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

STATE OF TEXAS,
STATE OF KANSAS,
STATE OF LOUISIANA,
STATE OF INDIANA,
STATE OF WISCONSIN, and
STATE OF NEBRASKA

Plaintiffs,

v.

UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, THOMAS E. PRICE, M.D., in his official capacity as SECRETARY OF HEALTH AND HUMAN SERVICES, UNITED STATES INTERNAL REVENUE SERVICE, and JOHN KOSKINEN, in his official capacity as COMMISSIONER OF INTERNAL REVENUE SERVICE

Defendants.

Civ. No. 7:15-cv-00151-O

BRIEF IN SUPPORT OF DEFENDANTS' MOTION FOR SUMMARY JUDGMENT AND IN OPPOSITION TO PLAINTIFFS' MOTION FOR SUMMARY JUDGMENT

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INTRODUCTION

Congress enacted the Patient Protection and Affordable Care Act ("ACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), to enable individuals, families, and small businesses to obtain accessible and affordable health insurance coverage. The ACA regulates insurers in many ways. Among the ACA's features is the Health Insurance Providers Fee ("HIPF"), at Section 9010 of the ACA, which is assessed and collected from providers of coverage for "United States health risks." As governmental entities, Plaintiffs in this action are expressly excluded from the categories of health insurance providers required to pay the HIPF. Plaintiffs, however, voluntarily contract with private managed care organizations ("MCOs") that are subject to the HIPF to deliver Medicaid services. Plaintiffs have launched an array of baseless constitutional and statutory claims challenging the HIPF on the theory that the costs of the HIPF (like all other costs borne by MCOs) are built into the capitation rates that Plaintiffs pay to the MCOs and therefore are really imposed on the states. But by this logic, states could challenge a federal tax imposed on any entity providing a good or service the state uses, the costs of which will likely increase because of the tax. And similarly, all individuals purchasing insurance or MCO services could also challenge the HIPF. Such generalized grievances, however, do not create standing.

In all events, the HIPF is no extraordinary measure, as Plaintiffs contend; it is simply another example of Congress's longstanding authority to levy a tax on private entities engaged in the business of providing health insurance. While Plaintiffs argue, implausibly, that they could not have anticipated that a new federal tax on MCOs might result in increased capitation rates in Plaintiffs' contracts with such organizations, basic concepts of both economics and actuarial science preclude virtually any other outcome. When the costs of providing a good or service increase, the costs of purchasing that good or service generally also increase. Here, the undisputed

record evidence shows that when Plaintiffs first contracted with the MCOs to provide Medicaid services, Plaintiffs were well aware that long-standing principles of actuarial soundness require that contracts with MCOs account for all reasonably anticipated costs, including costs from newly imposed taxes.

The Court in any event need not reach the merits of Plaintiffs' claims, because they founder on two jurisdictional grounds. First, Plaintiffs, as statutorily exempt entities, do not have standing to challenge the imposition of the HIPF on covered entities. Second, Plaintiffs' attempt to restrain the IRS's assessment and collection of the HIPF is barred by the Anti-Injunction Act, which imposes a substantive limitation on courts' subject matter jurisdiction.

Setting aside their jurisdictional defects, Plaintiffs' claims also fail on their merits. Plaintiffs' Spending Clause challenges fail at the outset because the HIPF is not an exercise of Congress's power under U.S. Const. Art. I, § 8, to spend for the general welfare. Rather, the HIPF is a constitutional exercise of Congress's taxing power: the HIPF is paid into the Treasury and enforced by the IRS under the Internal Revenue Code. It is well within Congress's power to tax insurance providers—and, for that matter, to tax the states directly, although Congress has not done the latter in enacting the HIPF. But even if Plaintiffs could get around their concession (and the reality) that "Congress recognized the HIPF as a tax," not an act of spending, the undisputed facts establish that the HIPF is not coercive, that it is sufficiently related to the purposes of both the ACA and Medicaid, and that there is no basis for concluding that Congress "surprised" the States with any retroactive condition in § 9010 of the ACA.

What is more, the HIPF does not violate any intergovernmental tax immunity that might exist because it is not imposed on the States, and further, it is not discriminatory. The HIPF is applied evenly to all covered MCOs, regardless of whether the MCOs do business with states or

with private entities. In any event, Plaintiffs already have litigated the legal issues pertinent to their Tenth Amendment claim, and they have lost in other fora. Plaintiffs thus are barred by the doctrine of issue preclusion from re-litigating those questions here.

