No. 01-1372

In the Supreme Court of the United States

MINNESOTA SENIOR FEDERATION, METROPOLITAN REGION, ET AL., PETITIONERS

v.

UNITED STATES OF AMERICA, ET AL.

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

BRIEF FOR THE RESPONDENTS IN OPPOSITION

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QUESTION PRESENTED

Whether the system that Congress has established for paying managed care organizations under the "Medicare + Choice" program violates the constitutional right to travel.

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OPINIONS BELOW

The opinion of the court of appeals (Pet. App. 1a-9a) is reported at 273 F.3d 805. The opinion of the district court (Pet. App. 1b-27b) is reported at 102 F. Supp. 2d 1115.

JURISDICTION

The judgment of the court of appeals was entered on December 13, 2001. The petition for a writ of certiorari was filed on March 13, 2002. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. The Medicare program was established in 1965 by Title XVIII of the Social Security Act, Pub. L. No. 89-97, 79 Stat. 291. The program provides medical coverage for disabled persons, persons who are at least 65 years old, and persons with end stage renal disease who meet specified eligibility requirements. Those persons are automatically enrolled in Medicare Part A, which pays for hospital and other institutional health care expenses. See 42 U.S.C. 1395 *et seq.*

Persons who are covered by Medicare Part A may purchase supplementary insurance for additional medical services (such as physicians services) under Medicare Part B by paying a monthly premium to the Federal Supplementary Medical Insurance Trust Fund. 42 U.S.C. 1395j to 1395w-4.

Under the traditional fee-for-service payment system, Medicare reimburses a provider for each service rendered. The amount of Medicare reimbursement depends, in part, on the geographic area in which the provider works. See, *e.g.*, 42 U.S.C. 1395w-4(e) (setting out "[g]eographic adjustment factors" for payment for physicians' services). The geographic adjustment factors are intended to reflect geographic variation in the cost of providing services. See, *e.g.*, 42 U.S.C. 1395w-4(e)(1)(A)(i) (requiring the Secretary to establish "an index which reflects the relative costs of the mix of goods and services comprising practice expenses * * * in the different fee schedule areas compared to the national average of such costs").

b. As an alternative to the fee-for-service system, Medicare beneficiaries may instead enroll with a managed care organization (such as an HMO), which enters into a payment contract with Medicare. From 1972

through 1998, such contracts were governed by Section 1876 of the Social Security Act, 42 U.S.C. 1395mm.

Section 1876 provided for two types of contracts, "cost" contracts under which a managed care organization was reimbursed for its reported costs (subject to auditing for reasonableness), and "risk" contracts under which a fixed monthly payment was made by Medicare. See 42 U.S.C. 1395mm(a), (g) and (h); see also 42 C.F.R. 417.530-417.536 (cost contract), 417.580-417.598 (risk contract).

Under a Section 1876 risk contract, the monthly capitation payment was based on an amount referred to as the "adjusted average per capita cost" (AAPCC). 42 U.S.C. 1395mm(a)(4); 42 C.F.R. 417.584. The AAPCC was Medicare's estimate of the average per capita amount it would cost to treat a beneficiary under the fee-for-service system. See 42 U.S.C. 1395mm(a)(4) ("the term 'adjusted average per capita cost' means the average per capita amount that the Secretary estimates in advance (on the basis of actual experience, or retrospective actuarial equivalent based upon an adequate sample and other information and data, in a geographic area served by an eligible organization or in a similar area, with appropriate adjustments to assure actuarial equivalence) would be payable in any contract year for services covered under parts A and B of this subchapter").

Because the AAPCC was intended to approximate the amount that Medicare would pay under the fee-for-service system, the AAPCC (like reimbursement under the fee-for-service system) depended in part on the geographic area in which the managed care organization was located. 42 C.F.R. 417.588(c)(1) ("[The Health Care Financing Administration (HCFA)] makes an adjustment to reflect the relative level of Medicare expendi-

tures for beneficiaries who reside in the [managed care organization's] geographic area (or a similar area). This adjustment is based on reimbursement for Medicare covered services and uses the most accurate and timely data that pertain to the [managed care organization's] geographic area and that is available to [HCFA] when it makes the determination."). The AAPCC also took into account other demographic factors, such as the age, sex and disability status of the managed care organization's enrollees. 42 C.F.R. 417.588(c)(3).

