IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs,* v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, AND DAVID J. KAUTTER, in his Official Capacity as ACTING COMMISSIONER OF INTERNAL REVENUE, *Defendants.*	§	Civil Action No. 7:15-CV-00151-O

MOTION FOR LEAVE TO FILE A SECOND AMENDED COMPLAINT

Plaintiffs, by and through counsel, and pursuant to Federal Rules of Civil Procedure 7 and 15(a)(2), hereby move the Court for leave to file a Second Amended Complaint. In support of this Motion, Plaintiffs hereby state as follows:

INTRODUCTION

This case involves the continued unlawful imposition of the Health Insurance Providers Fee ("HIPF") on Plaintiffs—governments expressly exempted by Congress from HIPF liability. This unlawful imposition comes at the hands of the federal government, including the U.S. Department of Health and Human Services ("HHS") and Internal Revenue Service ("IRS"). While the Court has addressed the unlawful

regulations of HHS, regulations of IRS, in the wake of the Court's decision, continue to operate in a manner that imposes HIPF liability on Plaintiffs. Thus, Plaintiffs seek leave to amend and add additional claims necessary to ameliorate harm regarding the 2018 HIPF.

When Congress passed and the President signed into law the Affordable Care Act ("ACA"), they expressly exempted States from paying the HIPF. But Congress also requires that contracts between States and managed care organizations ("MCOs") be "actuarial sound" to qualify for Medicaid and Children's Health Insurance Program ("CHIP") funding. As the Court is aware, HHS issued a final rule (the "Certification Rule"), which defined actuarial sound as meeting the actuarial standards set by a private association of actuaries. Those actuaries, in turn, determined that for MCO contracts to be actuarial sound, the HIPF must be included in capitation rates (insurance premiums) States pay MCOs for their services. In a prior order in this case, the Court declared that the Certification Rule delegated legislative power to a private entity in violation of the Constitution and Administrative Procedure Act. *Texas v. United States*, 300 F. Supp. 3d 810, 823 (N.D. Tex. 2018). As a remedy to that unlawful delegation of power, the Court ordered Defendants to disgorge the HIPF Plaintiffs paid for 2014, 2015, and 2016. ECF No. 100. Congress extended a moratorium for the 2017 HIPF.

Currently, the federal government is preparing to collect the 2018 HIPF. Now, even though the Court declared the Certification Rule unlawful, the solitary operation of IRS regulations work to create the same unlawful imposition of the HIPF upon Plaintiffs. The IRS imposes HIPF liability upon Plaintiffs' MCOs based on Medicaid and CHIP contracts with the States. Through the Court's prior ruling, actuarial discretion is restored and the Certification Rule no longer operates to require MCOs to pass the HIPF liability onto Plaintiff States through their capitation

rates in order to satisfy Congress's requirement that the MCO contracts be actuarial sound. However, as to the HIPF for 2018, actuaries have determined, in their professional judgment, that the HIPF must still be added to capitation rates for Medicaid and CHIP contracts to be actuarially sound. In other words, if the MCOs have to pay it, so do Plaintiffs, creating yet another result that is contrary to the express language of Congress—that Plaintiffs are exempt from paying the HIPF. IRS regulations still require MCOs to pay the HIPF and still require MCOs to pass that fee onto Plaintiff States through their capitation rates in order to satisfy Congress's requirement that the MCO contracts be actuarial sound.

Plaintiffs protested directly to IRS that capitation rates for Medicaid and CHIP premiums should not be included in the agency's calculations for HIPF liability. The IRS refused to respond to Plaintiffs. And now, just days ago, IRS sent Plaintiffs' MCOs the final bills for the 2018 HIPF. IRS failed to adjust any of the bills to remove from consideration the premiums for Medicaid and CHIP for Plaintiffs' MCO contracts. IRS undertook these actions, despite Plaintiffs formal protestations of the preliminary bills earlier this summer. As a result, in less than 30 days—on October 1, 2018—Plaintiffs' MCOs must remit to the IRS the 2018 HIPF, which will be passed onto Plaintiffs through their MCO contracts.

Plaintiffs now seek leave to amend their complaint to seek judicial relief related to the HIPF for fee year 2018. Only days ago, Plaintiffs received confirmation from their Medicaid and CHIP MCOs that Defendants continue to unlawfully impose the HIPF on Plaintiffs through their Medicaid and CHIP MCOs. Even though this Court ordered equitable disgorgement as a remedy for Plaintiffs to recoup the HIPF payments for 2014, 2015, and 2016, the money spent for the 2018 HIPF will be forever lost if an appellate decision invalidates this Court's order of equitable disgorgement. Plaintiffs seek leave to amend their complaint at the present time because their

claims related to the 2018 HIPF are ripe, and they are suffereing an irreparable injury.

Plaintiffs respectfully request that the Court expedite its consideration of this Motion, because Plaintiffs intend to file a motion for temporary restraining order and preliminary injunction the week of September 10, 2018 to stop Defendants from functionally collecting the 2018 HIPF from Plaintiff States' MCOs. The proposed Second Amended Complaint is attached to this Motion.

ARGUMENT

Courts should grant leave to amend pleadings "freely . . . when justice so requires." Fed. R. Civ. P. 15(a)(2). "[T]his mandate is to be heeded." *Foman v. Davis*, 371 U.S. 178, 182 (1962). "If the underlying facts or circumstances relied upon by a plaintiff may be a proper subject of relief, he ought to be afforded an opportunity to test his claim on the merits." *Id*. In fact, "Rule 15(a) 'evinces a bias in favor of granting leave to amend,' meaning a district court must have a 'substantial reason' to deny leave." *Greco v. NFL*, 116 F. Supp. 3d 744, 753 (N.D. Tex. 2015) (quoting *Chitimacha Tribe of La. v. Harry L. Laws Co.*, 690 F.2d 1157, 1163 (5th Cir. 1982); *Jamieson ex rel. Jamieson v. Shaw*, 772 F.2d 1205, 1208 (5th Cir. 1985)).

Courts deny motions to amend in limited circumstances involving "undue delay, bad faith or dilatory motive on the part of the movant, repeated failure to cure deficiencies by amendments previously allowed, undue prejudice to the opposing party by virtue of the allowance of the amendment, [and] futility of the amendment." *Rosenblatt v. United Way of Greater Hous.*, 607 F.3d 413, 419 (5th Cir. 2010) (internal quotation omitted). "Of course, the grant or denial of an opportunity to amend is within the discretion of the District Court, but outright refusal to grant the leave without any justifying reason appearing for the denial is not an exercise of

discretion; it is merely abuse of that discretion and inconsistent with the spirit of the Federal Rules." *Foman*, 371 U.S. at 182.

Good cause exists to grant Plaintiffs leave to amend because the amended complaint will provide updated facts related to Defendants' assessment and collection of the HIPF for fee year 2018, and Plaintiffs face a threat of irreparable harm that did not previously exist prior to IRS's final assessment of the 2018 HIPF on or after August 31, 2018. Moreover, none of the "substantial reasons" to deny leave are present: amendment is not sought to delay the case or prejudice Defendants, Plaintiffs have not repeatedly failed to cure deficiencies in their pleadings, and amendment is not futile.

I. The Amendment Is Not Sought for Purposes of Undue Delay, Bad Faith, or Dilatory Motive.

Plaintiffs do not file this Motion to cause undue delay, in bad faith, or with a dilatory motive. "[M]ere passage of time need not result in refusal of leave to amend; on the contrary, it is only *undue* delay that forecloses amendment." *Dussouy v. Gulf Coast Inv. Corp.*, 660 F.2d 594, 598 (5th Cir. 1981) (emphasis added). Parties may amend even when a case has been on file for several months or years. *See Greco*, 116 F. Supp. 3d at 755.

Plaintiffs do not seek to unduly delay the litigation. Rather, Plaintiffs seek judicial relief on related claims that only ripened this month. Because IRS issued the final bills to Plaintiffs' Medicaid and CHIP MCOs on or after August 31, 2018, Plaintiffs now know that they will once again be required to pay the HIPF. IRS undertook these actions despite Plaintiffs formal protests earlier this summer that asked the IRS to remove the 2018 HIPF from its calculation of MCO liability. Plaintiffs wish to include all claims of relief related to the HIPF in one suit to provide for judicial economy and prevent the unnecessary use of judicial recourses in multiple lawsuits related to the HIPF.

