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**UNITED STATES DISTRICT COURT
CENTRAL DISTRICT OF CALIFORNIA**

UNITED STATES OF AMERICA
ex rel. BENJAMIN POEHLING,

Plaintiff,

v.

UNITEDHEALTH GROUP, INC.
et al.,

Defendants.

Case No.: 2:16-cv-08697-FMO-PVCx

Assigned to Hon. Fernando M. Olguin

**NOTICE OF MOTION AND
MOTION BY CERTAIN MEMBERS
OF CONGRESS FOR LEAVE TO
FILE *AMICUS CURIAE* BRIEF IN
SUPPORT OF PLAINTIFF'S
MOTION FOR REVIEW OF
SPECIAL MASTER'S REPORT AND
RECOMMENDATION**

(Related to ECF Nos. 631, 636, 638)

Date: June 5, 2025

Time: 10:00 a.m.

Courtroom: 6D

350 W. First Street St.
Los Angeles, CA 90012

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TO ALL PARTIES AND THEIR ATTORNEYS OF RECORD:

PLEASE TAKE NOTICE that on or before the scheduled hearing in the above-captioned matter, on June 5, 2025, at 10:00 a.m., before the Honorable Fernando M. Olguin, in Courtroom 6D, located at 350 W. First Street, Los Angeles, California 90012, *Amici Curiae* Members of Congress will, and hereby do, move this Court for leave to file an *amicus curiae* brief in response to the Special Master's Report and Recommendation regarding Defendant UnitedHealth Group's ("United") motion for summary judgment and Plaintiff United States of America *ex rel.* Benjamin Poehling's ("Plaintiff") cross motion for summary judgment (ECF 631), and in support of Plaintiff's motion for review of Special Master's Report and Recommendation (ECF 636) and in response to United's opposition to the motion (ECF 638), which are scheduled to be heard at the above-referenced date, time, and location.

This motion is made following the conference of counsel for all parties to the litigation and for *amici curiae*, which took place pursuant to Local Rule 7-3, on May 9, 12 and 13, 2025. Counsel for *amici curiae* contacted counsel for the parties and proposed a stipulation for leave to file their brief and followed up with email correspondence setting forth *amici curiae*'s interest in the litigation and why their brief would be desirable and relevant to the disposition of the litigation. Counsel for *amici curiae* was unable to reach a stipulation prior to filing this motion.

Amici curiae are Members of Congress who are responsible for creating and maintaining the Medicare program through legislation, funding, and oversight, including ensuring its long-term solvency. With Congress focused on eliminating waste, fraud, and abuse, as well as ensuring the health and safety of American seniors who are paying for United's Medicare Advantage ("MA") plans, they have an interest in this litigation because United maintains a dominant share of the MA market and the MA program's ever-increasing cost poses an existential threat to the solvency of the Medicare program and increases the cost to all Medicare beneficiaries.

1 *Amici curiae's* brief would be desirable to the Court and relevant to the
2 disposition of the case. The Medicare Payment Advisory Commission ("MedPAC")
3 provides an annual status report to Congress on the MA program. The most recent
4 report highlights the exponential growth of the MA program and the higher payments
5 to MA plans, and it underscores the need for reforms to ensure fiscal sustainability
6 and equitable payment policies. The higher payments to MA plans increase Medicare
7 spending and Part B premiums for all beneficiaries, including those in traditional fee-
8 for-service ("FFS") Medicare. MedPAC estimates that MA plans will be *overpaid* by
9 \$1.2 trillion between 2025-2034, with \$520 billion coming from the Medicare
10 Hospital Insurance trust that funds Medicare Part A. The two largest factors
11 responsible for higher payments to plans in recent years are favorable selection and
12 coding intensity, both of which are at issue in this case, as explained in *amici curiae's*
13 brief.

14 United is the nation's largest insurer of MA plans, with 28% market share
15 nationally and 42% market share in metropolitan statistical areas ("MSAs"). United's
16 risk factor is 70% higher than the rest of the MA industry average, and its members'
17 sickness scores on average increased 55% in their first year in MA plans, which far
18 outpaced the 7% year-over-year rise in the sickness scores of patients who stayed in
19 traditional FFS Medicare. These risk factors and sickness scores are driven by the *post*
20 *hoc* diagnoses of United's coders, and have resulted in tens of billions of dollars in
21 additional MA payments to United. These overpayments not only affect the federal
22 budget, but they also affect the premiums paid by Medicare beneficiaries and the
23 solvency of a key funding source—the Medicare Hospital Insurance trust fund.
24 Accepting the Special Master's R&R would set a negative precedent and further
25 embolden United in its fraudulent upcoding practices

26 This motion is based on the below memorandum of points and authorities, the
27 proposed *amicus curiae* brief attached hereto, the pleadings and papers on file in this
28 action, and upon such other and further matters as the Court may deem appropriate.

MEMORANDUM OF POINTS AND AUTHORITIES

I. This Court Has Discretionary Authority to Permit Amicus Curiae Briefs

Federal district courts have broad discretion to allow parties to participate in lawsuits as *amici curiae*. See *Hoptowit v. Ray*, 682 F.2d 1237, 1260 (9th Cir. 1982), *overruled on other grounds by Sandin v. Conner*, 515 U.S. 472 (1995). Based on this broad discretion, federal district courts liberally allow parties to participate as *amici curiae*. See, e.g., *Stoyas v. Toshiba Corp.*, No. 15-CV-4194 DDP (JCX), 2021 WL 2315200, at *1 (C.D. Cal. June 7, 2021) (“[I]t is preferable to err on the side of permitting such [amicus] briefs ... [i]f an amicus brief that turns out to be unhelpful is filed, the [Court] . . . can then simply disregard the brief. On the other hand, if a good brief is rejected, the [Court] will be deprived of a resource that might have been of assistance.”); see also *Levin Richmond Terminal Corp. v. City of Richmond*, 482 F. Supp. 3d 944, 951 n.1 (N.D. Cal. 2020) (holding that district courts have broad discretion to appoint *amici curiae*, and accordingly granting non-parties’ motions for leave to file *amici curiae* briefs during a motion to dismiss proceeding).