Next, while 42 C.F.R. § 438.6 requires a state's managed-care contracts be certified as actuarially sound "by actuaries who . . . follow the practice standards established by the Actuarial Standards Board [(ASB)]," that regulation does not unconstitutionally delegate legislative power to a private entity, as Plaintiffs claim. When Congress established the requirement that rates be actuarially sound in Section 1903(m)(2)(A)(iii) of the Social Security Act, it authorized the Secretary of Health and Human Services (HHS) to enact regulations to define that term. The Secretary established the actuarial soundness standard through notice-and-comment rulemaking. At most, the ASB standards serve an advisory function; HHS' Centers for Medicare & Medicaid Services (CMS) considers and gives weight to the standards, but retains authority under its regulations to review capitation rates and determine whether they are actuarially sound.

Plaintiffs' other claims fare no better. Plaintiffs do not challenge the statutory requirement that their contracts with MCOs to provide health services to Medicaid-eligible individuals be actuarially sound. Their APA claims concerning HHS' implementing regulation are time-barred because they accrued in 2002, when CMS' actuarial-soundness regulation was promulgated, or, alternatively, no later than 2005, when guidance published by the American Academy of Actuaries (AAA) made it clear that capitation rates must account for all taxes to be actuarially sound. Even so, these claims lack merit because the actuarial-soundness regulations are authorized by Congress and are entitled to *Chevron* deference. And the adoption of Actuarial Standard of Practice (ASOP) 49 does not require notice-and-comment rulemaking because, as Plaintiffs concede, ASOP 49 did nothing to change generally accepted actuarial-soundness principles.

For these reasons, and for the reasons further explained below, Defendants' motion for summary judgment should be granted, and Plaintiffs' motion should be denied.

BACKGROUND

I. THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

In 2010, Congress enacted the ACA to address the affordability and availability of healthcare coverage. Among the ACA's features is the HIPF, ACA § 9010, a fee assessed on all covered providers of health coverage (either insurers or managed care organizations (MCOs)) for "United States health risks."[1] Certain entities are exempt from the HIPF, including nonprofit providers that receive more than 80 percent of their gross revenues from federal government programs targeting low-income, elderly, or disabled populations. *See* 26 C.F.R. § 57.2(b)(2)(iii). The amount of the HIPF that an entity must pay is based on the ratio of a provider's net premiums written to all net premiums written for United States health risks. *See* ACA § 9010(b)(1). As part of its December 2015 budget, Congress placed a moratorium on the HIPF for the 2017 calendar year. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, 129 Stat. 2242 (2015).

II. THE MEDICAID PROGRAM

Enacted in 1965, Medicaid is a cooperative federal–state program. States that choose to participate in the program and follow federal requirements receive federal funds (federal financial participation, or "FFP") to cover 50 to 100 percent of the costs of providing covered healthcare services to Medicaid-eligible persons.[2] Under Medicaid, a state develops a plan to provide

[1] "United States health risk" is defined as "the health risk of any individual who is" a United States citizen, a resident of the United States, or located in the United States. ACA § 9010(d).

[2] That the federal government, not the state, pays the majority of each state's Medicaid costs is just one reason that Plaintiffs' repeated assertions that "every penny of the HIPF is imposed on the states," Pls.' Mot. for Summ. J., at 12, ECF No. 54, are demonstrably false. *See* Decl. of Dr. James I. Golden (Golden Decl.) ¶¶ 5–6, DA2-4; *see also infra* note 9.

healthcare services to covered populations. This plan must be approved by CMS.[3]

In enacting Medicaid, Congress reserved the "right to alter, amend, or repeal any provision" of the program. 42 U.S.C. § 1304. Since then, the market for healthcare services has changed dramatically, and Congress has periodically invoked its right under section 1304 to ensure that Medicaid keeps up with the times.

For many years, states provided Medicaid healthcare coverage exclusively through a "fee-for-service" delivery system (FFS) and virtually all states (including Plaintiffs) continue to provide healthcare based on FFS for at least some of their Medicaid beneficiaries. Golden Decl. ¶¶ 8, 11, DA4, 5-6. Under FFS, states pay healthcare providers directly for services rendered to Medicaid-eligible individuals. In recent years, many states have chosen to use a "managed-care" delivery system to provide part of their Medicaid coverage in designated parts of the state or to particular Medicaid-eligible groups, although they are not required to do so. In that system, the purchaser of health coverage—often an individual's employer or, in the case of Medicaid beneficiaries, a state—pays a private MCO a fixed monthly fee per covered individual, called a "capitation rate," intended to approximate the cost of providing healthcare services to that individual. An MCO establishes and maintains a network of providers for the delivery of covered health services supplied to the enrolled individual. Congress included measures in the Omnibus Budget Reconciliation Act of 1981 that made it easier for states to offer Medicaid services through managed-care arrangements. Pub. L. No. 97-35, 95 Stat. 357. But because managed-care contracts