Plaintiffs also file this motion in good faith. The proposed amended complaint seeks to address an imminent threat of irreparable injury that was not present when the first amended complaint was filed. Defendants have already filed a notice of appeal, and rather than await an appellate decision that could potentially remove Plaintiffs' sole remedy of equitable disgorgement, Plaintiffs move to include the related claim in this lawsuit and seek immediate injunctive relief to prevent payment of the HIPF.

II. Plaintiffs Have Not Repeatedly Failed to Cure Deficiencies by Prior Amendments.

In Plaintiffs' First Amended Complaint additional parties were added, and new causes of action were asserted based on the facts known at that time. *See generally* ECF No. 19. Now, Plaintiffs are not adding any new defendants. Instead, they ask the Court for leave to amend the complaint a second time based on the new threat of irreparable harm that has arisen through the imposition of the 2018 HIPF on Plaintiffs' Medicaid and CHIP MCOs. IRS did not issue the final 2018 HIPF bills until August 31, 2018. Plaintiffs could not have amended their complaint any earlier. But if Plaintiffs do not seek equitable relief this month, they will be required to pay the unlawful HIPF for 2018, and if the Defendants prevail on appeal in challenging the disgorgement of prior HIPF payments, then, based on this Court's rulings, Plaintiffs will lose all ability to prevent payment of the HIPF or recover it after payment. This amended complaint does not cure prior deficiencies, it adds a new claim based on the same law and facts based on the most recent HIPF bills.

III. The Amendment Will Not Unduly Prejudice Defendants.

Permitting Plaintiffs to file a Second Amended Complaint will not unduly prejudice the federal government. Plaintiffs are not attempting to avoid a ruling on summary judgment. The Court has ruled. But no final judgment has been entered in this matter, and Defendants would suffer little, if any, prejudice because they

have prepared their case based on prior HIPF assessments and collection. In addition, the inclusion of the 2018 HIPF claims will provide the parties with the opportunity to resolve all related HIPF claims in one lawsuit. In light of their request to stay a final judgment, Defendants should welcome the inclusion of the 2018 HIPF claims as opposed to defending the related HIPF claims in a separate lawsuit.

IV. The Amendment Is Not Futile.

Finally, it is not futile for Plaintiffs to amend their complaint. To determine whether amendment is futile, courts "apply the same standard of legal sufficiency as applies under Rule 12(b)(6)." *Stripling v. Jordan Prod. Co., LLC*, 234 F.3d 863, 873 (5th Cir. 2000) (citations and internal quotation marks omitted). In other words, a futility finding is warranted if "the amended complaint would fail to state a claim upon which relief could be granted." *Id*. However, "[i]f a proposed amendment is not clearly futile, then denial of leave to amend is improper." *Moore v. Dallas Indep. Sch. Dist*., 557 F. Supp. 2d 755, 759–60 (N.D. Tex. 2008) (citations omitted).

Here, Plaintiffs move to add a related legal claim that only recently became ripe for judicial review—the 2018 HIPF. Once IRS issued final bills confirming that the 2018 HIPF had been assessed against Plaintiffs' Medicaid and CHIP MCOs, Plaintiffs became obligated to reimburse the MCOs for their respective share of the 2018 HIPF. In the Second Amended Complaint, Plaintiffs request declaratory and injunctive relief that would prevent IRS from collecting the 2018 HIPF in a manner that unlawfully requires Plaintiffs to pay the HIPF. The Court may properly award the declaratory and injunctive relief sought in the Second Amended Complaint.

None of this prejudices Defendants. Plaintiffs could file a new case challenging the 2018 HIPF. Instead, they seek leave to amend their complaint and adjudicate the 2018 HIPF in this case. Plaintiffs are not adding defendants; they are only adding claims against the 2018 HIPF. Moreover, because the Court has

adjudicated the parties' motions for summary judgment, the amendment does not prejudice Defendants' ability to pursue relief under that motion. While Defendants may disagree with the Court's conclusions and choose to appeal, they may continue to do so while the Court resolves the 2018 HIPF during the month of September. Defendants will not be prejudiced by Plaintiffs' Second Amended Complaint.

CONCLUSION

Good cause exists to grant Plaintiffs leave to file a second amended complaint. Thus, Plaintiffs respectfully request that the Court grant this motion for leave to amend, and order the Clerk of Court to file the Second Amended Complaint for Declaratory and Injunctive Relief, attached hereto as Exhibit A.

Respectfully submitted this 7th day of September, 2018.

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CERTIFICATE OF CONFERENCE

I hereby certify that, on August 29, 2018, Plaintiffs' counsel conferred with Defendants' counsel concerning this motion. On September 6, 2018, Defendants advised Plaintiffs that they are opposed to this motion.

/s/ Austin R. Nimocks
AUSTIN R. NIMOCKS

CERTIFICATE OF SERVICE

I hereby certify that on September 7, 2018, I electronically filed the foregoing document through the Court's ECF system, which automatically serves notification of the filing on counsel for all parties.

/s/ Austin R. Nimocks
AUSTIN R. NIMOCKS

IN THE UNITED STATES DISTRICT COURT
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WICHITA FALLS DIVISION

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs,* v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, AND DAVID J. KAUTTER, in his Official Capacity as ACTING COMMISSIONER OF INTERNAL REVENUE, *Defendants.*	§ §	Civil Action No. 7:15-CV-00151-O

SECOND AMENDED COMPLAINT FOR DECLARATORY, INJUNCTIVE, AND MONETARY RELIEF

TO THE HONORABLE JUDGE OF SAID COURT:

Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska (collectively "Plaintiffs") seek declaratory and injunctive relief against the United States of America, United States Department of Health and Human Services ("Department"), Alex Azar, in his official capacity as Secretary of Health and Human Services, United States Internal Revenue Service, and David J. Kautter, in his official capacity as Acting Commissioner of Internal Revenue, regarding Defendants' actions implementing the portions of the Patient Protection and Affordable Care Act known as the Health Insurance Providers Fee. Plaintiffs also seek monetary relief against

the United States in the form of a return of the Health Insurance Providers Fees previously made.

I. PARTIES

1. Plaintiffs are Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska.

2. Defendants are the United States of America, the United States Department of Health and Human Services ("Department"), Alex Azar, in his Official Capacity as Secretary of Health and Human Services, the United States Internal Revenue Service ("IRS" or "Service"), and David J. Kautter, in his Official Capacity as Acting Commissioner of Internal Revenue.

II. JURISDICTION AND VENUE

3. This Court has jurisdiction pursuant to 28 U.S.C. § 1331 because this suit concerns the constitutionality of the Health Insurance Providers Fee in the Patient Protection and Affordable Care Act. This Court also has jurisdiction to compel the Secretary of Health and Human Services and Commissioner of Internal Revenue to perform their duties pursuant to 28 U.S.C. § 1361.

4. Plaintiffs' claims for declaratory and injunctive relief are authorized by 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of this Court.

5. Venue is proper under 28 U.S.C. § 1391(e)(1)(B) because the United States, two of its agencies, and two of its officers in their official capacity are Defendants; and a substantial part of the events giving rise to the Plaintiff States' claims occurred in this District.

III. FACTUAL BACKGROUND

6. This dispute arises primarily from the March 2015 publication of Actuarial Standard of Practice Number 49, which for the first time notified the several States that, functionally, they were being assessed or taxed the Health

Insurance Providers Fee (imposed as a collective lump sum on all covered health insurance providers) as part of the Affordable Care Act. Plaintiffs have now paid the fee for years 2014, 2015, and 2016, and herein contend that this new regulatory framework poses myriad statutory and constitutional problems.

A. The Medicaid Program.

7. The United States Congress created the Medicaid program in 1965. *See* Social Security Amendments Act of 1965, Pub. L. 89-97, 79 Stat. 286 (1965). The Medicaid program is jointly funded by the United States and the States to provide healthcare to individuals with insufficient income and resources. *See generally* 42 U.S.C. §§ 1396–1396w.

8. To participate in Medicaid, Plaintiffs must provide coverage to a federally-mandated category of individuals and according to a federally-approved State plan. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.10–430.12. All 50 States participate in the Medicaid program. *Federal Financial Participation in State Assistance Expenditures; Federal Matching Shares for Medicaid, the Children's Health Insurance Program, and Aid to Needy Aged, Blind, or Disabled Persons for October 1, 2014 to September 30, 2015*, 79 Fed. Reg. 3385 (Jan. 21, 2014).

9. Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska have been participating in the Medicaid program since shortly after its creation. *United States Advisory Commission on Intergovernmental Relations* at 91, *"Intergovernmental problems in Medicaid,"* September 1968, *available online at* http:// digital.library.unt.edu/ark:/67531/metadc1397/. Because Medicaid is an entitlement program, Plaintiffs cannot limit the number of eligible people who can enroll, and Medicaid must pay for all services covered under the program. Generally, Medicaid pays for acute and other health care primarily for low-income families, children, related caretakers of dependent children, pregnant women, people age 65 or older, and adults and children with disabilities. *See*, *e.g.*, *Texas Health and Human Services*

Commission, Texas Medicaid and CHIP in Perspective: 10th Ed., 2-2 (2015), *available online at* https://hhs.texas.gov/sites/default/files/documents/laws-regulations/reports-presentations/2015/medicaid-chip-perspective-10th-edition/10th-edition-complete.pdf at 1-1 to 1-2.

10. Providing health care to individuals with insufficient income or resources through the Medicaid program is a significant function of the Plaintiffs' governments. For example, Texas provides Medicaid services to around one in seven of Texas's total population (3.7 million of the 26.4 million total population) and Medicaid spending accounted for around 26% of Texas's total budget in fiscal year 2013 (and 28% of the 2015 budget). *Id.* at 1-1. Kansas, in its 2015 fiscal year, provided Medicaid services to more than 350,000 citizens—well more than 10% of its population. *See Kansas Medical Assistance Report*, *Kansas Medical Assistance Report*, *Kansas Medical Assistance Program - Beneficiaries By Population Group*, *Fiscal Year 2015* at 2, *available online at* http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2015.pdf. Louisiana provides Medicaid services to approximately 3 in 10 of Louisiana's population (1.37 million Louisianans). *Louisiana Medicaid Annual Report*, *State Fiscal Year 2012/13* at 3, *available at* http://new.dhh.louisiana.gov/assets/medicaid/AnnualReports/Medicaid_12_13_WEB.pdf. Indiana provides Medicaid services to approximately 1.3 million citizens, nearly 20% of its population. *State of Indiana, Office of Medicaid Policy and Planning, Enrollment Count by Age Group and Health Plan* at 1, *available at* http://www.in.gov/fssa/files/Copy_of_DA20005__Monthly__Enrollment_November_2015.pdf. Based on current population estimates, Wisconsin is providing Medicaid services to approximately 1 in 5 residents (1.19 million Wisconsin residents). *Wisconsin Department of Health Services*, *Health Care Enrollment Statistics*, *available online at* https://www.forwardhealth.wi.gov/WIPortal/content/Member/caseloads/enrollment/enrollment.htm.spage. As of January 2016, the State of

Nebraska provides Medicaid services to approximately 231,302 Nebraskans, which is over 12% of the State's population.

B. The Children's Health Insurance Program.

11. The United States Congress created the Children's Health Insurance Program ("CHIP") in 1997. *See* Balanced Budget Act of 1997, Pub. L. 105-33, Title IV, Subtitle J, 111 Stat. 251 (Aug. 5, 1997). The federal government and Plaintiffs jointly fund CHIP to provide healthcare for uninsured children that do not qualify for Medicaid. *See* 42 U.S.C. § 1397aa; *Eligibility-Medicaid.gov*, http://www.medicaid.gov/chip/eligibility-standards/chip-eligibility-standards.html.

12. CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance. CHIP provides basic primary health care services to children, as well as other medically necessary services, including dental care. CHIP services are generally delivered by managed care organizations selected by the States through a competitive bidding process. The Plaintiff States began participating in CHIP sometime after its creation in 1997.

13. Providing health care services to uninsured children through CHIP is a significant function of the Plaintiffs' governments. For example, there were around 333,000 Texas children in CHIP as of June 2015. *Statewide CHIP Enrollment, Renewals, Attempted Renewals, and Disenrollment by Month*, *available online at* https://hhs.texas.gov/sites/default/files/documents/about-hhs/records-statistics/research-statistics/medicaid-chip/2018/chip-enrollment-detail-june-2018.xlsx. As of October 2015, Kansas had approximately 54,442 children enrolled in its CHIP program. *Kansas Medical Assistance Report*, *Kansas Medical Assistance Program - Beneficiaries By Population Group - Fiscal Year 2016* at 2, *available online at* http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2016.pdf. There were around 123,350 Louisiana children and pregnant women in CHIP as of June 30, 2014. *Louisiana Department of Health and Hospitals*, *Status Report on Louisiana*

Children's Health Insurance Program, Aug. 19, 2014, *available online at* http://new.dhh.louisiana.gov/assets/medicaid/lachip/2014LaCHIPLegisReport.pdf. As of November 2015, Indiana had approximately 85,493 children enrolled in its CHIP program. *State of Indiana, Office of Medicaid Policy and Planning, Enrollment Count by Age Group and Health Plan* at 10, *available at* http://www.in.gov/fssa/files/Copy_of_DA20005__Monthly__Enrollment_November_2015.pdf. As of November 2015, Wisconsin officials derived from internal statistics that the state had approximately 54,627 children enrolled in its CHIP program. And as of January 2016, Nebraska has approximately 29,042 children and pregnant women enrolled in its CHIP program.

C. Plaintiffs' Use of Managed Care Organizations to Participate in Medicaid and CHIP.

14. Plaintiffs provide a significant portion of Medicaid, and a substantial majority of CHIP health care services, through managed care arrangements. *See, e.g.*, *Managed Care State Profiles and State Data Collections-Medicaid.gov*, *available online at* https://www.medicaid.gov/medicaid/managed-care/state-profiles/index.html; *Texas Health and Human Services Commission, Texas Medicaid Program: Managed Care Medical and Dental Plans*, *available online at* https://hhs.texas.gov/services/health/medicaid-chip/programs/medical-dental-plans; *see also Texas Health and Human Services Commission*, *Texas Medicaid and CHIP in Perspective: 10th Edition*, 7-1 to 7-34 (2015) (providing an overview of the use, history, and success of managed care utilization in Texas); *Kansas Medical Assistance Report*, *Kansas Medical Assistance Program - Beneficiaries by Population Group, Fiscal Year 2015* at 2, *available online at* http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2015.pdf; *Kansas Medical Assistance Report*, *Kansas Medical Assistance Program - KanCare Beneficiary Counts, Fiscal Year 2015* at 7, *available online at* http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2015.pdf; *Indiana Family and Social Services Commission, Managed Care*, *available online at* http://

provider.indianamedicaid.com/provider-specific-information/managed-care.aspx (providing overview of Indiana's use of managed care); *Wisconsin Department of Health Services*, *Health Care Enrollment Statistics*, *available online at* https://www.forwardhealth.wi.gov/WIPortal/Tab/42/icscontent/Member/caseloads/enrollment/enrollment.htm.spage. Currently, the majority of Nebraska's Medicaid and CHIP programs are serviced through contracts with three managed care organizations for physical health services (*e.g.*, doctor visits, hospital care), and a fourth entity for behavioral health services. Beginning January 1, 2017, the Nebraska Department of Health and Human Services will launch Heritage Health, a new health care delivery system that combines Nebraska's current physical health, behavioral health, and pharmacy programs into a single comprehensive and coordinated system for Nebraska's Medicaid and CHIP enrollees.

15. In a managed care arrangement, Plaintiffs enter into contracts with managed care organizations, whereby the organizations agree to deliver healthcare services in exchange for a fixed monthly payment, known as a "capitation payment" or "capitation rate." *See Centers for Medicare & Medicaid Services*, *Managed Care*, *available online at* https://www.medicaid.gov/medicaid/managed-care/index.html.

16. For example, in Texas, managed care organizations provided Medicaid services to around 87% of Texas's full benefit Medicaid population in fiscal year 2015, and payments to managed care organizations for Medicaid health care services totaled approximately $16.6 billion and accounted for around 17% of Texas's budget. In Kansas, managed care organizations provide Medicaid services to around 94% of Kansas's Medicaid population, and Kansas spent approximately 18% of its total state budget in fiscal year 2015 on Medicaid. In Louisiana, managed care organizations provided Medicaid services to around 43% of Louisiana's full benefit Medicaid population, and federal Medicaid funds account for around 22% of the appropriated budget for fiscal year 2016. In Indiana, managed care organizations service 78.2% of

the state's Medicaid population, and federal Medicaid funds accounted for approximately 22% of Indiana's budget in fiscal year 2015. In Wisconsin, managed care organizations provide Medicaid services to around 66% of Wisconsin's Medicaid population. Furthermore, Wisconsin will spend approximately 25% of its 2015-2017 biennial budget on Medicaid services. In Nebraska, managed care organizations service the majority of Medicaid and CHIP programs. In 2015, Nebraska expended approximately $1,796,646,410 on its Medicaid and CHIP programs, with approximately 37% ($655,890,380) of those expenditures on managed care organizations.

