexibility regulation." *Id.* at 14; *see* 45 C.F.R. § 153.320(d); *compare* Pls.' Br. 37-38.

According to the United States, New York did not obtain that mandatory HHS approval—and it could not have done so for the 2017 benefit year because 2020 is the first year that the new regulation will apply. *See* U.S. Br. 6-7. The contested New York regulation is therefore preempted by the ACA's statutory and regulatory scheme.

The Superintendent's argument to the contrary has always been based on the assertion that HHS understands the scheme very differently, and that HHS's views "deserve considerable deference." Superintendent Reply 10. Until the United States filed its brief, the Superintendent staunchly claimed that HHS endorsed unilateral state action like New York's, and that HHS had even expressly approved of New York's regulation through a paragraph in the preamble of the 2018 Federal Register notice for the "state-flexibility regulation" and through informal guidance, telephone conversations, and an email. The United States' brief conclusively rejects those assertions and explains that HHS has consistently interpreted the statutes and regulations as barring States from unilaterally adopting regulations like New York's.

But the Superintendent *is* now right that "HHS's views deserve considerable deference here." *Id.* As the Supreme Court recently clarified in *Kisor v. Wilkie*, 139 S. Ct. 2400 (2019), courts should defer to agencies' interpretations of their own regulations when the interpretation is authoritative and well-considered, and when it implicates the agency's expertise. HHS's interpretation fits the bill: it is the considered view of the agency, presented neutrally in a case in which it has no direct interest, and it implicates the agency's expertise with respect to the risk-adjustment scheme it administers. The district court's judgment must therefore be reversed.

I. HHS HAS CONFIRMED THAT THE SUPERINTENDENT MISINTERPRETED THE ACA AND ITS REGULATIONS.

From the outset, the Superintendent's leading argument has been that the contested New York regulation cannot conflict with the ACA's statutory and regulatory scheme because HHS endorsed the view that States do not need federal approval in order to adopt regulations like New York's. *See, e.g.*, Superintendent Br. 21-23. In the alternative, the Superintendent has asserted that HHS has provided any necessary "approval" of the New York regulation through formal and informal statements. *See* Superintendent Br. 14-15; Superintendent Reply 10-11. The United States' brief decisively rejects both positions.

A. The Superintendent built her defense of New York's regulation around a preamble to HHS's "state-flexibility regulation," which was printed in the Federal Register in April 2018. *See* Patient Protection and Affordable Care Act; HHS Notice of Benefit and Payment Parameters for 2019, 83 Fed. Reg. 16,930, 16,960 (Apr. 17, 2018). As the United States' brief explains, that preamble—which accompanied "the rule that finalized HHS's state-flexibility regulation"—"specifically addressed New York's regulation." U.S. Br. 11. The preamble observed that States may use "local approaches" to "ease the transition for new participants to the health insurance markets," and that States "do not generally need HHS approval as these States are acting under their own State authority and

using State resources." 83 Fed. Reg. at 16,960. But the preamble immediately contrasted those "local approaches" with the approach embodied in the newly promulgated "state-flexibility regulation," which "involves a reduction to the risk adjustment transfers calculated by HHS." That kind of "flexibility . . . will require HHS review as outlined above." *Id.*

The Superintendent repeatedly asserted that HHS viewed New York's regulation as one of the "local approaches" that "do not generally need HHS approval." *See, e.g.*, Superintendent Br. 21-23 (quoting 83 Fed. Reg. at 16,960); Superintendent Reply 3-5 (same). The United States, however, has now confirmed what the preamble already "made clear": "a reduction to the risk-adjustment transfers is *not* the type of 'local approach[ ] under State legal authority' that a State may implement unilaterally." U.S. Br. 12 (emphasis added). Rather, as Plaintiffs have long contended, the "local approaches" HHS had in mind were "modifications to the States' own insurance regulations" and other actions States could take " 'acting under their own State authority and using State resources.' " *Id.* at 13 (quoting 83 Fed. Reg. at 16,960); *compare* Pls.' Reply 7-8. "New York's regulation does not satisfy that requirement, because it relies heavily on *federal* resources to redistribute *federal* transfers between private parties." U.S. Br. 13.

B. The United States' brief is equally unequivocal in disavowing the Superintendent's alternate assertion that HHS somehow provided the requisite "approval" for New York's regulation through informal guidance, phone calls, or an email. The brief explains that "informal communications" between New York and HHS did not and could not authorize New York unilaterally to reverse HHS-administered risk-adjustment payments. U.S. Br. 14-16; *compare* Pls.' Reply 13-14. Indeed, the Superintendent herself ceased explicitly asserting those communications as a basis for interpreting the statute and regulations in her reply brief. All for good reason, because these sorts of casual communications have *never* been viewed as an authoritative embodiment of an agency's position, and they certainly do not come close to the sort of formal "determination" with respect to the permissibility of a state scheme that the ACA's statutes and regulations contemplate. U.S. Br. 14-16.