[3] The Children's Health Insurance Program (CHIP) was established in 1997 to provide healthcare coverage to uninsured children who do not qualify for Medicaid. Medicaid and CHIP operate virtually identically in all respects relevant to this litigation. Moreover, although Plaintiffs refer to CHIP in their Amended Complaint, *see generally* Am. Compl., ECF No. 19, nowhere in their Amended Complaint or Memorandum do they cite any of the regulations governing the CHIP program, including the CHIP-specific actuarial-soundness regulation, 42 C.F.R. § 457.1203. Accordingly, all references herein to Medicaid also include CHIP.

involve transferring the risk for the cost of providing Medicaid services to private MCOs, Congress thought it best to make FFP available only for contracts that met certain specifications. One such specification—a restriction at issue here—is the requirement that capitation payments made to MCOs be "actuarially sound" so that the risk being transferred was priced appropriately using actuarial principles. *Id*. at 814 (codified at 42 U.S.C. § 1396b(m)(2)(A) (1981)).

HHS initially interpreted the actuarial-soundness requirement to mean that the cost to states for a managed-care contract could not "exceed the cost . . . of providing those same services on a fee-for-service basis . . ." (also known as the upper-payment-limit or UPL). 42 C.F.R. § 447.361 (repealed). However, there developed a broad consensus among states, MCOs, actuaries, and others that this approach was unworkable. *See* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 40,996–97 (June 14, 2002) (to be codified at 42 CFR pts. 400, 430, 431, 434, 435, 438, 440, and 447); *see also, e.g.*, Admin. Record ("AR") Part I of II, at 0538–43, ECF No. 50-2, AR0576–87, AR0560–61, AR0562–74, AR 0590–91, AR Part II of II, at 0806–07, ECF No. 50-3 (all comments from various states commending HHS's proposal to replace the UPL). In 2002, HHS promulgated a regulation containing new actuarial-soundness requirements. Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. at 40,989. After considering a variety of methods for determining actuarial-soundness, HHS concluded that using "accepted actuarial principles and practices . . . [was] the best approach in that it gives [s]tates and actuaries maximum flexibility while still ensuring that rates [will be] certified as actuarially sound." Medicaid Program at 40,998. The 2002 regulation requires that managed-care contracts be certified by an "actuar[y] who meet[s] the qualification standards established by the American Academy of Actuaries and follow[s] the practice standards established by the Actuarial Standards

Board." 42 C.F.R. § 438.6(c)(1)(i)(C) (2015).[4] At the time that CMS issued section 438.6(c)(1)(i)(C), those ASOPs included accounting for taxes and fees when calculating risk for purposes of establishing capitation rates. *See infra* Part III(A), at 40–41.

In the ACA, Congress amended the statute requiring that capitation payments made to MCOs be "actuarially sound" to provide that "capitation rates paid to [Medicaid MCOs] shall be based on actual cost experience related to [prescription drug] rebates and *subject to the Federal regulations requiring actuarially sound rates*. . . ." ACA § 2501 (emphasis added), 124 Stat. at 308 (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)). Five years later, the ASB issued ASOP 49, which provides guidance about how actuaries should properly develop and evaluate Medicaid MCO capitation rates. *See* Actuarial Standards Board, Medicaid Managed Care Capitation Rate Development and Certification: ASOP No. 49 ("ASOP 49") (Mar. 2015). Consistent with well-established and generally accepted actuarial principles and standards, ASOP 49 states that to be actuarially sound, MCO rates must account for any taxes and fees for which MCOs are liable, *see id.* at 10, but it also contemplates that actuaries may exercise their professional judgment to

[4] Effective July 2016, HHS amended the actuarial soundness regulations. *See* Medicaid and Children's Health Insurance Program (CHIP) Programs, 81 Fed. Reg. 27,498 (May 6, 2016) (to be codified at 42 CFR pt. 431, 433, 438, 440, 457 and 495). HHS recodified the actuarial soundness requirement, including the definitions of "actuary" and "actuarially sound capitation rates," but did not alter the definitions from the prior version in any substantive way relevant here. *Compare* 42 C.F.R. § 438.2 (2016) ("*Actuary* means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board.") and 42 C.F.R. § 438.4 (2016) (defining "actuarially sound capitation rates" as rates which "[h]ave been developed in accordance with . . . generally accepted actuarial principles and practices . . .") *with* 42 C.F.R. § 438.6(c)(1)(i) (2015) ("*Actuarially sound capitation rates* means capitation rates that—(A) Have been developed in accordance with generally accepted actuarial principles and practices; . . . and (C) Have been certified . . . by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board"). Because Plaintiffs challenge the version of the regulations in effect in 2015, and because the definitions relevant to Plaintiffs' claims are unchanged, this brief cites and refers to the 2015 version of the regulation.