“‘An *amicus* brief should normally be allowed’ when, among other considerations, ‘the *amicus* has unique information or perspective that can help the court beyond the help that the lawyers for the parties are able to provide.’” *Re2con, LLC v. Telfer Oil Co.*, No. 2:10-cv-00786-KJM-KJN, 2012 WL 6570902 at *1 (E.D. Cal. Dec. 17, 2012) (quoting *Cnty. Ass’n for Restoration of Env’t (CARE) v. DeRuyter Bros. Dairy*, 54 F. Supp. 2d 974, 975 (E. D. Wash. 1999)); *In re Roxford Foods Litig.*, 790 F. Supp. 987, 997 (E.D. Cal. 1991) (“[A]n individual seeking to appear as *amicus* must merely make a showing that his participation is useful to or otherwise desirable to the court.”) (quoting *United States v. Louisiana*, 751 F. Supp. 608, 620 (E.D. La. 1990)). Here *amici curiae* fulfill the “classic role” of an *amicus curiae* to “assist[] in a case of general public interest, supplementing the efforts of counsel, and drawing the court’s attention to law that escaped consideration.” *Miller-Whol Co., Inc. v. Comm’r of Labor and Indus. State of Mont.*, 694 F.2d 203, 204 (9th

1 Cir. 1982).

2 Though there is no rule for the filing of *amicus* briefs in the district court, the
3 court may look to Federal Rule of Appellate Procedure 29 for guidance. Rule 29
4 provides that an officer of the United States, like the *amici curiae* Members of
5 Congress, may file an *amicus curiae* brief without leave of court or the need for a
6 stipulation by all parties to the litigation. Fed. R. App. P. 29(a)(2). Rule 29 also allows
7 the Court to specify a later timeline for filing and to provide time for an opposing
8 party to answer. *Id.* at 29(a)(6). As provided in Rule 29, *amici curiae*’s proposed brief
9 explains “the movant’s interest” in the case, and explains “the reason why an *amicus*
10 brief is desirable and why the matters asserted are relevant to the disposition of the
11 case.” *Id.* at 29(a)(3).

12 **II. Summary of Proposed Brief**

13 The Court should allow this case to proceed to jury trial in a public courtroom.
14 Plaintiff has presented ample evidence for the Court to find a triable issue of material
15 fact to mandate denial of United’s motion and to warrant a jury trial on the merits.

16 In corporate settings far removed from any healthcare facility and completely
17 untethered to the care actually rendered to any patient, MA insurers like United review
18 medical charts and *upcode* the medical diagnoses first issued by the healthcare
19 providers actually treating the patient.¹ Significantly, the patient receives no extra
20 care, treatment, or benefit of any kind from United’s chart review or its *post-hoc*

21
22
23 ¹ The irony that United engages in this practice when payment flows from the federal government’s
24 coffers to United on healthcare claims is as thick as United’s expert coder’s audit file. In the private
25 payor space when United is paying healthcare claims, United calls this practice fraud because that
26 is exactly what it is. See, e.g., Paige Minemyer, *UnitedHealth lawsuit claims TeamHealth upcoded*
27 *claims for \$100M in fraud*, [https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-](https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-teamhealth-upcoded-claims-for-100m-fraud)
28 [teamhealth-upcoded-claims-for-100m-fraud](https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-teamhealth-upcoded-claims-for-100m-fraud) (Oct. 28, 2021) (“The suit . . . claims the company
purposefully upcoded for tens, if not hundreds, of thousands of medical claims.”). In fact, when it
is United’s money at issue—as opposed to the money of the federal government and the American
taxpayer—United has lambasted this exact same practice it admits to engaging in. *Id.* (“It is
TeamHealth’s coders who decide which codes to utilize, applying TeamHealth’s policies. It is
TeamHealth that submits claims to insurance companies . . . And it is TeamHealth—not the medical
groups or the doctors or other providers—that keeps the profits from its fraudulent billing.”).

1 manipulation of the patient's diagnoses. Yet United engages in this practice for one
2 very simple and nefarious reason: to receive higher payments from the federal
3 government. Indeed, an OIG Report found that 20 of 162 MA insurers derived \$9.2
4 billion in payments from diagnoses identified during chart reviews. Proposed
5 legislation is pending to bar CMS from using diagnoses collected from chart reviews
6 to adjust MA payments.

7 Here, the record demonstrates that United's own expert coders reviewed
8 medical records and *did not find support for 1.97 million diagnosis codes that United*
9 *submitted to CMS for payment.* (ECF 636 at 15-17.) That evidence alone should have
10 ended the inquiry. But the Special Master seems to have been persuaded by United's
11 curious and self-inflicted attack on the credibility of their own expert coders' audits.
12 (*Id.* at 17-18.) The conclusions of United's *own coders* constitutes credible evidence
13 that should be considered and weighed by a jury. Indeed, this type of evidence-
14 weighing should be deferred to trial and play no role in summary judgment. It appears,
15 however, that the Special Master undertook weighing of the evidence when it was in
16 conflict, rather than ending the inquiry, finding a triable issue of material fact, and
17 denying United's motion. (*Id.* at 18-20.)