17. Additionally, managed care organizations provide the substantial majority of health care services provided to children in the Plaintiff States' CHIP programs. For example, in Texas, managed care organizations provide all CHIP health care services and accounted for around 1% of Texas's budget in fiscal year 2015. In Kansas, managed care organizations provide all CHIP health care services, at a cost of $98.6 million in fiscal year 2015. *See Kansas Medical Assistance Report*, *Kansas Medical Assistance Program - Expenditures by Population Group, Fiscal Year 2015* at 6, *available online at* http://www.kdheks.gov/hcf/medicaid_reports/download/MARFY2015.pdf. In Louisiana, managed care organizations provide the substantial majority (94%) of CHIP health care services. As of September 2015, 79.4% of Indiana's Medicaid and CHIP programs are serviced through managed care organizations. In Wisconsin, as of December 2015, internal statistics demonstrate that approximately 90% of the CHIP health care services are provided through managed care organizations. The majority of Nebraska's CHIP services, except long-term services and supports, are provided through managed care organizations.

D. The Health Insurance Providers Fee.

18. In 2010, the United States created a sweeping new regulatory framework for the nation's healthcare system by passing what is commonly referred

to as the "Affordable Care Act." *See Patient Protection and Affordable Care Act*, Pub. L. 111-148, 124 Stat. 119–1025 (Mar. 23, 2010). One portion of this legislation imposed a "Health Insurance Providers Fee" on all covered health insurance providers. *See* Pub. L. 111-148, 124 Stat. 865–866. The purpose of the fee was to generate revenue from a windfall Congress expected insurers to receive by increasing enrollment. *See, e.g.*, Insurance & Financial Advisor, *$13 billion in Obamacare Taxes Passed Along to States*, May 20, 2015, *available online at* http://ifawebnews.com/2015/05/20/13-billion-in-obamacare-taxes-passed-along-to-states/.

19. The Health Insurance Providers Fee is imposed as a lump sum on all covered health insurance providers collectively, starting at $8 billion total in 2014, and increasing to $14.3 billion by 2018. *See* Pub. L. 111-148, § 9010(b), 124 Stat. 865–866; 26 C.F.R. § 57.4(a)(3). After 2018, the Health Insurance Providers Fee is scheduled to continue to increase. *Id.* On December 18, 2015, Congress enacted, and the President signed into law, a *temporary*, one-year moratorium on the Health Insurance Providers Fee for 2017. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, Div. P, Title II, § 201, 129 Stat. 2242, 3037–38 (2015). In the meantime, and after 2017, States will continue to bear the cost of the Health Insurance Providers Fee.

20. By statute and rule, the amount owed by any individual managed care organization is determined by the net premiums written for health insurance of United States health risks. Pub. L. 111-148, § 9010(b), 124 Stat. 865–866; 26 C.F.R. § 57.4(a)(2).

21. Nothing in the language of the Affordable Care Act provides clear notice to Plaintiffs that a condition of the federal funding for their Medicaid and CHIP managed care organizations was paying the Health Insurance Providers Fee and associated costs to the managed care organizations to pay to the federal government.

As explained below, this notice was not even provided by rule but was ultimately provided by a private entity wielding legislative authority.

22. By rule, nonprofit managed care organizations that receive more than 80% of their gross revenues from government programs serving low income, elderly, and disabled populations are exempt from the fee. 26 C.F.R. § 57.2(b)(2)(iii). And nonprofit managed care organizations not qualifying for exclusion can deduct 50% of their premium revenue from the fee calculation. Plaintiffs employ for-profit managed care organizations to provide their Medicaid and CHIP benefits. Contracting with nonprofit managed care organizations that are exempt from the fee is often impossible because of the relative scarcity of such nonprofit organizations, and because not all that do exist apply to become managed care organizations with the Plaintiffs. For example, Texas is currently contracting with all nonprofit Medicaid managed care organizations in Texas who desire to contract with Texas. Yet, as demonstrated herein, Texas still incurs substantial liability through the imposition of the Health Insurance Providers Fee.

23. Because the Internal Revenue Service considers the Health Insurance Providers Fee a federal excise tax, amounts paid under the fee are not deductible as business expenses for purposes of federal income taxes. 26 C.F.R. § 57.8.

E. The Delegation of Rulemaking Authority to a Private Entity Under the Actuarial Soundness Requirements.

24. "Federal lawmakers cannot delegate regulatory authority to a private entity. To do so would be 'legislative delegation in its most obnoxious form.'" *Ass'n of Am. R.R.s v. Dep't of Transp.*, 721 F.3d 666, 670 (D.C. Cir. 2013), *rev'd on other grounds*, 135 S. Ct. 1225 (2015) (quoting *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936)); *see also A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935) ("Could trade or industrial associations or groups be constituted legislative bodies for that purpose because such associations or groups are familiar with the

problems of their enterprises? . . . The answer is obvious. Such a delegation of legislative power is unknown to our law, and is utterly inconsistent with the constitutional prerogatives and duties of Congress.").

25. Federal law requires that the negotiated capitation rates be "actuarially sound." 42 U.S.C. § 1396b(m).

26. To be deemed "actuarially sound" for purposes of Medicaid or CHIP, federal regulations require an actuary's certification that, under the standards established by the American Academy of Actuaries, capitation rates are sufficient to cover the insurance providers' expected costs and insurance risks for the coming year. *See* Certification Rule, 42 C.F.R. §§ 438.2–438.4, formerly codified at 42 C.F.R. § 438.6.

27. The American Academy of Actuaries is a private, membership-based professional organization. *See American Academy of Actuaries, About Us*, *available online at* http://www.actuary.org/content/about-us.

28. Among other things, the American Academy of Actuaries "sets qualification, practice, and professionalism standards for actuaries credentialed by one or more of the five U.S.-based actuarial organizations of the United States." *Id.*

29. To set practice standards for actuaries, the American Academy of Actuaries has created and works with an independent, private organization known as the Actuarial Standards Board. *See American Academy of Actuaries*, *How Does The Academy Maintain Standards of Professionalism for Actuaries?*, *available online at* http://www.actuary.org/content/how-does-academy-maintain-standards-professionalism-actuaries; *Actuarial Standards Board*, *About ASB*, *available online at* http://www.actuarialstandardsboard.org/about-asb/.

30. The Actuarial Standards Board "establishes and improves standards of actuarial practice. These Actuarial Standards of Practice ('ASOPs') identify what the actuary should consider, document, and disclose when performing an actuarial

assignment. The [Actuarial Standards Board]'s goal is to set standards for appropriate practice for the U.S." *Actuarial Standards Board, About ASB*, *available online at* http://www.actuarialstandardsboard.org/about-asb/.

31. In March 2015, the Actuarial Standards Board adopted an Actuarial Standard of Practice for setting actuarially sound capitation rates in managed care organization agreements. *Actuarial Standards Board, Actuarial Standard of Practice No. 49* (Mar. 2015), *available online at* http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

32. Actuarial Standard of Practice Number 49 requires capitation rates to recover from States the amount of all taxes managed care organizations are required to pay. *Id.*

33. Actuarial Standard of Practice Number 49 further requires that, if such taxes are not deductible as expenses for corporate income tax purposes, as is the case for the Health Insurance Providers Fee, the rate must be adjusted to compensate for additional tax liability. *See id.*

34. Generally, if a capitation rate for a managed care organization agreement does not comply with Actuarial Standard of Practice Number 49, an actuary will be unable to certify that such capitation rate is actuarially sound. *See Actuarial Standards Board, Actuarial Standard of Practice No. 1* (Mar. 2013), *available online at* http://www.actuarialstandardsboard.org/asops/introductory actuarialstandardpractice/ (indicating that Actuarial Standards of Practice are generally mandatory); *Actuarial Standard of Practice No. 49* (Mar. 2015) (providing that actuaries "should include an adjustment for any taxes, assessment, or fees that the [managed care organizations] are required to pay out of the capitation rates").

35. Without such certification of an actuary, a managed care organization agreement will not be eligible for participation in Medicaid and CHIP. *See* 42 U.S.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. §§ 438.2–438.4 (formerly codified at 42 C.F.R.

§ 438.6(c)(1)(i)(C)).

36. In conjunction with applicable law and regulations, Actuarial Standard of Practice Number 49 requires States to pay managed care organizations an amount sufficient to cover the Health Insurance Providers Fee and any amount of additional taxes that the managed care organizations incur as a result of those payments.