deviate from the guidelines where appropriate, *see id.* at 12.[5]

STANDARD OF REVIEW

A motion for summary judgment should be granted "if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law," Fed. R. Civ. P. 56(a), and is appropriate where, as here, "the only issue before the court is a pure question of law." *Sheline v. Dun & Bradstreet Corp.*, 948 F.2d 174, 176 (5th Cir. 1991); *see also Neff v. Am. Dairy Queen Corp.*, 58 F.3d 1063, 1065 (5th Cir. 1995) ("Consequently, we hold that because the disputed issue in this case is purely legal, it was appropriately resolved through summary judgment."). A genuine dispute of material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Although the Court must consider the evidence with all reasonable inferences in the light most favorable to the nonmovant, the nonmoving party must produce specific facts to demonstrate that a genuine issue exists for trial. *See Webb v. Cardiothoracic Surgery Assocs. of N. Tex., P.A.*, 139 F.3d 532, 536 (5th Cir. 1998) (citations omitted). Conclusory allegations and denials, speculation, improbable inferences, unsubstantiated assertions, and legalistic argumentation are not adequate substitutes for specific facts showing that there is a genuine issue for trial. *See Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1428-29 (5th Cir. 1996) (en banc), *superseded by statute on other grounds*, 28 U.S.C. § 636(b)(1); *see also SEC v. Recile*, 10 F.3d 1093, 1097 (5th Cir. 1993).

[5] Before publishing the final rule amending the actuarial-soundness regulations in May 2016, HHS received 879 timely comments, including from each of the Plaintiffs other than Nebraska. Golden Decl. ¶ 17, DA8-10. As noted, the new rule contained definitions of "actuary" and "actuarially sound capitation rates" that are substantively identical to those in the prior version of the regulation, and none of the Plaintiffs' submitted comments that addressed these definitions. *Id.* CMS has also offered guidance to actuaries about accounting for the HIPF in managed-care rate certification. *See* Decl. of Christopher J. Truffer (Truffer Decl.) ¶¶ 1a, 19, 24b & Ex. L, DA146, DA158, DA161-62, DA359-67.

ARGUMENT

I. THIS COURT LACKS SUBJECT MATTER JURISDICTION.

A. Plaintiffs Lack Article III Standing.

Article III of the U.S. Constitution restricts federal courts' jurisdiction to "cases" and "controversies." "One element of the case-or-controversy requirement is that plaintiffs must establish that they have standing to sue." *Clapper v. Amnesty Int'l, USA*, 133 S. Ct. 1138, 1146 (2013) (citation omitted). To establish standing, Plaintiffs must show that they have suffered an injury that is "[1] concrete, particularized, and actual or imminent; [2] fairly traceable to the challenged action; and [3] redressable by a favorable ruling." *Id.* at 1147 (citation omitted). Although "[a]t the pleading stage, general factual allegations of injury resulting from the defendant's conduct may suffice," on a motion for summary judgment, "the plaintiff can no longer rest on such 'mere allegations,' but must 'set forth' by affidavit or other evidence 'specific facts.'" *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992).

As explained in Defendants' Motion to Dismiss, because Plaintiffs challenge an act of Congress whose object is not the States, the standing inquiry here must therefore be "'especially rigorous'" and Plaintiffs' burden is "'substantially more difficult to establish.'" *See* Defs.' Mot. to Dismiss Pls.' Am. Compl. ("Defs.' MTD"), at 8, ECF No. 27 (quoting *Clapper*, 133 S. Ct. at 1147, and *Lujan*, 504 U.S. at 562). Although this Court rejected Defendants' arguments at the motion to dismiss stage, it is now clear that Plaintiffs' claims are baseless.

1. Plaintiffs' Claimed Injury from the HIPF Is Not Fairly Traceable to the Federal Government.

Section 9010 of the ACA imposes the HIPF on MCOs, not on the States. Accordingly, to find that Plaintiffs have standing here would mean that any state would have standing to sue the federal government to challenge any federal action that results in any downstream cost increase

for any entity with which the state or one of its instrumentalities does business. Similarly, any person with health insurance through a health insurance provider subject to the HIPF would have standing to sue the federal government. And it would mean that the federal government would have standing to bring suit against the states for the various taxes the states themselves have imposed on MCOs that result in a downstream increase in the cost of Medicaid to the federal government, which pays the majority share of Medicaid costs for Plaintiffs. *See supra* 4. Such a jurisdictional rule has no bounds and is irreconcilable with the basic constitutional tenet that federal courts are "courts of limited jurisdiction," *see, e.g.*, *Kokkonen v. Guardian Life Ins. Co. of Am.*, 511 U.S. 375, 377 (1994); therefore, it must be rejected.