18 Setting aside that United's internal analysis found that it was submitting
19 unsubstantiated diagnosis codes and claims for payment to CMS, it is vital to
20 understand the widespread impact of United's leeching of the MA program. As noted
21 above, MedPAC's report to Congress highlights the exponential growth of the MA
22 program and the higher payments to MA plans, which increases Medicare spending
23 and Part B premiums for all beneficiaries, including those in traditional FFS
24 Medicare. According to MedPAC's report, the two largest factors responsible for
25 higher payments to plans in recent years are favorable selection and coding intensity,
26 both of which are at issue in this case and both drive the fraud, waste and abuse in the
27 MA program.

28 United is the nation's largest insurer of MA plans. Its risk factor scores and the

sickness scores of its members are not only higher than the MA industry average, but they far outpace the year-over-year rise in the sickness scores of patients who stayed in traditional FFS Medicare. These scores are driven by the diagnoses identified by United's Monday morning quarterbacking coders, not by any healthcare professional actually treating a member. This results in tens of billions of dollars in additional MA payments to United. These overpayments not only affect the federal budget, but they also affect the premiums paid by Medicare beneficiaries and the solvency of a key funding source—the Medicare Hospital Insurance trust fund. Accepting the Special Master's Report and Recommendation would set a negative precedent and further embolden United in its fraudulent upcoding practices.

Despite receiving billions of dollars in additional payments, MA insurers like United refuse to provide their enrollees with access to quality care and limit their access to high-rated hospitals and facilities. United invests its ill-gotten gains in technology such as AI to deny post-acute care requests, harming elderly enrollees, and United now faces litigation for AI-driven denials of post-acute care. United's fraudulent upcoding has resulted in severe overpayments of millions of federal dollars to United with no added benefit to its Medicare beneficiaries.

III. Conclusion

The *amici curiae* request that the Court reject the Special Master's Report and Recommendation, deny United's motion for summary judgment, and allow the case to proceed to jury trial. The MA program needs reforms to ensure the fiscal sustainability of the Medicare program and to address fraud, waste, and abuse by corporate health insurers. But that reform can start internally at United when it is held to account for the largescale fraud it has committed against CMS. United's dominant market share and its adept exploitation of the MA program through its unscrupulous practices harm American seniors and taxpayers while United steals money on inflated claims it submits to CMS. The *amici curiae* urge the Court to allow the case to proceed to jury trial to address these issues in a public courtroom, with all of the evidence

1 before the jury to analyze and render a verdict.

2 Date: May 15, 2025

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3
4 By: /s/ Richard T. Collins
5 Richard T. Collins
6 Attorneys for *Amici Curiae*
7 Members of Congress
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UNITED STATES OF AMERICA
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Defendants.

Case No.: 2:16-cv-08697-FMO-PVC

Assigned to Hon. Fernando M. Olguin

**PROPOSED AMICI CURIAE BRIEF
OF CERTAIN MEMBERS OF
CONGRESS IN OPPOSITION TO
THE SPECIAL MASTER'S REPORT
AND RECOMMENDATION
REGARDING MOTION FOR
SUMMARY JUDGMENT AND
MOTION FOR PARTIAL
SUMMARY JUDGMENT**

(Related to ECF Nos. 631, 636, 638)

Date: June 5, 2025

Time: 10:00 a.m.

Courtroom: 6D

350 W. First Street St.
Los Angeles, CA 90012

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STATEMENT OF INTEREST

Certain Members of Congress¹ hereby submit this *Amici Curiae* brief in response to the Special Master's Report and Recommendation ("R&R"), in opposition to Defendant UnitedHealth Group's ("United") motion for summary judgment, and in support of Plaintiff's motion for review of the R&R (ECF 636). *Amici curiae* are responsible for creating and maintaining the Medicare program, including the Medicare Advantage ("MA") program, through legislation, funding, and oversight, including ensuring its long-term solvency.

Amici curiae represent the elderly and the disabled with respect to legislation that ensures an expedient and cost-effective healthcare system. The issues underpinning this case could have a significant impact on the fiscal sustainability of Medicare, the American taxpayers, and vulnerable populations in need of proper medical care. With Congress focused on protecting American taxpayers from fraud, waste and abuse, as well as ensuring the health and safety of American seniors who are paying for United's MA plans, *amici curiae* have an interest in this litigation. United maintains a dominant share of the MA market, and the MA program's ever-increasing cost poses an existential threat to the solvency of the Medicare program. United's practices increase the cost to all Medicare beneficiaries. *Amici curiae*'s brief would be desirable to the Court and relevant to the disposition of the case.

MEMORANDUM OF POINTS AND AUTHORITIES

I. INTRODUCTION

This case presents an irony that would leave Shakespeare envious. In the private payor space, when United's money is at stake to pay healthcare claims, United questions the diagnoses, the medical necessity of treatment, and scrutinizes

¹ Yassamin Ansari, Becca Balint, Greg Casar, Steve Cohen, Valerie Foushee, Sylvia Garcia, Jesús G. "Chuy" García, Maggie Goodlander, Val Hoyle, Glenn Ivey, Pramila Jayapal, Henry C. "Hank" Johnson, Jr., Sydney Kamlager-Dove, Ro Khanna, James P. McGovern, LaMonica McIver, Eleanor Holmes Norton, Ilhan Omar, Chellie Pingree, Delia Ramirez, Jan Schakowsky, Mark Takano, Rashida Tlaib, Jil Tokuda, Derek Tran, Nydia M. Velázquez, Bonnie Watson Coleman, Nikema Williams