37. This fee is substantial. For example, in August 2015, the State of Texas's funded portion of the amount paid to the Medicaid and CHIP managed care organizations was approximately $84,637,710.00 to cover costs associated with the Health Insurance Providers Fee for the 2013 calendar year (including the taxes managed care organizations must pay regarding payments to cover the fee but not including the portion of the fee the federal government funds). Additionally, Texas has appropriated over $241 million in state funds to cover the Health Insurance Providers Fee for the next biennium. In 2014, Kansas's funded portion of the amount paid to the Medicaid and CHIP managed care organizations was approximately $32,837,960.00 to cover costs associated with the Health Insurance Providers Fee for 2013 (including the taxes managed care organizations must pay regarding payments to cover the fee but not including the portion of the fee the federal government funds). The State of Louisiana's funded portion of the amount paid to the Medicaid and CHIP managed care organizations was approximately $31,342,739.00 to cover costs associated with the Health Insurance Providers Fee for the 2014 payments (including the taxes managed care organizations must pay regarding payments to cover the fee but not including the portion of the fee the federal government funds). Indiana's funded portion of the amount paid to the Medicaid and CHIP managed care organizations was approximately $5,859,523.00 to cover costs associated with the Health Insurance Providers Fee for the 2014 payments (including the taxes managed care organizations must pay regarding payments to cover the fee but not including the portion of the fee the federal government funds). In calendar years 2014 and 2015,

Wisconsin spent over $23 million in Health Insurance Providers Fees (not including the portion of the fee the federal government funds). As of September 30, 2014, Nebraska incurred approximately $3,516,500.00 in Health Insurance Providers Fees to be reimbursed to its managed care organizations.

38. In the next decade, the Health Insurance Providers Fee is projected to allow the federal government to collect between $13 and $15 billion from the States. *Milliman, Inc., PPACA Health Insurer Fee Estimated Impact on State Medicaid Programs and Medicaid Health Plans*, at 2 (Jan. 31, 2012), *available online at* http://us.milliman.com/uploadedFiles/insight/health-published/ppaca-health-insurer-fee.pdf.

39. By functionally requiring that the Plaintiffs reimburse managed care organizations for payment of tax liabilities, the United States has imposed those taxes on the Plaintiffs.

F. Coercion of the Plaintiffs into Paying the Costs of the United States' Preferred Policy.

40. The Centers for Medicare & Medicaid Services, under the Department of Health and Human Services, must approve all of Plaintiffs' proposed capitation rates. The Centers for Medicare & Medicaid Services have thus specifically approved the amount of the Health Insurance Providers Fee that the Plaintiffs must pay the federal government through their Medicaid and CHIP managed care organizations. For example, the Centers for Medicare & Medicaid worked directly with Texas in 2015 to confirm the precise amount of increase in capitation rates Texas owed as a direct result of the Health Insurance Providers Fee.

41. If capitation rates for any managed care organization agreement under Medicaid or CHIP are not actuarially sound, then payments pursuant to such plans would be legally ineligible for federal matching funds under Medicaid or CHIP. *See* 42 U.S.C. § 1396b(m)(2)(A)(iii).

42. As stated above, Medicaid spending accounts for a substantial percentage of the Plaintiffs' total budgets. For example, in Texas, the federal portion of the state Medicaid budget is $17.3 billion, or approximately 17% of the total state budget for fiscal year 2015. In Kansas, the federal portion of the state Medicaid budget for fiscal year 2015 was approximately $1.6 billion, or nearly 11% of its total approved budget. In Louisiana, federal Medicaid funds account for around 22% of the appropriated budget for fiscal year 2016. Similarly in Indiana, federal Medicaid and CHIP funds account for 22% of the budget for fiscal year 2015. In Wisconsin, the federal portion of the state Medicaid budget is $10.3 billion, or approximately 14% of the 2015–2017 biennial budget. In Nebraska, the federal portion of the state Medicaid budget was about $1,024,342,032, or approximately 23% of the total state budget of $4,419,566,113 for the fiscal year ended June 30, 2015. *See* http://das.nebraska.gov/accounting/budrept/buddoc15.pdf.

43. Thus, the federal government would be legally entitled to deny federal funds that comprise a substantial portion of the Plaintiffs' budgets if the Plaintiffs refuse to pay the unconstitutional Health Insurance Providers Fee.

44. By placing in jeopardy a substantial percentage of the Plaintiffs' budgets if the Plaintiffs refuse to help pay the costs of the United States' preferred policy, the United States has left the Plaintiffs no real choice but to acquiesce in such policy. *See NFIB v. Sebelius*, 132 S. Ct. 2566, 2605 (2012) ("The threatened loss of over 10 percent of a State's overall budget, in contrast, is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion.").

45. Further, Plaintiffs have no meaningful choice between continuing to use managed care organizations—and paying the Health Insurance Providers Fee—or reverting to the former model of paying providers for services. The former model of paying providers for services is significantly less cost effective and often results in worse participant satisfaction than the managed care organization model. Therefore,

this "choice" is really no choice at all, which is why each Plaintiff has continued to pay the fee rather than risk Medicaid funding or be forced to revert to the former model.

G. Imposition of the 2018 HIPF on Plaintiffs.

46. Even if Defendants may not use Actuarial Standard of Practice ("ASOP") 49 as a legal requirement and its mandate that the HIPF be added to a capitation rate for the rate to be actuarially sound under 42 U.S.C. § 1396b(m)(2)(A)(iii), Defendants are still violating Plaintiffs rights under the Constitution and APA. If actuaries do not use ASOP 49, they will once again have discretion to discern actuarial soundness using general principles of actuarial analysis.

47. Apart from ASOP 49, actuaries assessed the impact of the 2018 HIPF upon government contracts with MCOs for Medicaid and CHIP. In sum, given the nature and size of the 2018 HIPF, when it comes to the 2018 HIPF liability, Congress's admonition of "actuarial sound[ness]," *see* 42 U.S.C. § 1396b(m)(2)(A)(iii), and the general principles of actuarial soundness, nonetheless require that the 2018 HIPF still be added to the negotiated capitation rates of Plaintiffs' Medicaid and CHIP contracts.

48. Therefore, the HIPF, which operates as a unique and significant federal premium tax, has no chance of masquerading as just another cost of doing business that is able to lose itself within an MCO's cost structure.

49. Specifically, Plaintiffs are collectively required to pay a portion of the $14.3 billion to cover the HIPF added to their Medicaid and CHIP managed care contracts in direct contrast to their statutory exemption from the HIPF. Unlike negotiable terms in the managed care contracts, the HIPF must be included in the capitation rates Plaintiffs pay to the MCOs or they will lose their federal funding for Medicaid and CHIP.

50. For the 2018 HIPF, the IRS is to assess and collect a total of

$14,300,000,000 from "covered entities." 26 C.F.R. § 57.4(a)(3). This HIPF is based on premiums from January 1, 2017 through December 31, 2017. Plaintiffs do not quarrel with the total amount that the IRS is to collect. As per Congress, the IRS should collect $14,300,000,000 in 2018 for the HIPF.

51. However, the IRS unlawfully calculated the distribution of liability for the $14,300,000,000 HIPF for 2018. It did this by using in its calculations and assessment of liability the premiums (capitation rates) of Plaintiffs' MCOs for Medicaid and CHIP.

52. The IRS regulations, and its current methods for calculating the ratio-based distribution of this predetermined liability, produce an unlawful result by levying it, in part, upon the MCOs that provide Medicaid and CHIP for Plaintiffs. This levy then requires Plaintiffs, who are exempt from HIPF liability, to reimburse the MCOs for the HIPF in order to meet Congress's standard of "actuarial sound[ness]" for Medicaid and CHIP contracts with MCOs. *See* 42 U.S.C. § 1396b(m)(2)(A)(iii).

53. On or before April 17, 2018, all Medicaid and CHIP MCOs for Plaintiffs filed a completed Form 8963 with the IRS. As per IRS regulations, the MCOs reported all net premiums, even those that may be exempt from HIPF liability. 26 C.F.R. § 57.3. Per its regulations, the IRS assumes responsibility for excluding from its calculations premiums that should not result in HIPF liability. 26 C.F.R. § 57.4.

54. On or before June 15, 2018, all MCOs for Plaintiffs received a Letter 5066C, which is the IRS's notice of its preliminary calculations of the 2018 HIPF liability. The IRS did not exclude from its calculations premiums for Medicaid and CHIP for Plaintiffs.