Moreover, the States' purported injuries derive from their *choices* to engage entities subject to the HIPF, and it is hornbook law that a plaintiff "cannot manufacture standing merely by inflicting harm on [himself]." *Clapper*, 133 S. Ct. at 1151. No federal law requires the States to contract with MCOs subject to the fee. If the States find the HIPF's effect on MCO pricing onerous, they can choose to employ a different healthcare delivery model that would not be subject to the fee. Plaintiffs respond that they have no choice because (1) HIPF-exempt MCOs are not sufficiently available to them, and (2) "[t]ransitioning from managed care back to fee-for-service is virtually unconscionable." Pls.' Mot. for Summ. J. ("Pls.' Br.") at 15-19, ECF No. 54. At the pleading stage, this Court found that "from the face of the Amended Complaint, it does not appear that Plaintiffs 'manufacture[d] standing' by hand-picking some MCOs above others, since the necessary number of exempt or discounted MCOs does not even exist." Mem. Op. and Order ("Op."), at 15, ECF No. 34. However, review of Plaintiffs' own evidence makes clear that the allegations in the Amended Complaint lack the factual support necessary for summary judgment.

As to Indiana, Texas, and Wisconsin, the evidence Plaintiffs submitted does not

substantiate the contention that HIPF-exempt MCOs are not sufficiently available:

- Indiana contracts with two non-profit MCOs exempt from the HIPF, but has chosen to limit the number of members receiving care through those contracts. App. to Pls.' Mot. for Summ. J. at A0122, ¶ 10, ECF No. 54-1 (Moser Decl.) ("The maximum number of members I am comfortable putting in any one Medicaid plan is 400,000.") Although Indiana alleges that these MCOs "are not capable of handling all Indiana Medicaid members," this claim is unsubstantiated. *Id.* at A0129, ¶ 2 (2d. Moser Decl.). Moreover, Indiana provided no evidence reflecting whether, even within the self-imposed enrollment limit, the state sought to maximize the number of members receiving care through these exempt MCOs in order to minimize the size of its Medicaid contracts that must account for an MCO's payment of the HIPF. Accordingly, Plaintiffs have not established that in Indiana the necessary number of exempt MCOs does not exist.

- Although Plaintiffs assert that "the operational footprint of . . . [HIPF-exempt] MCOs is insufficient to cover Texas's 13 geographical Service Delivery Areas for Medicaid," ECF No. 54 at 15, this statement is not supported by the cited report. *See* A1041-45 (Rymal Report), ECF No. 54-1. Rather, what the report states is that "Federal law and CMS require that there be at least two MCOs in every service area," and "[b]ased on the historic responses to HHSC managed care RFP's, there are insufficient non-profit MCOs to provide services in all the geographic service areas in Texas to ensure Medicaid clients have the required choice of provider." A1044. But CMS regulations permit a state to limit a beneficiary's choice to one managed care plan in a rural area. Golden Decl. ¶ 18, DA10. Plaintiffs have offered no evidence showing how many geographic service areas in Texas are served by only one non-profit MCO nor whether any of those areas would not qualify for the rural coverage exemption; as a result, Plaintiffs have not established that in Texas, the necessary number of exempt MCOs does not exist. *See* A1043-44.

- Similarly, as to Wisconsin, the evidence does not establish that the necessary number of exempt MCOs does not exist. Rather, Plaintiffs assert without substantiation that "[a]s is required under member choice provisions within Medicaid, . . . there must be at least two MCOs in a geographic region" and "Wisconsin does not and most likely would not have multiple non-profit MCOs in all regions of the . . . state." Decl. of Kevin Moore, at A1163 (Moore Report), ECF No. 54-1. Just as with Texas, Plaintiffs have offered no evidence showing how many geographic regions in Wisconsin are not served by multiple non-profit MCOs nor whether any of those regions would not qualify for the rural coverage exemption. *Id.*; *see* Golden Decl. ¶ 18, DA10.

Furthermore, each of these states actually increased the fraction of Medicaid services that are provided through a managed care delivery system and decreased the proportion provided through

a FFS delivery system after passage of the ACA, despite knowledge of the HIPF.[6] And Plaintiffs nowhere indicate that they have even discussed with their for-profit MCO contractors the option of switching to non-profit status with respect to their Medicaid business.