1 each jot and tittle on the claim forms submitted by healthcare providers, resulting
2 in underpayments and claim denials. Of course, those healthcare providers actually
3 know and care for their patients because they have treated them. And those same
4 providers must verify that all codes are accounted for and properly submitted on a
5 claim form to have a hope of receiving fair reimbursement. When professional
6 medical coders assist in that process, United cries “fraud,” accuses the healthcare
7 provider of upcoding and submitting fraudulent claims for payment, and then puts
8 its own expert coders to work to scour claim forms to back up its allegations.²

9 Yet, when United is not footing the bill to reimburse healthcare providers for
10 treatment rendered but instead stands to be *paid* by the federal government for
11 treatment rendered, such as in its role as a participant in the MA program, United
12 takes an entirely different tack. It deploys its expert coders to “find” diagnoses that
13 the trained healthcare providers simply “missed.” United then uses those diagnoses
14 to deliberately bloat the claims it submits for reimbursement through the MA
15 program. To be clear, the patients receive no additional care, no additional
16 treatment, and patient outcomes fare no better when United upcodes these claims.
17 The physician is not consulted about allegedly mis-diagnosing its patient, and
18 quality of care does not improve or change one bit. Rather, United upcodes these
19 claims solely to inflate its receivables from CMS’s coffers.

20 The Court should allow this case to proceed to jury trial in a public
21 courtroom. United’s practice of having its coders review patient charts in search of
22 diagnoses to bill should not be conducted under cover of darkness, but should be

23 ² See, e.g., *United Healthcare Services, Inc. v. Team Health Holdings, Inc.*, Case No. 3:21-cv-
24 00364, ECF No. 1 at ¶ 1 (E.D. Tenn., filed Oct. 27, 2021) (“Since at least 2016, TeamHealth has
25 covertly and methodically engaged in a classic form of healthcare fraud called upcoding. Upcoding
26 occurs when a healthcare provider submits a claim to an insurer or claim administrator utilizing a
27 [CPT] code that misrepresents the services provided, thus using the code to deceive the insurer or
28 claim administrator into overpaying. Here, TeamHealth has deliberate upcoded tens, if not hundreds,
of thousands of claims to the United Plaintiffs . . . resulting in United Plaintiffs overpaying
TeamHealth by more than one hundred million dollars.”); Paige Minemyer, *UnitedHealth lawsuit
claims TeamHealth upcoded claims for \$100M in fraud*, at
[https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-teamhealth-upcoded-claims-
for-100m-fraud](https://www.fiercehealthcare.com/payer/unitedhealth-lawsuit-claims-teamhealth-upcoded-claims-for-100m-fraud) (Oct. 28, 2021).

1 explained and scrutinized in the light of a federal courtroom. Plaintiff has presented
2 ample evidence for the Court to find a triable issue of material fact and deny
3 United's motion in favor of a jury trial on the merits. Indeed, the record
4 demonstrates that United's own expert coders reviewed medical records and *did*
5 *not find support for 1.97 million diagnosis codes* that United submitted to CMS for
6 payment. (ECF 636 at 15-17.) But the Special Master seems to have been persuaded
7 by United's curious attack on the credibility of its own audits. (*Id.* at 17-18.) The
8 conclusions of United's coders, however, are credible pieces of evidence that
9 should be considered and weighed by a jury, not by the Special Master on summary
10 judgment. Yet, it appears the Special Master weighed the evidence when it was in
11 conflict, rather than ending the inquiry, finding a triable issue of material fact, and
12 denying United's motion. (*Id.* at 18-20.)

13 The Medicare Payment Advisory Commission ("MedPAC") annually
14 reports to Congress on the MA program. The most recent report highlights the
15 program's exponential growth and higher payments to MA plans, while
16 underscoring the need for reforms for fiscal sustainability and equitable payment
17 policies.³ Higher payments to MA plans increase Medicare spending and Part B
18 premiums for all beneficiaries, including those in traditional fee-for-service
19 ("FFS") Medicare. MedPAC estimates MA plans will be *overpaid* by \$1.2 trillion
20 between 2025-2034, with \$520 billion paid by the Medicare Hospital Insurance
21 trust that funds Medicare Part A. According to the report, these higher payments to
22 plans are largely due to favorable selection and coding intensity, both of which are
23 at issue in this case and both drive the fraud, waste and abuse in the MA program.

24 United is the nation's largest insurer of MA plans, with 28% market share
25 nationally and 42% market share in metropolitan statistical areas ("MSAs").
26 United's risk factor is 70% higher than the rest of the MA industry average, and its

27 ³ MedPAC, Executive Summary, Report to the Congress, *Medicare Payment Policy*, (March 2025)
28 at xiii, at <https://www.medpac.gov/document/march-2025-report-to-the-congress-medicare-payment-policy/> (hereinafter "MedPAC Report").

members’ sickness scores on average increased 55% in their first year in MA plans, which far outpaced the 7% year-over-year rise in the sickness scores of patients who stayed in traditional FFS Medicare. These risk factors and sickness scores are driven by the *post hoc* diagnoses of United’s coders, and have resulted in tens of billions of dollars in additional MA payments to United. These overpayments not only affect the federal budget, but they also affect the premiums paid by Medicare beneficiaries and the solvency of a key funding source—the Medicare Hospital Insurance trust fund. Accepting the Special Master’s R&R would set a negative precedent and further embolden United in its fraudulent upcoding practices.