55. Following the notice of the IRS's preliminary calculations of the 2018 HIPF liability, Plaintiffs wrote to the IRS to contest its calculations of the 2018 HIPF liability. Plaintiffs explained their exemption from HIPF liability in the ACA, referred

to the Court's March 5, 2018 Order in this litigation, and identified with specificity the premiums that should be removed from the IRS's calculations because Congress expressly exempted the states from paying the HIPF. Regarding Texas, for example, the IRS erroneously included in its calculations and distribution of HIPF liability $11,794,848,747.00 in Medicaid and CHIP premiums.

56. To date, Plaintiffs have received no substantive response to their protest.

57. On or about August 31, 2018, Plaintiffs' Medicaid and CHIP MCOs began receiving from the IRS their final calculations for their 2018 HIPF liability via Letter 5067C. None of the final calculations for Plaintiffs' Medicaid and CHIP MCOs were adjusted to remove from consideration premiums for Medicaid and CHIP for Plaintiffs. Nor did the IRS provide any form of substantive response or explanation as to why none of the final calculations for Plaintiffs' Medicaid and CHIP MCOs were adjusted to remove from consideration premiums for Medicaid and CHIP for Plaintiffs.

58. Each Letter 5067C sent to Plaintiffs' Medicaid and CHIP MCOs demanded payment of the assessed HIPF liability no later than October 1, 2018.

H. IRS Action and Inaction Irreparably Injures Plaintiffs.

59. As long as Part 57, as currently constituted, remains in place, liability for the HIPF will be unlawfully imposed upon Plaintiffs through Medicaid and CHIP contracts that are subject to the actuarial soundness requirement of 42 U.S.C. § 1396b(m)(2)(A)(iii). For the HIPF liability for 2018, this is evidenced by the IRS's calculations, actions, and inactions as chronicled in the prior paragraphs.

60. Notwithstanding the unlawfulness of the Certification Rule, the actuarial soundness requirement of 42 U.S.C. § 1396b(m)(2)(A)(iii) has caused

Plaintiffs' actuaries, employing their best judgment and discretion, to conclude that actuarial soundness in 2018 can only result from a full, dollar-for-dollar imposition upon Plaintiffs of any 2018 HIPF liability upon their Medicaid or CHIP MCOs.

61. Because Plaintiffs are required to pay the 2018 HIPF, dollar-for-dollar through their managed care contracts, all in contravention of Plaintiffs' exemption from HIPF liability under the ACA, Plaintiffs are entitled to a temporary restraining order and preliminary injunction against the IRS, the Acting Commissioner, and federal officials tasked with calculating and collecting the 2018 HIPF. Specifically, the IRS, the Acting Commissioner, and federal officials tasked with calculating and collecting the 2018 HIPF should be enjoined from collecting the 2018 HIPF for fee year 2018 from Plaintiffs' Medicaid and CHIP MCOs. This injunction will prevent Plaintiffs from being required to pay any assessed portion of the 2018 HIPF.

62. Without this injunction, Plaintiffs suffer the risk of irreparable injury and the imposition of an unwarranted liability without access to a judicial remedy because Plaintiffs are not taxpayers for purposes of seeking a refund, and Defendants refuse to make provision for Plaintiffs to seek a refund for unlawfully assessed 2018 HIPF liability. *See* 26 C.F.R. § 57.9.

63. As a result, immediate judicial and injunctive relief is the only legal avenue by which Plaintiffs can contest the legality of the liability for the 2018 HIPF that Defendants now seek to impose on Plaintiffs.

IV. CLAIMS FOR RELIEF

COUNT I

Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that the Health Insurance Providers Fee Violates Constitutional Standards of Clear Notice

64. Plaintiffs incorporate the allegations contained in paragraphs 1 through 63 as if fully set forth herein.

65. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "contrary to constitutional right, power, privilege, or immunity." 5 U.S.C. § 706(2)(B).

66. When Congress exercises its Spending Clause power against the States, principles of federalism require conditions on Congressional funds given to States must enable a state official to "clearly understand," from the language of the law itself, what conditions the State is agreeing to when accepting the federal funds. *Arlington Cent. Sch. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006).

67. The Affordable Care Act, and positive federal law as a whole, is completely silent as to whether States must pay the Health Insurance Providers Fee to the federal government through their Medicaid and CHIP managed care organizations or risk loss of their federal Medicaid and CHIP funds for managed care. Therefore, the Health Insurance Providers Fee is unconstitutional as applied to the Plaintiffs because it fails to provide the Plaintiffs clear notice on the conditions of accepting federal funding. *See id*. (holding that a federal law failed to provide clear notice to the States even though the congressional record indicated the law meant to

require States to pay expert fees to a prevailing party but the text of the law "does not even hint" that States must pay the fees).

COUNT II

Declaratory Judgment Under 5 U.S.C. § 706 that the Rule Implementing the Health Insurance Providers Fee Is Arbitrary and Capricious

68. Plaintiffs incorporate the allegations contained in paragraphs 1 through 67 as if fully set forth herein.

69. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law." 5 U.S.C. § 706(2)(A).

70. The delegation by the Department of Health and Human Services (under the Centers for Medicare & Medicaid Services) of ultimate decision-making authority to the Actuarial Standards Board on whether States must pay their Medicaid and CHIP managed care organizations the Health Insurance Providers Fee is arbitrary and capricious and not otherwise in accordance with law.

COUNT III

Declaratory Judgment Under 5 U.S.C. § 706 that the Rule Implementing the Health Insurance Providers Fee Was Imposed Without Observance of Procedure Required by Law

71. Plaintiffs incorporate the allegations contained in paragraphs 1 through 70 as if fully set forth herein.

72. The Administrative Procedures Act requires this Court to hold unlawful and set aside any agency action taken "without observance of procedure required by law." 5 U.S.C. § 706(2)(D).

73. The Department of Health and Human Services is an "agency" under

the Administrative Procedures Act, 5 U.S.C. § 551(1), and the regulations and rules imposing the Health Insurance Providers Fee upon the States is a "rule" under the Administrative Procedures Act. 5 U.S.C. § 551(4).

74. With exceptions that are not applicable here, agency rules must go through notice-and-comment rulemaking. 5 U.S.C. § 553.

75. The Department of Health and Human Services failed to properly engage in notice-and-comment rulemaking by delegating final authority and discretion to the Actuarial Standards Board without observance of procedure required by law.

COUNT IV

Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that the Health Insurance Providers Fee Unconstitutionally Coerces a Sovereign

76. Plaintiffs incorporate the allegations contained in paragraphs 1 through 75 as if fully set forth herein.

77. The Health Insurance Providers Fee of the Affordable Care Act, Pub. L. 111-148, 124 Stat. 865–66, is an unconstitutionally coercive exercise of Congressional authority.

COUNT V

Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that the Agency Action Is Contrary to Constitutional Right and in Excess of Statutory Authority

78. Plaintiffs incorporate the allegations contained in paragraphs 1 through 77 as if fully set forth herein.

79. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "contrary to constitutional right" or "in excess of statutory jurisdiction, authority, or limitations." 5 U.S.C. § 706(2)(B)–(C).

80. The determination that the Plaintiffs must pay the Health Insurance

Providers Fee to the United States through Medicaid and CHIP managed care organizations constitutes an unconstitutional delegation of Congress's legislative power to a private entity in contravention of the United States Constitution, article 1, section 1.

81. Additionally, the agency interpretation of the Affordable Care Act is beyond its lawful authority because it is not entitled to *Chevron* deference. When analyzing an agency interpretation of a statute, courts apply the two-step framework of determining whether the statute is ambiguous and, if so, if the agency's interpretation is reasonable. *Chevron U.S.A., Inc. v. Natural Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984). The theory is that a statutory ambiguity is an implicit delegation, but questions of "deep 'economic and political significance'" are exceptions to the delegation rule. *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (quoting *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014)).

82. First, the Affordable Care Act is not ambiguous as to whether Plaintiffs must pay the Health Insurance Providers Fee to the federal government through the Medicaid and CHIP managed care organizations. Nothing in the language of the Act itself indicates or implies that Plaintiffs must pay the fee.

83. Second, the decision to tax Plaintiffs and put in legal jeopardy their legal entitlement to a significant portion of their budgets are questions of deep economic and political significance Congress would not have delegated to the Department of Health and Human Services apart from an express grant of authority.

COUNT VI

Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that the Health Insurance Providers Fee Unconstitutionally Taxes a Sovereign

84. Plaintiffs incorporate the allegations contained in paragraphs 1 through 83 as if fully set forth herein.

85. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "contrary to constitutional right, power, privilege, or immunity." 5 U.S.C. § 706(2)(B).