For each Medicare beneficiary enrolled in a managed care organization with a risk contract, Medicare would pay the organization 95% of the AAPCC rate corresponding to the demographic class to which each beneficiary was assigned. 42 U.S.C. 1395mm(a)(1)(C); 42 C.F.R. 417.584(b)(1). If the managed care organization's costs exceeded the Medicare payment, the organization was at risk for the difference. If the Medicare payment exceeded the market cost of the managed care organization's benefits package (adjusted for the demographics of the Medicare population), the organization was required to pass the "savings" along to its enrollees.

Specifically, a managed care organization was required to submit to HCFA its "adjusted community rate" (ACR) for the Medicare package of services. 42 U.S.C. 1395mm(e)(3); 42 C.F.R. 417.594. The ACR represented the organization's commercial premium charge for the Medicare benefits package, adjusted for the higher utilization of services expected from the Medicare population. If the ACR was lower than the Medicare payment, the managed care organization was required to use the difference to provide additional

benefits or reduced premiums or cost-sharing. 42 U.S.C. 1395mm(g)(2).[1]

c. The Balanced Budget Act of 1997 (BBA) provided that Section 1876 risk contracts could not be renewed after January 1, 1999. 42 U.S.C. 1395mm(k)(1)(B) (Supp. V 1999). The Medicare + Choice program replaced the Section 1876 risk contracts, as of that date. 42 U.S.C. 1395w-21 to 1395w-28 (Supp. V 1999).[2]

As relevant here, the Medicare + Choice program altered the formula by which capitation payments for managed care organizations with risk contracts are calculated. 42 U.S.C. 1395w-23(c) (Supp. V 1999). HCFA had observed that the AAPCC "had been legitimately criticized for its wide range of payment rates among geographic regions—in some cases it varied by over 20 percent between adjacent counties." 63 Fed. Reg. 34,968, 35,004 (1998). Congress addressed that concern in the Medicare + Choice program by reducing the extent to which the capitation rate depends upon the managed care organization's geographic area.

Under the Medicare + Choice program, the capitation rate is the greatest of three possible amounts: (1) a "blended" capitation rate (described below); (2) a minimum monthly payment, which in 1998 was $367; or (3) a minimum increase of two percent over the previous year's capitation rate. 42 U.S.C. 1395w-23(c)(1) (Supp. V 1999); 42 C.F.R. 422.252.

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[1] As an alternative, the managed care organization could return the savings to Medicare. 42 U.S.C. 1395mm(g)(2). But as the complaint explains, most managed care organizations opted to pass their savings along to beneficiaries. See Pet. App. 8c.

[2] Existing cost contracts have been allowed to continue. 42 U.S.C. 1395mm(h)(5) (Supp. V 1999).

The blended capitation rate is the sum of a percentage of an area-specific capitation rate that is based on the AAPCC, and a percentage of the national average Medicare capitation rate. 42 U.S.C. 1395w-23(c)(1)(A) (Supp. V 1999). The relative percentages vary over the six-year period in which the blended rate is implemented. 42 U.S.C. 1395w-23(c)(2) (Supp. V 1999). In the year 2000, for example, the area-specific percentage was 74% and the national percentage was 26%. 42 U.S.C. 1395w-23(c)(2)(C) (Supp. V 1999). After the year 2002, the area-specific and the national percentages will be 50% each. 42 U.S.C. 1395w-23(c)(2)(F) (Supp. V 1999). Thus, while the BBA provisions governing the Medicare + Choice program did not abandon the old AAPCC rates entirely, the new rates were designed to narrow, over time, the amount of payment variation across the country.[3]

As under the Section 1876 risk contracts, a managed care organization with a risk contract under the Medicare + Choice program is required to pass any "savings" along to beneficiaries, by providing additional benefits or reductions in enrollee premiums or cost-sharing in an amount equal to the difference between its ACR and the Medicare payment rate. 42 U.S.C. 1395w-24(f)(1) (Supp. V 1999); 42 C.F.R. 422.312.