As to the remaining states, Plaintiffs' evidence shows that two transitioned from FFS to a managed care delivery system only *after* passage of the ACA, and the third significantly increased the fraction of Medicaid services provided through a managed care delivery system and decreased the proportion provided through a FFS delivery system during that same period:

- "In Calendar Year (CY) 2013, Kansas changed from a fee for service model of providing Medicaid and CHIP services to a managed care model. . . ." Decl. of Michael Randol (Randol Decl.), at A0133, ECF No. 54-1.

- "In 2010, when the Affordable Care Act ('ACA') was passed, approximately 100% of [Louisiana's] Medicaid and LaCHIP clients received their covered benefits through a fee-for-service ('FFS') delivery model. However, in February [2016], [Louisiana] shifted away from FFS models to managed care models." Decl. of Jen Steele (Steele Decl.) at A0291, ECF No. 54-1.

- "Nebraska Medicaid has utilized managed care in three urban counties since 1995, and added the seven surrounding counties in August 2010. As of July 1, 2012, Nebraska's managed care program was expanded statewide for physical health services. . . . On September 1, 2013, Nebraska shifted its behavioral health program to an at-risk managed

[6] *See* A0120 (Moser Decl.) (*citing* FSSA Home, *Medicaid Monthly Enrollment Reports*, http://www.in.gov/fssa/ompp/4881.htm, which reflects that between March 2015 (when ASB published ASOP 49) and December 2016, Medicaid beneficiaries enrolled in Indiana's managed care program increased from 70 percent to 80 percent, equaling approximately 300,000 people); A1006 (Carruth Rep.), ECF No. 54-1 ("In 2010, . . . approximately 70 percent of Medicaid clients received their covered benefits through Managed Care Organizations ('MCOs') that contract with [Texas]. As of August 2016, approximately 88 percent of Medicaid clients receive services through MCOs."); A1008 (Carruth Rep.) (noting that in calendar year 2017, "fully 93 percent of [Texas Medicaid] clients will be served in managed care"). Plaintiffs submitted no facts about Wisconsin's Medicaid enrollment. *See generally* Moore Report at A1161-66. However, publicly available data prepared by Wisconsin and CMS makes clear that since 2010, the percentage of Wisconsin Medicaid beneficiaries enrolled in managed care increased from 54 percent to approximately 65 percent. *Compare* CMS, Medicare-Medicaid Enrollee State Profile: Wisconsin, at 8 (undated), http://www.integratedcareresourcecenter.com/PDFs/StateProfileWI.pdf ("In 2010, 54% of Wisconsin Medicaid enrollees were in mandatory managed care programs. . . ."), *with* Michael Heifetz, Medicaid Dir., Wisc. Dep't of Health Servs., Wisc. Medicaid Update, at 5 (2016), http://www.hfmawisconsin.com/uploads/5/3/3/0/53303397/session_301_wisconsin_medicaid_ update.pdf ("About 35% [of Wisconsin Medicaid beneficiaries] are enrolled in [fee-for-service] and about 65% are enrolled in managed care."); *see also id.* ("The percentage of members who receive coverage through managed care in Wisconsin has been increasing over the past several years.").

> care model." A0485, ECF No. 54-1 (Lynch Report). Moreover, as to Nebraska's statewide physical health services, Plaintiffs' evidence does not establish that managed care is the only delivery system or was in the three urban counties prior to the ACA's passage. *Id.*

It is fair to presume that Plaintiffs undertook these transitions after finding that the benefits of relying on a managed care system outweighed the modest downstream costs to them associated with the HIPF. After transitioning from one delivery system to another with full knowledge of the HIPF, it is Plaintiffs that have no credible argument that Defendants caused their injury.

And even if the foregoing were not true, the States may avoid any alleged economic burden from the HIPF itself by choosing an alternative healthcare delivery system for providing Medicaid services other than managed care. *See* Ernest G. Jaramillo III, Salud Actuarial Consulting, ("Jamarillo Report") at 5-6 (Oct. 2016), DA391-92; *see also* Golden Decl. ¶11, DA5-6 (noting that "Medicaid FFS delivery systems are still employed by most states for at least some part of the Medicaid-eligible population"). There is certainly nothing in the Medicaid Act (or, for that matter, in the ACA) that requires states to use managed care.[7]

Thus, Plaintiffs' insistence that they "cannot contract with non-profit, HIPF-exempt MCOs," Pls. Br. at 15, and that to "avoid the HIPF" they must "fundamentally redesign[] Plaintiffs' healthcare systems," Pls. Br. at 19, is insufficient to demonstrate standing at the summary judgment stage. Plaintiffs' evidence demonstrates that they have made choices of their own prerogative regarding their healthcare delivery model for Medicaid, and making a choice to expose oneself to purported injury when there is a way to avoid it is not an injury fairly traceable to the federal government.[8]

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[7] Further, although Plaintiffs assert they have experienced "substantial" "savings associated with managed care," these are mere allegations for which Plaintiffs have offered no reliable supporting evidence. ECF No. 54 at 17-18; *see also* Golden Decl. ¶ 13, DA6-7.