86. The Health Insurance Providers Fee of the Affordable Care Act, Pub. L. 111-148, 124 Stat. 865–866, is an unconstitutional tax on Plaintiffs in violation of the Tenth Amendment of the United States Constitution and the doctrine of intergovernmental tax immunity.

COUNT VII

Claim for Refund Against the United States Under 26 U.S.C. § 7422 for Previously Paid Health Insurance Providers Fees

87. Plaintiffs incorporate the allegations contained in paragraphs 1 through 86 as if fully set forth herein.

88. Plaintiffs have all paid the United States, through Medicaid and CHIP managed care organizations, the Health Insurance Providers Fee and associated federal income tax the organizations must pay due to the States' payment of the fee. For example, for 2014, Texas has paid the United States approximately $84,637,710.00 for costs associated with the Health Insurance Providers Fee, Kansas has paid the United States approximately $32,837,960 for costs associated with the Health Insurance Providers Fee, and Louisiana has paid the United States approximately $31,342,739 for costs associated with the Health Insurance Providers Fee. In 2014, Indiana paid $17.5 million to cover Health Insurance Providers Fees, Wisconsin, through Medicaid and CHIP managed care organizations, has paid the United States approximately $23 million for costs associated with the Health Insurance Providers fee, and Nebraska incurred approximately $3,516,500.00 in Health Insurance Providers Fees to be reimbursed to its managed care organizations.

89. Plaintiffs are entitled to a refund from the United States because the fee violates the clear notice rule, is arbitrary and capricious, failed to follow statutorily

required procedures, is unconstitutionally coercive, exceeds constitutional and statutory authority, constitutes an unconstitutional tax of a sovereign, and is insufficiently related to federal Medicaid funding to the States.

COUNT VIII

Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that the Health Insurance Providers Fee, As Applied to Plaintiff States' Medicaid Programs, Is Insufficiently Related to the Affordable Care Act to be a Legitimate Exercise of Congress's Spending Power

90. Plaintiffs incorporate the allegations contained in paragraphs 1 through 89 as if fully set forth herein.

91. The limitations on Congress's spending power require, among other things, that federal restrictions on the spending of funds appropriated to the States must relate "to the federal interest in particular national projects or programs." *South Dakota v. Dole*, 483 U.S. 203, 207–08 (1987).

92. Under the Affordable Care Act, to continue to receive Medicaid funding to provide health care for the poorest of the poor, the State must pay the Health Insurance Providers Fee, the purpose of which is to generate revenue to help fund health insurance subsidies for those that do not qualify for Medicaid.

93. The requirement that States pay the Health Insurance Providers Fee is insufficiently related to the Medicaid funding the States receive from the federal government to comply with the Tenth Amendment.

COUNT IX

Claim for Injunction Against Federal Officials from Collecting the Unconstitutional Health Insurance Providers Fee

94. Plaintiffs incorporate the allegations contained in paragraphs 1 through 93 as if fully set forth herein.

95. Plaintiffs are entitled to a permanent injunction against the federal officials from prospectively collecting the Health Insurance Providers Fee because the

fee violates the clear notice rule, is arbitrary and capricious, failed to follow statutorily required procedures, is unconstitutionally coercive, exceeds constitutional and statutory authority, constitutes an unconstitutional tax of a sovereign, and is insufficiently related to federal Medicaid funding to the States.

COUNT X

Alternatively, Declaratory Judgment Under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that, if Section 9010(f) of the Affordable Care Act Bars This Claim for Refund, Section 9010(f) Is Unconstitutional As Applied to the Plaintiff States

96. Plaintiffs incorporate the allegations contained in paragraphs 1 through 95 as if fully set forth herein.

97. The Defendants are likely to contend that section 9010(f) of the Affordable Care Act bars any claim for a refund.

98. To the extent that the Defendants make such an argument and prevail, then section 9010(f) of the Affordable Care Act, as applied to the Plaintiffs, would violate the Tenth Amendment by enabling the federal government to impose an unconstitutional tax on the States while foreclosing the return of such funds.

COUNT XI

Declaratory and Injunctive Relief Under 5 U.S.C. § 706 or 28 U.S.C. §§ 2201 and 2202 that the IRS's Regulations Regarding the Distribution of HIPF Liability Violate the ACA.

99. Plaintiffs incorporate the allegations contained in paragraphs 1 through 98 as if fully set forth herein.

100. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A)–(C).

101. The IRS promulgated regulations regarding the HIPF. *See* 26 C.F.R.

Part 57. The regulations do not comply with the ACA by failing to properly account for and address Plaintiffs' exemption from HIPF liability.

102. Among other things, in as much as section 57.4 addresses certain exemptions, it fails to properly address Plaintiffs' exemption from the HIPF, or otherwise exempt premiums received by covered entities for Medicaid and CHIP services. *See* 26 C.F.R. § 57.4.

103. Section 57.6 does not provide for the correction of the errors complained of herein, or otherwise provide for Plaintiffs to participate in the error correction process. *See* 26 C.F.R. § 57.6.

104. Section 57.9 does not provide for Plaintiffs to be able to make a refund claim, even where Plaintiffs are, as they are here, saddled with the ultimate liability and responsibility for the HIPF. *See* 26 C.F.R. § 57.9.

105. These preceding paragraphs are some examples of how Part 57 is legally insufficient and not intended to be exhaustive. At bottom, Part 57 conflicts with the ACA.

COUNT XII

Declaratory and Injunctive Relief Under 5 U.S.C. § 706 or 28 U.S.C. §§ 2201 and 2202 that the Application of IRS's Regulations to the Distribution of the 2018 HIPF Liability Violates the ACA by Unlawfully Functioning to Impose the Health Insurance Provider Fee on Plaintiffs.

106. Plaintiffs incorporate the allegations contained in paragraphs 1 through 105 as if fully set forth herein.

107. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "(A) arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A)–(C).

108. The IRS promulgated regulations regarding the HIPF. *See* 26 C.F.R. Part 57. To the extent that the implementation or enforcement of any part or all of these regulations results in 2018 HIPF liability upon Plaintiffs, the application those regulations are arbitrary, capricious, an abuse of discretion, otherwise not in accordance with law, contrary to constitutional right, power, privilege, or immunity, in excess of statutory jurisdiction, authority, or limitations, or short of statutory right.

109. Additionally, to the extent that IRS regulations function or operate to impose the HIPF upon Plaintiffs, said imposition is an unconstitutional tax on Plaintiffs in violation of the Tenth Amendment of the United States Constitution and the doctrine of intergovernmental tax immunity.

COUNT XIII

Declaratory and Injunctive Relief Under 5 U.S.C. § 706 or 28 U.S.C. §§ 2201 and 2202 that Defendants Have Unlawfully Withheld and Unreasonably Delayed Agency Action to Remedy Both the Deficiencies in IRS's Regulations and the Application of IRS's Regulations to the Distribution of the 2018 HIPF Liability.

110. Plaintiffs incorporate the allegations contained in paragraphs 1 through 109 as if fully set forth herein.

111. The Administrative Procedure Act requires this Court to "compel agency action unlawfully withheld or unreasonably delayed." 5 U.S.C. § 706(1).

112. As demonstrated herein, Defendants have not sought to remedy the deficiencies in its regulations regarding the HIPF. *See* 26 C.F.R. Part 57. This agency action, both unlawfully withheld and unreasonably delayed, is compelled by the text of the ACA and the clear inconsistencies of Part 57 with the ACA. This agency action is unreasonably delayed, especially in light of this Court's ruling on March 5, 2018.

113. Defendants have failed to make any effort to appropriately harmonize and implement Congress's actuarial soundness requirement, 42 U.S.C. § 1396b(m)(2)(A)(iii), with Plaintiffs' exemption from HIPF liability, ACA

§ 9010(c)(2)(B) (2010). "The justification for the *in pari materia* canon is that Congress should be assumed to have legislated with reference to the other provision." *Little v. Shell Expl. & Prod. Co.*, 690 F.3d 282, 289 (5th Cir. 2012). Reading the two provisions *in pari materia* demands that MCO premiums for Plaintiffs' Medicaid and CHIP services be exempted from Defendants' calculations and distribution of the HIPF liability such that Plaintiffs can maintain their exemption from HIPF liability while simultaneously engaging in Medicaid and CHIP contracts with MCOs that are actuarially sound.