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[3] The blended rate did not have an immediate impact, because the blended rate is adjusted by a budget neutrality factor designed to ensure that Medicare's aggregate payment under that rate equals the amount that Medicare would have paid under the AAPCC rate alone. 42 U.S.C. 1395w-23(c)(5) (Supp. V 1999). In the years 1998 and 1999, the budget neutrality factor reduced the blended rate to the point where no county's payment rate was based upon the blended rate, because one of the two other rates was higher in every county. 63 Fed. Reg. at 35,005.

2. Petitioner Mary Sarno is a Medicare beneficiary enrolled with a managed care plan under the Medicare + Choice program. The complaint alleges that she would like to move from Broward County, Florida to Minnesota, but that she has not moved because her health care coverage in Minnesota would be far less comprehensive than her coverage in Broward County, and would be insufficient to meet her health care needs. Pet. App. 4c-5c.

The complaint also alleges that the Medicare + Choice formula used for reimbursing managed care organizations with risk contracts does not bear a rational relationship to a legitimate governmental purpose and thus violates the equal protection component of the Fifth Amendment. Pet. App. 16c. The complaint further alleges that the reimbursement formula violates Sarno's constitutional right to travel because the geographic funding disparities it creates have deterred her from moving to Minnesota. *Id.* at 17c.[4]

3. The district court granted the government's motion to dismiss the complaint. Pet. App. 1b-27b. The court held that the Medicare + Choice reimbursement formula is rationally related to Congress's legitimate goals of containing Medicare costs and expanding health care delivery options. *Id.* at 17b. The court explained that the reimbursement formula contains costs by ensuring that Medicare does not pay more to managed care organizations than it pays in the same county under the traditional fee-for-service system. *Ibid.* The court recognized that the reimbursement

[4] The State of Minnesota alleged in district court that the Medicare + Choice reimbursement formula violated Tenth Amendment rights. Pet. App. 13c-16c. The district court rejected that claim, *id.* at 10b-16b, and the State did not appeal, *id.* at 2a.

formula sometimes results in payment rates that vary geographically and that do not precisely reflect a managed care organization's actual costs. *Id.* at 20b. The court explained, however, that those variations are a result of geographic differences in the historical fee-for-service costs. See *ibid.* The court rejected as untenable the suggestion that Congress acted irrationally in relying on those historical numbers as a basis for the reimbursement formula. See *ibid.*

The court likewise rejected the contention that the Medicare + Choice reimbursement formula violates Sarno's constitutional right to travel. The court explained that the right to travel "protects the right of a citizen of one State to enter and to leave another State, the right to be treated as a welcome visitor rather than an unfriendly alien when temporarily present in the second State, and, for those travelers who elect to become permanent residents, the right to be treated like other citizens of that State." Pet. App. 22b (quoting *Saenz* v. *Roe*, 526 U.S. 489, 500 (1999)). The court held that the Medicare + Choice reimbursement formula implicates none of those principles. The court explained that, unlike the durational residency requirement at issue in *Saenz*, the reimbursement formula does not distinguish between long-term and new residents. See *id.* at 24b. The court explained that the second component of the right to travel as articulated in *Saenz* does not apply because Sarno does not seek to be treated as a "welcome visitor" in Minnesota; rather, she seeks to become a permanent resident. *Ibid.* The court explained that the reimbursement formula does not pose an "actual obstacle" to Sarno's right to free interstate movement. *Id.* at 25b. Finally, the court declined "to expand the right to travel to fit this case based on a few citations to inapposite precedents." *Id.* at 26b.

4. The court of appeals affirmed. Pet. App. 1a-9a. The court rejected petitioners' equal protection claim for the reasons given by the district court, observing that it was neither irrational nor arbitrary for Congress to devise a payment formula based on local health care costs and then to encourage cost-efficient managed care providers to increase benefits for their Medicare enrollees. *Id.* at 5a-6a.