[8] The Fifth Circuit's jurisdictional holding in *Texas v. United States*, 809 F.3d 134, 150-162 (5th Cir. 2015),

Even if Plaintiffs do elect to provide Medicaid services through MCOs subject to the fee, the States still exercise substantial control over their capitation rates. Contrary to Plaintiffs' unsupported assertions, states have leverage in rate negotiations with MCOs. *See* Truffer Decl. ¶¶16(a)(i), 24(c), DA155, DA162-63. While a state's capitation rates with certain for-profit MCOs may rise as a result of the HIPF, the extent of this increase will be decided during the negotiation process, a process in which the federal government is entirely uninvolved. Plaintiffs' injury, therefore, is most "fairly traceable" to choices made by the States and the MCOs they elect to contract with—not the HIPF.[9]

2. Plaintiffs Have Suffered No Injury from the Actuarial Soundness Requirements Set Forth in HHS' Regulations.

Plaintiffs also challenge the requirement that the state's chosen actuary meet certain basic qualification standards and adhere to actuarial standards of practice when certifying that an MCO's capitation rates are actuarially sound. The actuarial soundness standards are set forth in a substantive regulation, previously codified at 42 C.F.R. § 438.6(c)(1)(i)(C) (2015), which itself

as revised (Nov. 25, 2015), *cert. granted*, 136 S. Ct. 906 (2016), does not show otherwise. The court there found standing in the particular circumstances of that case, where Texas claimed that its only options were to incur a pecuniary loss by paying state-law subsidies for driver's licenses for aliens who were the subject of a new federal policy or to change the state law that required the subsidies. But the court also recognized that an injury is self-inflicted and insufficient to confer standing where, as here, a federal policy leaves states the option to "achieve[] their policy goal in myriad ways." *Id.* at 159. Here, as explained above and in the Golden Decl. ¶¶ 12, 21, DA6, DA10-11 and Jaramillo Report at 5-6, DA391-92, Plaintiffs could have used a different delivery model, non-profit MCOs, or a combination of alternative approaches to avoid any impact of the HIPF. Indeed, each Plaintiff uses one or more of these alternatives to provide Medicaid to some of its Medicaid-eligible populations. States can also use the negotiation process with their preferred MCOs to produce contracts that may ameliorate any impact of the HIPF by, for example, negotiating to reduce what they must pay for other aspects of the MCOs' services that are folded into the capitation rate. Truffer Decl. ¶¶ 16(a)(i), 24(c), DA155, DA162-63.

[9] Moreover, Plaintiffs' repeated assertions that "every penny of the HIPF is imposed on the states," ECF No. 54 at 12, are incorrect, for several reasons: (1) the HIPF is imposed on insurers, not the states; (2) the HIPF is assessed against insurers' revenues in several lines of business, of which Medicaid is only one; and (3) the federal government, not the state, pays the majority of that state's Medicaid costs. *See* Truffer Decl. ¶ 23, DA161; Golden Decl. ¶ 5-6, DA2-4.

exacts no injury, and Plaintiffs have asserted none separate and apart from the regulation's role in ensuring that in certifying the actuarial soundness of states' MCO contracts, the HIPF be taken into account. Despite several opportunities to do so, the Plaintiffs have not opposed using these standards, and a number of states have supported using them. *See, e.g.*, Golden Decl. ¶¶ 15, 17, DA7-10; *see also, e.g.*, Texas Health and Human Serv. Comm'n, Uniform Managed Care Terms and Conditions at AR0538, ECF No. 54-1, *id.* at AR0576, *id.* at AR0560, *id.* at AR0562, *id.* at AR 0590, *id.* at AR0806 (comments from states commending HHS's proposal to replace the UPL). And the States presumably would have no interest in paying actuarially *un*sound capitation rates, as that risks the MCOs being unable to provide healthcare services to Medicaid beneficiaries and leaving both the States and their resident beneficiaries in the lurch. *Cf.* A0122 (Moser Decl.). Louisiana (in fact, through the same witness the state relies on in this case), has even *publicly supported* the very ASOP it complains about here, lauding the ASB's "goal of establishing guidance and standards for actuaries preparing Medicaid capitation rates." Letter from Jen Steele, Medicaid Deputy Director, State of Louisiana Department of Health and Hospitals, to Actuarial Standards Board (May 15, 2014), attached as Ex. I to Truffer Decl, DA304-06. Indeed, every one of the Plaintiffs has expressly incorporated the ASB's standards into their own regulation of intra-state insurance contracts.[10] So to the extent that the States experience higher capitation rates as a