II. ARGUMENT

A. Fraud, Waste, and Abuse Threaten the Fiscal Sustainability of the Medicare Program

1. MA Has Failed to Achieve Its Initial Aims Despite Costs Growing Exponentially Compared to Traditional Medicare

The MA Program was supposed to decrease costs and increase access to healthcare for elderly and disabled Americans, while simultaneously adding efficiency to the healthcare system. Corporate health insurers like United have guaranteed MA’s failure by wringing the program dry with their insatiable appetite for profit. MedPAC’s report notes that the goal for MA was to expand access to high-quality care and ensure the MA program “obtains good value for its expenditures.”⁴ In reality, however, the growing costs of the MA program threaten the viability of the Medicare program as a whole and the solvency of the Medicare Trust Funds.⁵ Notably, MA has not “delivere[d] savings since its inception.”⁶

⁴ *Id.*

⁵ See Ltr. from U.S. Rep. P. Jayapal *et al.* to CMS (March 27, 2025), at 1 (hereinafter, “Jayapal Ltr.”), at <https://jayapal.house.gov/wp-content/uploads/2025/03/25.03.27-2025-Letter-to-CMS-HHS-on-Medicare-Advantage-Final.pdf>.

⁶ See Ltr. from Sen. E. Warren and U.S. Rep. P. Jayapal to CMS, at 1 (Jan. 25, 2025) (“Warren Ltr.”), at <https://www.warren.senate.gov/imo/media/doc/2024.01.25%20Letter%20to%20CMS%20on%20Medicare%20Advantage%20overpayments.pdf>.

1 MedPAC estimates that this year alone, the Medicare program “will spend 20
2 percent more for MA enrollees than it would spend if those beneficiaries were
3 enrolled in FFS Medicare, a difference that translates into *a projected \$84 billion*.”⁷

4 Despite the increase in government spending for the MA program, there is
5 little evidence to suggest that the program has increased access to quality care or
6 efficiency in the healthcare system. In fact, MA plans offer lower quality networks
7 and less access to care—leading to higher mortality rates in some circumstances.⁸
8 MA enrollment has increased two-fold since 2010, and in 2024, 54% of eligible
9 Medicare beneficiaries enrolled in MA.⁹ Giving the increasing enrollment
10 numbers, costs, and lack of increased positive health outcomes associated with MA,
11 it is imperative to enforce laws that will help protect the overall solvency of the
12 Medicare program, which is expected to run a deficit beginning in 2029,¹⁰ and to
13 achieve the purposes underpinning the creation of the MA program.

14 **2. The MA Program Is Rampant with Fraud, Waste, and Abuse**

15 Private insurers’ administration of Medicare threatens the purpose behind the
16 MA program, expands the privatization of healthcare, and incentivizes fraud,
17 waste, and abuse. Government administered medical care was intended for the
18 benefit of the American people and not for the benefit of corporate insurers that
19 collect and retain overpayments derived from fraudulent practices—often through
20 submitting unsupported diagnostic data (“upcoding”) to the tune of billions of
21 dollars per year.¹¹ Over the course of the next 10 years, overpayments to insurers
22 are estimated to rise to *\$1.2 trillion*.¹² These are staggering amounts, all of which
23 should be spent improving the American healthcare system, not lining corporate

24 ⁷ MedPAC Report, *The Medicare Advantage Program: Status Report*, Ch. 11, at 320, at
25 [https://www.medpac.gov/wp-](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf)
26 [content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf](https://www.medpac.gov/wp-content/uploads/2025/03/Mar25_Ch11_MedPAC_Report_To_Congress_SEC.pdf).

27 ⁸ Warren Ltr. at 7.

28 ⁹ MedPAC Report, *The Medicare Advantage Program: Status Report*, Ch. 11, at 330.

¹⁰ Jayapal Ltr. at 2.

¹¹ MedPAC Report, *The Medicare Advantage Program: Status Report*, Ch. 11, at 331.

¹² See Committee for a Responsible Budget, *Medicare Advantage Will Be Overpaid by \$1.2 Trillion*
(March 26, 2025), at <https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion>.

1 health insurers' pockets.

2 MA insurers primarily engage in fraud and abuse by taking advantage of the
3 MA risk assessment process and by upcoding diagnoses so they can receive
4 exorbitant MA payments. Consistent with the evidence from United's coders, MA
5 insurers perform a diagnostic chart review process in which they identify diagnoses
6 that a healthcare provider never submitted.¹³ When United "adds on" these
7 diagnoses, it does so solely to leech more money from the government. No
8 additional treatment or healthcare services are provided to the patient. Thus, United
9 systematically submits claims for payment to the government for services that were
10 not rendered in violation of the False Claims Act ("FCA").

11 As the U.S. Office of Inspector General (OIG) noted in a 2021 Report, the
12 "risk adjust[ed] payments by using beneficiaries' diagnoses to pay higher capitated
13 payments . . . may create financial incentives for MA companies to make
14 beneficiaries appear as sick as possible."¹⁴ The same report found that 20 of the 162
15 MA insurers in existence at the time derived \$9.2 billion in payments from
16 diagnoses identified during the *post hoc* chart review process.¹⁵ A more recent
17 article by the Committee for a Responsible Federal Budget projected insolvency of
18 the Medicare Hospital Insurance trust fund's by 2036, and encouraged lawmakers
19 to reform MA, reduce overpayments to private insurers, and "reduce overall waste
20 and abuse in the program."¹⁶

21 U.S. Legislators are also actively weighing in on insurers' fraudulent
22 upcoding practices. A recent bill introduced in the Senate, the "No Unreasonable
23 Payments, Coding, Or Diagnoses for the Elderly Act or the No UPCODE Act,"
24

25 ¹³ Office of Inspector General, *Some Medicare Advantage Companies Leveraged Chart Reviews*
26 *and Health Risk Assessments to Disproportionately Drive Payments*, OEI-03-17-00474 (Sept.
2021), at <https://oig.hhs.gov/oei/reports/OEI-03-17-00474.pdf> (hereinafter, "OIG Report").