114. Moreover, in the last several years, Defendants have issued multiple notices and decisions, as well as amended regulations, regarding the HIPF, none of which have sought to address, much less discuss, Plaintiffs' exemption from the HIPF. For example, in Health Insurance Providers Fee, 83 FR 8173-01 (Feb. 26, 2018), Defendants addressed the definition of a "covered entity" and exemptions from the HIPF, but failed to address Plaintiffs.

115. Defendants also failed to properly assess the distribution of the liability for the 2018 HIPF and exempt from its calculations MCO premiums for Medicaid and CHIP programs for Plaintiffs.

116. Defendants also failed to respond in any regard to the timely petitions of Plaintiffs to remedy their initial calculations regarding the distribution of the liability for the 2018 HIPF, and to properly exempt from its calculations MCO premiums for Medicaid and CHIP programs for Plaintiffs.

117. These preceding paragraphs are some examples of how Defendants unlawfully withheld or unreasonably delayed agency action in this matter and are not intended to be exhaustive.

V. PRAYER FOR RELIEF

Plaintiff States respectfully request that the Court:

A. Declare that the application of the Health Insurance Providers Fee to Plaintiffs and their Medicaid and CHIP managed care organizations is unconstitutional in that it violates the clear notice rule;

B. Declare that the federal rules applying the Health Insurance Providers Fee to Plaintiffs and their Medicaid and CHIP managed care organizations are arbitrary and capricious;

C. Declare that the federal rules applying the Health Insurance Providers Fee to Plaintiffs and their Medicaid and CHIP managed care organizations are substantively and procedurally unlawful under the Administrative Procedures Act;

D. Declare that the federal rules applying the Health Insurance Providers Fee to Plaintiffs and their Medicaid and CHIP managed care organizations are unconstitutionally coercive;

E. Declare that the delegation to a private entity to determine whether the Plaintiffs must pay the Health Insurance Providers Fee constitutes an unconstitutional delegation of Congress's legislative power and exceeds statutory authority;

F. Declare that the federal rules applying the Health Insurance Providers Fee to Plaintiffs and their Medicaid and CHIP managed care organizations are an unconstitutional tax on the Plaintiffs in violation of the Tenth Amendment of the United States Constitution and the doctrine of intergovernmental tax immunity;

G. Declare that the requirement that States pay the Health Insurance Providers Fee is insufficiently related to the Medicaid funding the States receive from the federal government to comply with the Spending Clause;

H. Declare that, in the event the Court concludes that section 9010(f) of the Affordable Care Act bars this claim for a refund, section 9010(f) is unconstitutional as applied to Plaintiffs;

I. Permanently enjoin Defendants and their employees, agents, and successors in office from enforcing the Health Insurance Providers Fee of the Affordable Care Act against Plaintiffs or the Medicaid and CHIP managed care organizations with which they contract;

J. Permanently enjoin Defendants and their employees, agents, and successors in office from denying federal Medicaid and CHIP funds to Plaintiffs based in whole or in part on the refusal of the Plaintiffs or the Medicaid and CHIP managed care organizations with which they contract to pay the Health Insurance Providers Fee;

K. Permanently enjoin Defendants and their employees, agents, and successors in office from failing or refusing to approve Medicaid or CHIP proposed capitation rates of Plaintiffs based in whole or in part on Plaintiffs refusal to pay the Health Insurance Providers Fee;

L. Order a refund of the amounts Plaintiffs have paid (or may pay during the course of this litigation) under the Health Insurance Providers Fee, including any prejudgment or post-judgment interest as allowed by law;

M. Declare that 26 C.F.R. Part 57 is arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law to the extent that its provisions result in liability to Plaintiffs for the 2018 HIPF;

N. Declare that Defendants have acted in an arbitrary and capricious manner, abused their discretion, or otherwise not acted in accordance with law by failing and refusing efforts to read *in pari materia* 42 U.S.C. § 1396b(m)(2)(A)(iii) and ACA § 9010(c)(2)(B) (2010);

O. Declare that provisions of 26 C.F.R. Part 57 are in excess of statutory jurisdiction, authority, or limitations, or short of statutory right to the extent that they result in liability to Plaintiffs for the 2018 HIPF;

P. Declare that provisions of 26 C.F.R. Part 57 are contrary to constitutional right, power, privilege, or immunity to the extent that its provisions result in liability to Plaintiffs for the 2018 HIPF;

Q. Direct Defendants to revise 26 C.F.R. Part 57, and particularly 26 C.F.R. § 57.4, to add an exclusion that properly encompasses and accounts for Plaintiffs' exemption in ACA § 9010(c)(2)(B).

R. Direct Defendants, for agency action unlawfully withheld and unreasonably delayed, to immediately notify Plaintiffs' Medicaid and CHIP MCOs of Defendants' intent to issue new, amended final fee calculations (Letters 5067C) for 2018 HIPF liability to Plaintiffs' Medicaid and CHIP MCOs which properly exempt from its calculations MCO premiums for Medicaid and CHIP programs for Plaintiffs;

S. Direct Defendants, for agency action unlawfully withheld and unreasonably delayed, to immediately extend indefinitely the October 1, 2018 payment deadline for 2018 HIPF liability for Plaintiffs' Medicaid and CHIP MCOs in light of Defendants' intent to issue new, amended final fee calculations (Letters 5067C) for 2018 HIPF liability;

T. Direct Defendants, for agency action unlawfully withheld and unreasonably delayed, to respond to Plaintiffs' timely protests regarding 2018 HIPF liability and confirm Plaintiffs' exemption from 2018 HIPF liability;

U. Direct Defendants, for agency action unlawfully withheld and unreasonably delayed, to issue new, amended final fee calculations (Letters 5067C) for 2018 HIPF liability to Plaintiffs' Medicaid and CHIP

MCOs which properly exempt from its calculations MCO premiums for Medicaid and CHIP programs for Plaintiffs;

V. Enjoin Defendants from receiving or collecting, from Plaintiffs' Medicaid and CHIP MCOs, any and all payments, or portions of payments, for the 2018 HIPF that are based, in part or in whole, upon Defendants' calculations for 2018 HIPF liability involving premiums (capitation rates) for Plaintiffs' Medicaid and CHIP services;

W. Direct that Defendants deposit into the registry of the Court, in accordance with Rule 67 of the Federal Rules of Civil Procedure and other applicable law, any monies received or collected from Plaintiffs' Medicaid and CHIP MCOs for 2018 HIPF liability that are based, in part or in whole, upon Defendants' calculations for 2018 HIPF liability involving premiums (capitation rates) for Plaintiffs' Medicaid and CHIP services; and

X. Grant Plaintiffs such other and further relief to which they are justly entitled at law and in equity.

Respectfully submitted this 7th day of September, 2018.

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ATTORNEYS FOR PLAINTIFFS

CERTIFICATE OF SERVICE

I certify that on the 7th day of September, 2018, the foregoing was electronically filed with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ Austin R. Nimocks
AUSTIN R. NIMOCKS

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
WICHITA FALLS DIVISION

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs,* v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, ALEX AZAR, in his Official Capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, AND DAVID J. KAUTTER, in his Official Capacity as ACTING COMMISSIONER OF INTERNAL REVENUE, *Defendants.*	§	Civil Action No. 7:15-CV-00151-O

[PROPOSED] ORDER GRANTING PLAINTIFFS' MOTION FOR LEAVE TO FILE A SECOND AMENDED COMPLAINT

On this day came to be considered Plaintiffs' Motion for Leave to File a Second Amended Complaint (the "Motion"). This Court finds that Plaintiffs have shown good cause to amend the Complaint to include their claims related to the 2018 Health Insurance Providers Fee ("HIPF"). The Court also finds that the requested amendment was brought in good faith because the new claims recently ripened. The amendment will not unduly prejudice Defendants because Defendants have prepared a case related to the prior HIPF payments, a final judgment has not been entered, and Defendants specifically moved the Court to delay the entry of final judgment. ECF No. 101. Further, Plaintiffs have stated a claim for which relief can be granted,

and Plaintiffs have not repeatedly failed to cure deficiencies by prior amendments. Being fully advised, and for good cause shown, Plaintiffs' Motion is GRANTED.

Accordingly, it is ORDERED that the Clerk of Court is directed to file and docket as a new filing and docket entry Plaintiffs' proposed Second Amended Complaint for Declaratory and Injunctive Relief attached to their motion to amend as Exhibit A in this matter.

SO ORDERED this the _____ day of _____, 2018.

_____
HON. REED O'CONNOR
UNITED STATES DISTRICT JUDGE