The court of appeals also rejected petitioner's right to travel claim, agreeing with the district court that the Medicare + Choice formula implicates none of the concerns identified in *Saenz*. Pet. App. 7a. The court rejected the contention that a federal program that fails to achieve national uniformity in the distribution of government benefits should be subject to strict scrutiny simply because the disuniformity may deter persons from moving from some States to others. *Id.* at 8a. The court noted that petitioners' theory would call into question a wide range of federal programs, including the Medicaid program, the Temporary Assistance to Needy Families (TANF) program, and numerous agricultural subsidies, all of which provide different benefit levels based upon regional price conditions. *Id.* at 8a n.4.

ARGUMENT

The decision below is correct and does not conflict with a decision from any other court of appeals. The petition should therefore be denied.

1. Petitioners have abandoned their equal protection challenge to the Medicare + Choice formula, implicitly recognizing that the formula rationally serves Congress's goals of containing Medicare costs while expanding health care delivery options. Although petitioners press their right to travel claim, they do not

suggest that the Medicare + Choice formula implicates the concerns identified in *Saenz*.

Instead, petitioners urge (Pet. 11) that the right to travel should be expanded to require strict scrutiny of any federal program that discourages interstate migration. Petitioners rely on dicta from the plurality opinion in *Attorney General of New York* v. *Soto-Lopez*, 476 U.S. 898, 903 (1986), that stated that a law "implicates the right to travel when it actually deters such travel." Like the California law at issue in *Saenz*, however, the New York law at issue in *Soto-Lopez* implicated right to travel principles because it distinguished between two classes of state residents. The New York law gave civil service preference to residents whose military service post-dated their move to New York but denied such a preference to residents whose military service pre-dated their move to New York. The *Soto-Lopez* decision thus provides no support for the unprecedented expansion of right to travel principles that petitioners propose, an expansion that would call into question numerous federal programs. See Pet. App. 8a; see also *Saenz*, 526 U.S. at 493 (recognizing that the TANF program produces significant geographic variations in benefits, without suggesting that those variations implicate the right to travel).

2. Petitioners also argue (Pet. 11-15) that certiorari should be granted to resolve whether the right to travel equally applies to state and federal laws. The court of appeals, however, did not hold that the right to travel does not apply to federal laws. Rather the court of appeals rejected as "clearly too broad" petitioners' argument "that a federal program that fails to achieve nationwide uniformity in the distribution of government benefits is subject to strict scrutiny because it will deter travel to unfavored locales." Pet. App. 8a.

Petitioners cite no decision adopting such an expansive view of the right to travel, and we are not aware of any. It would, for example, be wholly implausible for petitioners to suggests that the States are constitutionally required to provide their residents with all categories of benefits that any sister State chooses to provide to its residents, let alone that the benefits must be provided to an identical degree.[5]

Petitioners are also incorrect in suggesting (Pet. 13-15) that the decision below conflicts with *Bethesda Lutheran Homes & Services, Inc.* v. *Leean*, 122 F.3d 443 (7th Cir. 1997). The court in *Bethesda Lutheran* invalidated a Wisconsin law and federal Medicaid regulations because those provisions prevented mentally incompetent persons from becoming Wisconsin residents and receiving any benefits under Medicaid. See *id.* at 448. Petitioners do not allege that the Medicare + Choice formula prevents Sarno from becoming a Minnesota resident or obtaining Medicare benefits; they assert only that differential Medicare benefits makes Minnesota residency less attractive to her. The courts below correctly found no unconstitutional infirmity in that result, and further review by this Court is unwarranted.[6]

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[5] Petitioners therefore err in suggesting (Pet. 16-20) that this Court should grant review in order to consider the source and contours of the right to travel.

[6] Because petitioners do not state a cognizable constitutional claim, they are further incorrect in arguing (Pet. 21-22) that they should be afforded an opportunity to take discovery to adduce proof that the challenged Medicare provisions deter interstate relocation.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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