26 ¹⁴ *Id.*

27 ¹⁵ *Id.*

28 ¹⁶ Committee for a Responsible Federal Budget, *Medicare Advantage Will Be Overpaid by \$1.2*
Trillion (Mar. 26, 2025), at <https://www.crfb.org/blogs/medicare-advantage-will-be-overpaid-12-trillion>.

1 would bar CMS from using diagnoses collected from chart reviews to adjust
2 payments, and would require CMS to account for differences in coding patterns
3 between MA and traditional Medicare when determining payment adjustments.¹⁷
4 As certain Members of Congress have consistently noted to CMS, these wasteful
5 practices are jeopardizing Medicare as a whole and must be addressed for the
6 program to remain viable.¹⁸

7 **B. MA Insurers' Abuse Harms American Seniors and Taxpayers**

8 MA insurers' fraud and abuse cannot be understated. Its impact is deep and
9 wide and borne by American taxpayers and American seniors. MA overpayments
10 are entirely "financed by the taxpayers and beneficiaries who fund the Medicare
11 program."¹⁹ MedPAC "estimates that Part B premium payments will be about \$13
12 billion higher in 2025 because of higher Medicare payments to MA plans
13 (equivalent to roughly \$198 per beneficiary per year)."²⁰ Astonishingly, even with
14 this sheer volume of taxpayer money flowing into the insurance ecosystem, the
15 Commonwealth Fund's 2024 Biennial Health Insurance Survey found that 23% of
16 U.S. working-age adults were "underinsured, meaning they had coverage for a full
17 year that didn't provide them with affordable access to healthcare."²¹

18 Overpayments and a crippling financial burden aren't the end of the story for
19 the American taxpayers and seniors. There is no upside, no return on their massive
20 investment. MA insurers do not provide their enrollees access to high-quality
21 hospitals, healthcare providers, facilities, networks, and necessary treatments for
22 complicated diagnoses (*e.g.*, rare cancers).²² A comprehensive report by the Kaiser
23 Family Foundation in 2022 details where the MA program performs worse than

24 ¹⁷ See S.1105 — 119th Congress (2025-2026), No UPCODE Act, Introduced March 25, 2025, at
25 <https://www.congress.gov/bill/119th-congress/senate-bill/1105/text>.

26 ¹⁸ See Warren Ltr.; Jayapal Ltr.

27 ¹⁹ MedPAC Report, *The Medicare Advantage Program: Status Report*, Ch. 11, at 321.

28 ²⁰ *Id.* at 331.

²¹ The Commonwealth Fund, *The State of Health Insurance Coverage in the U.S.* (Nov. 21, 2024),
at <https://www.commonwealthfund.org/publications/surveys/2024/nov/state-health-insurance-coverage-us-2024-biennial-survey>.

²² Warren Ltr. at 7.

1 traditional Medicare, and indicates that MA enrollees receive less high-quality care
2 and access to the highest-rated hospitals for cancer care, skilled nursing facilities,
3 and home health agencies.²³

4 The inability to access care has caused some of the most sick and vulnerable
5 Americans to disenroll from the MA program.²⁴ For example, enrollees with
6 Alzheimer’s disease and dementia have “consistently higher rates of contract exit
7 and switch to traditional Medicare” compared to other beneficiaries.²⁵ Further,
8 according to an analysis conducted by the Wall Street Journal under a research
9 agreement with the federal government and the review of a vast number of available
10 medical records, United enrollees were 15 times more likely to have been
11 diagnosed with diabetic cataracts—a *rare* diagnosis that *increases* the base pay rate
12 per member significantly—than the average patient in the traditional Medicare
13 program.²⁶ As early as 2017, the Government Accountability Office urged CMS to
14 use data on disenrollment and health status to inform its oversight of the MA
15 program, noting that its MA survey data indicated that those in poor health
16 “reported problems with coverage of preferred doctors and hospitals as well as
17 problems getting access to care as leading reasons they chose to leave their
18

19 ²³ “Five of six studies . . . that looked at quality ratings of health care facilities and providers used
20 by [MA] enrollees and traditional Medicare beneficiaries found that [MA] enrollees were less likely
21 than traditional Medicare beneficiaries to receive care in the highest- or lowest-rated hospitals
22 overall or in the highest-rated hospitals for cancer care, skilled nursing facilities (SNFs), and home
23 health agencies.” Nancy Ochieng & Jeannie Fuglesten Biniek, *Beneficiary Experience, Affordability, Utilization, and Quality in Medicare Advantage and Traditional Medicare: A Review of the Literature*, Kaiser Family Found. (Sep. 16, 2022), at <https://www.kff.org/medicare/report/beneficiary-experience-affordability-utilization-and-quality-in-medicare-advantage-and-traditional-medicare-a-review-of-the-literature/>.

24 Hannah O. James, MS *et al.*, Medicare Advantage Enrollment and Disenrollment Among Persons With Alzheimer Disease and Related Dementias, *JAMA Health Forum* (Sep. 15, 2023) at 8, at <https://jamanetwork.com/journals/jama-health-forum/fullarticle/2809665#249242500>.

25 ²⁵ *Id.*

26 ²⁶ “Some diagnoses claimed by insurers were demonstrably false, the Journal found, because the conditions already had been cured. More than 66,000 Medicare Advantage patients were diagnosed with diabetic cataracts even though they already had gotten cataract surgery, which replaces the damaged lens of an eye with a plastic insert.” Christopher Weaver, *et al.*, *Insurers Pocketed \$50 Billion From Medicare for Diseases No Doctor Treated*, *WALL ST. J.*, July 8, 2024, at <https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d>.

contracts.”²⁷ Additionally, MA insurers have recently leveraged artificial intelligence tools to make consequential coverage decisions in an arbitrary manner on behalf of enrollees, denying necessary care to elderly and gravely ill individuals in dire medical circumstances, including those who have experienced stroke, cancer, or who seek end of life care.²⁸

Corporate health insurers’ abuses have derailed the MA program from its dual aims of “sav[ing] taxpayer dollars and improv[ing] quality of care.”²⁹ American taxpayers are stuck footing the bill and vulnerable individuals have gone without necessary care. Private MA insurers increasingly take advantage of a system that incentivizes them to make their enrollees look as sick as possible,³⁰ while simultaneously refusing to provide proper coverage for treatment and care of enrollees who desperately need it. Because MA payments are linked to a risk assessment model, which insurers like United have taken advantage of using strategic upcoding tactics, the MA program has resulted in unintended harm to the very individuals it was designed to benefit.