II. THE VIEWS OF HHS ARE ENTITLED TO SUBSTANTIAL DEFERENCE.

The views expressed in the United States' brief are those dictated by the plain text of the ACA's statutory and regulatory provisions, and so this is a straightforward preemption case. Although the statute and regulations have always been unambiguous, *see* Pls.' Br. 43, to the extent there is any ambiguity, HHS's now-authoritative understanding of the regulatory scheme it implements is entitled

to substantial deference under the *Auer* deference doctrine. *Halo v. Yale Health Plan, Dir. of Benefits & Records Yale Univ.*, 819 F.3d 42, 53 (2d Cir. 2016) (A "Department's interpretation of its own regulation is 'controlling unless plainly erroneous or inconsistent with the regulation.' " (quoting *Auer v. Robbins*, 519 U.S. 452, 461 (1997)); *see* Superintendent Reply 11 n.3 ("HHS's interpretation of its own regulations is also entitled to deference." (citing *Auer*, 519 U.S. at 461)).

In reaffirming the *Auer* doctrine this past term in *Kisor*, the Supreme Court expressly considered the case of an agency interpretation presented in an *amicus* brief like this one. Although the Court recognized a "general rule . . . not to give deference to agency interpretations advanced for the first time in legal briefs," it explained that the rule was not absolute and that "*Auer* itself deferred to a new regulatory interpretation presented in an amicus curiae brief in this Court." *Kisor*, 139 S. Ct. at 2417 n.6. Because "the agency was not a party to the litigation, and had expressed its views only in response to the Court's request," "there was simply no reason to suspect that the interpretation did not reflect the agency's fair and considered judgment on the matter in question." *Id.* (internal quotation marks and alterations omitted). So too here.

Moreover, none of the limitations on *Auer* that *Kisor* elaborated are applicable in this case. First, the *Kisor* Court noted that "a court should not afford *Auer* deference unless the regulation is genuinely ambiguous." *Id.* at 2415. To the

extent that constraint has any effect here, it favors Plaintiffs: If the ACA regulations are unambiguous, it is because they clearly preempt the contested New York regulation. Second, *Kisor* also explained that "the agency's reading must . . . be reasonable." *Id.* (internal quotation marks omitted). HHS's reading is more than reasonable: It is what the plain language of the statute and regulations most strongly requires. Third, HHS's position expressed in the United States' brief is "the agency's 'authoritative' or 'official position,' " another requirement for deference. *Id.* at 2416 (citation omitted). Fourth, the interpretation does indeed "implicate [the agency's] substantive expertise," *id.* at 2417, because it gives effect to HHS's "complex" "risk-adjustment methodology" that has been "refined . . . over time," U.S. Br. 4. The Superintendent herself agrees, having explained that HHS's views are entitled to "deference . . . [b]ecause of the complexity of administering massive health care programs." Superintendent Reply 10.

Finally, the interpretation "reflect[s] [HHS's] fair and considered judgment" for just the same reasons that the Secretary of Labor's interpretation did when put forward at the invitation of the Court in *Auer*. *Kisor*, 139 S. Ct. at 2417-18 & n.6 (internal quotation marks omitted).[1] And it does not "create[ ] unfair surprise to

[1] At times, the Superintendent has relied on the presumption against preemption to support her position. *See, e.g.*, Superintendent Br. 21. A similar presumption was at issue in *Auer*, but the Court explained that "a rule governing judicial interpretation of statutes and regulations" was "not a limitation on the

regulated parties." *Id.* (internal quotation marks omitted). The Superintendent cannot point to any prior authoritative statements from HHS advancing a contrary view. Rather, she has predicated her erroneous understanding of HHS's position almost entirely on an untenable reading of the 2018 regulatory preamble that actually "made clear" what the United States further explains here: " 'a reduction to the risk adjustment transfers calculated by HHS' " cannot be accomplished unilaterally by a State; it " 'require[s] HHS review' " and approval.[2] U.S. Br. 12 (quoting 83 Fed. Reg. at 16,960).

Thus, to the extent there is any ambiguity—though Plaintiffs have said all along there is not, and the United States agrees—HHS's interpretation should be given controlling weight. Under that interpretation, the contested New York regulation is in conflict with the ACA and its regulations and so is preempted.

Secretary's power to resolve ambiguities in his own regulations." 519 U.S. at 462-463. Likewise here: because the Secretary of Health and Human Services is "free to write the regulations as broadly as he wishes"—with preemptive effect—HHS's interpretation is not constrained by the presumption against preemption, but is "subject only to the limits imposed by statute." *Id.* at 463.

[2] At very best for the Superintendent, the preamble might be viewed as ambiguous. *See* Oral Arg. at 3:22 (Judge Pooler describing the guidance as "amazingly unhelpful"). But even if it were ambiguous, that would not justify the Superintendent's belief that New York could take unilateral action, particularly in light of the clear statutory and regulatory text stating otherwise.

III. CONCLUSION

The judgment of the district court should be reversed, and this Court should remand with instructions to grant summary judgment in Plaintiffs' favor and to permanently enjoin the Superintendent from enforcing the challenged regulations.

Respectfully submitted,

/s/ Neal Kumar Katyal
NEAL KUMAR KATYAL
BENJAMIN A. FIELD
HOGAN LOVELLS US LLP
555 Thirteenth Street, N.W.
Washington, D.C. 20004
(202) 637-5600
neal.katyal@hoganlovells.com

STEVEN ROSENBAUM
COVINGTON & BURLING LLP
1 CityCenter
850 10th Street, N.W.
Washington, D.C. 20001

Counsel for Plaintiffs-Appellants UnitedHealthcare of New York, Inc. and Oxford Health Insurance, Inc.

cc: All counsel of record (via CM/ECF)