C. United Poses an Existential Threat to Medicare

1. United Imposes the Heaviest Burden on Medicare

United’s disproportionate size imposes the heaviest burden on the Medicare Program. United is the world’s most egregious upcoder and chief among the private MA insurers employing fraudulent and abusive tactics to retain funds that rightfully belong either in the Medicare Trust Funds or in the hands of the American taxpayers. United reported over \$400 billion in revenues during 2024—an 8%

²⁷ U.S. Government Accountability Office, Report to Congressional Requesters, *CMS Should Use Data on Disenrollment and Beneficiary Health Status to Strengthen Oversight* (April 2017) at 11, 20, at <https://www.gao.gov/assets/gao-17-393.pdf>.

²⁸ Jayapal Ltr. at 3.

²⁹ *Id.* at 1.

³⁰ OIG Report, n.10, “MA enrollees appear more high risk than enrollees in [traditional Medicare], even when studies show that they are not.”

1 increase year-over-year.³¹ Not only is United the largest health insurer in the United
2 States, but it is astoundingly America's fourth largest company and the eighth
3 largest company in the world.³² This is a matter of great public interest and United's
4 upcoding practices should be examined by a jury and the public.

5 United's gamesmanship exacerbates the MA program's problems and presents
6 an existential threat to the sustainability of the traditional Medicare program. United
7 has been accused of fraud in several lawsuits, including the present case, by both
8 whistle-blowers and the U.S. government, and the OIG has reported on its
9 overbilling.³³ Now, it is reported that the DOJ is investigating United for criminal
10 Medicare fraud arising out of its MA business practices.³⁴ Such opportunistic
11 practices by one of the largest companies in the world presents a threat to Medicare's
12 solvency and unnecessary hurdles for taxpayers and the elderly who rely government
13 funded healthcare programs for care. They must trust that such funds are being used
14 efficiently, and that laws designed to prevent defrauding the government are enforced.

15 **2. United Harms MA Enrollees by Refusing to Use the**
16 **Unjustified Funds It Receives to Pay for Their Care**

17 United not only insists it has no obligation to return its ill-gotten federal
18 funds, but it also harms the American people and its MA enrollees, particularly
19 American seniors, by employing those funds to increase its data-driven algorithms
20 and predictive technology to strategically deny requests for post-acute care. Last
21 year, the U.S. Senate Permanent Subcommittee on Investigations released a staff

22
23 ³¹ UnitedHealth Group, UnitedHealth Group Reports 2024 Results (Jan. 16, 2025), at
[https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2024/2025-16-01-uhg-](https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2024/2025-16-01-uhg-reports-fourth-quarter-results.pdf)
[reports-fourth-quarter-results.pdf](https://www.unitedhealthgroup.com/content/dam/UHG/PDF/investors/2024/2025-16-01-uhg-reports-fourth-quarter-results.pdf).

24 ³² Erika Fry, *How UnitedHealthcare and other mega-insurers came to dominate the \$4.5 trillion*
health care industry that Americans both hate and rely upon, FORTUNE (Dec. 14, 2024), at
25 <https://fortune.com/2024/12/14/unitedhealthcare-brian-thompson-health-insurance/>.

26 ³³ Reed Abelson & Margot Sanger-Katz, 'The Cash Monster Was Insatiable': How Insurers
Exploited Medicare for Billions, N.Y. TIMES, Oct. 8, 2022, at
27 <https://www.nytimes.com/2022/10/08/upshot/medicare-advantage-fraud-allegations.html>.

28 ³⁴ Christopher Weaver & Anna W. Mathews, *UnitedHealth Group is Under Criminal Investigation*
for Possible Medicare Fraud, WALL ST. J., May 14, 2025, at [https://www.wsj.com/us-](https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f)
[news/unitedhealth-medicare-fraud-investigation-df80667f](https://www.wsj.com/us-news/unitedhealth-medicare-fraud-investigation-df80667f).

1 report detailing harrowing findings on insurer’s practices (including United’s) that
2 have harmed the elderly:

3 [MA] insurers are intentionally using prior authorization to
4 boost profits by targeting costly yet critical stays in post-
5 acute care facilities. Insurer denials at these facilities, which
6 help people recover from injuries and illnesses, can force
7 seniors to make difficult choices about their health and
8 finances in the vulnerable days after exiting a hospital.³⁵

Regarding United specifically, the report noted:

9 (1) [United] was evaluating the use of automated prior
10 authorization procedures; (2) the company knew from
11 testing that at least one of these automation technologies
12 resulted in an increase in the share of those requests being
13 denied; (3) this model was associated with less time spent
14 evaluating prior authorization requests; and (4) the
15 company was interested in reducing the money it spent on
16 human reviewers of cases for the group covering [MA]
17 plans. All of this was taking place as UnitedHealthcare’s
18 post-acute care denial rate was set to surge: It went from
19 10.9 percent in 2020, to 16.3 percent in 2021, to 22.7
20 percent in 2022.³⁶

21 United now faces class action litigation for its illegal use of artificial
22 intelligence to drive denials of post-acute care for the elderly.³⁷ Notably, in that
23 class action, the Minnesota District Court recently held that certain common law
24 claims against United were not preempted by the Medicare Act.³⁸ The Court
25 reached its decision by citing to contract principles, reasoning that its analysis
26 would only require interpretation of *United’s contractual promises* to enrollees—
27 including promises to pay all medically necessary expenses and promises that
28 claims decisions would be made by physicians and not by AI algorithms.³⁹ Those
promises were broken. United’s pervasive practices of making false statements, its
lack of disclosure, its unauthorized retention of government and taxpayer money,

³⁵ U.S. Senate, *Refusal of Recovery: How Medicare Advantage Insurers Have Denied Patients Access to Post-Acute Care*, at 4 (Oct. 17, 2024), at <https://www.hsgac.senate.gov/wp-content/uploads/2024.10.17-PSI-Majority-Staff-Report-on-Medicare-Advantage.pdf> (“Senate Investigative Report”).

³⁶ *Id.* at 23.

³⁷ See Pls.’ First Am. Class Action Compl., *Estate of Gene B. Lokken v. UnitedHealth Group Inc.*, No. 0:23-cv-03514 (Dist. Minn 2025).

³⁸ Mem. Op. and Order, *Estate of Gene B. Lokken*, No. 0:23-cv-03514 (Dist. Minn 2025).

³⁹ *Id.* at 3.

1 and (perhaps most importantly) its denial of coverage for the vulnerable enrollees
2 it promised to insure have caused immeasurable harm to the American people.

3
4 **D. The Court Should Allow the Present Case to Proceed to Jury Trial**

5 **1. The Government Has Presented Ample Evidence for the**
6 **Court to Allow This Case to Proceed to Jury Trial**

7 The Court should reject the Special Master's R&R, deny United's motion for
8 summary judgment (ECF 615), and allow a jury to weigh the disputed evidence and
9 render a verdict on the hotly contested factual issues in this case. Plaintiff has
10 adduced sufficient evidence from which a jury could reasonably conclude that
11 United violated the FCA and that its conduct satisfies the reverse false claims
12 provision, which imposes liability where a person "knowingly conceals or
13 knowingly and improperly avoids or decreases an obligation to pay or transmit
14 money or property to the Government." 31 U.S.C. § 3729(a)(1)(G).

15 By United's own admission, its coders who reviewed medical charts for
16 diagnoses are trained to code at a 95% or above accuracy rate. (ECF 616 at 23.)
17 United disingenuously suggests Plaintiff should have independently reviewed the
18 underlying medical records to support its claims.⁴⁰ But this argument ignores that
19 United's own coders reviewed the records multiple times over and it was *United*
20 that found *no support* for the diagnosis codes it submitted for payment.⁴¹ United's
21 dismissively responds that its coders sometimes "miss" codes and that coding
22 complexities may have confused the coders and Plaintiff.⁴² Yet, as Plaintiff asserts,
23 United was comfortable relying on the upcoding decisions made by those same
24 coders to generate MA program overpayments.⁴³ United cannot have it both ways.
25 It cannot argue, on one hand, that chart review is error prone and may be too

26
27 ⁴⁰ ECF 616 at 35.

⁴¹ *Id.* at 43.

⁴² ECF 623 at 5.

⁴³ ECF 616 at 44.

1 complex to consistently identify unsupported codes, while simultaneously
2 maintaining that its additional codes (and associated overpayments) are justifiable.
3 If the coding process is as accurate as the record indicates, a jury will have a
4 reasonable basis to conclude that United knowingly retained overpayments for
5 unjustified diagnosis codes in violation of the FCA. Even so, questions about
6 coding accuracy and validity—as well as questions about expert testimony—go to
7 the weight and credibility of the evidence. Such factual disputes should have the
8 benefit of a jury’s consideration.⁴⁴

9 **2. The Special Master’s R&R Would Set a Negative Precedent**
10 **and Embolden Insurers’ Bad Faith Conduct**

11 As the statistics cited herein demonstrate, bad faith conduct, upcoding, and
12 increased coverage denials are not limited to United—though United is a
13 particularly egregious offender. The analysis conducted by the Wall Street Journal
14 and findings published by the Senate Permanent Subcommittee show that other
15 large MA insurers also engage in diagnostic upcoding and deny coverage for post-
16 acute care at an unusually high rate.⁴⁵ A ruling in favor of United would dispose of
17 the present case prematurely before a jury has the opportunity to weigh in on
18 United’s conduct, and would embolden other insurers to continue gaming the MA
19 program with practices that harm American taxpayers and the elderly. Plaintiff’s
20 legal positions, its evidence, and the principles of fairness and justice demand that
21 the Court allow the present case to proceed to a jury trial. A competent jury
22 composed of a sample group of the very people that United’s conduct currently
23 harms, and who the *amici curiae* have sworn to serve and protect, should be
24 permitted to hear and weigh the evidence, and to render judgment with their verdict.

25
26
27 ⁴⁴ *Id.*

28 ⁴⁵ Senate Investigative Report, n.31 at 19; Christopher Weaver, *et al.*, *Insurers Pocketed \$50 Billion From Medicare for Diseases No Doctor Treated*, WALL ST. J., July 8, 2024, at <https://www.wsj.com/health/healthcare/medicare-health-insurance-diagnosis-payments-b4d99a5d>.

1 **III. CONCLUSION**

2 The *amici curiae* request that the Court reject the Special Master's R&R,
3 deny United's motion for summary judgment, grant the United States
4 Government's motion for summary judgment, and allow the parties to proceed to a
5 jury trial in the present case.

6 Date: May 15, 2025

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