[10] *See* Ind. Code § 27-1-12.8-23(d)(4)(A) (2013) (requiring insurance opinions be "based on [] standards adopted by the Actuarial Standards Board"); Kansas Insurance Dep't, *Policy and Procedure Relating to Actuarial Opinions and Memorandums*, at 4 (July 9, 2004), http://www.ksinsurance.org/documents/department/regulations-adopted/article-1/40-1-44-attachment.pdf (requiring actuarial analyses to "conform to the Standards of Practice as promulgated . . . by the Actuarial Standards Board"); La. Stat. § 22:752(D)(3) (2014) (requiring actuarial opinions for life insurance contracts to "be based on standards adopted from time to time by the Actuarial Standards Board. . ."); Neb. Rev. Stat. § 44-424(3) (requiring insurance opinions be based on "standards adopted . . . by the Actuarial Standards Board . . ."); 28 Tex. Admin. Code § 21.2211(b) ("The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice . . . promulgated by the Actuarial Standards Board. . ."); Wis. Stat. § 623.06(c)(2) (2017) (requiring life

result of the HIPF, the certification requirement in CMS' rate-setting regulation is not the cause.[11] Nor would invalidation of the HHS regulations redress Plaintiffs' grievances because the Medicaid statute itself requires actuarially sound rates for Medicaid MCO contracts and presumably, Plaintiffs—which have offered no evidence that a change in longstanding HHS regulations would enable them to satisfy actuarial soundness while entirely ignoring the HIPF—would also want sound rates.

B. The Anti-Injunction Act Deprives the Court of Jurisdiction Over Plaintiffs' Claims Challenging the HIPF.

Even assuming that the States could establish standing, their claims challenging the HIPF would be barred by the Anti-Injunction Act (AIA), which provides that "no suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, *whether or not such person is the person against whom such tax was assessed.*" 26 U.S.C. § 7421(a) (emphasis added). In Counts I, IV, VI, and VIII, the States assert claims seeking equitable relief that would prevent Defendants from assessing and collecting the HIPF from MCOs. Because the AIA bars relief that would reduce "anyone's taxes," *Alexander v. Americans United Inc.*, 416 U.S. 752, 760 (1974), the States' claims challenging the HIPF should be dismissed for lack of jurisdiction.

1. The Anti-Injunction Act Applies to Plaintiffs' Claims Because § 9010(a) of the ACA Requires That the HIPF Be Treated As a Tax for Purposes of Subtitle F of the Internal Revenue Code.

opinions to comply with "standards adopted . . . by the actuarial standards board. . .").

[11] Defendants recognize that the Court found *sua sponte* that for the purposes of Defendants' motion to dismiss, Plaintiffs' allegations had satisfied prudential standing requirements. However, Defendants respectfully note that in its opinion denying in part Defendants' motion, the Court mistakenly stated that the definition of "covered entity" in § 9010 "expressly includes 'any governmental entity.'" Op. at 18. Defendants respectfully note that, to the contrary, the definition of "covered entity" in § 9010 expressly "*does not include* . . . any governmental entity" (emphasis added), and request that the Court's prior finding be reconsidered in light of the statutory language.

The AIA divests the court of jurisdiction over "any claim brought by any person," *including constitutional claims*, that would affect the IRS's ability to assess and collect taxes. *Alexander*, 416 U.S. at 759 (the "constitutional nature" of a claim is "of no consequence" for purposes of the AIA); *see Bob Jones Univ. v. Simon*, 416 U.S. 725, 740 (1974) (AIA applies to a "regulatory measure [that is] beyond the taxing power of Congress). "The manifest purpose of [the AIA] is to permit the United States to assess and collect taxes alleged to be due without judicial intervention . . . ." *Enochs v. Williams Packing & Navigation Co.*, 370 U.S. 1, 7 (1962); *see also Cohen v. United States*, 650 F.3d 717, 727 (D.C. Cir. 2011) (discussing the tax exception to the Declaratory Judgment Act, 28 U.S.C. § 2201(a), which is "coterminous" with the Anti–Injunction Act).[12] While "Congress cannot change whether an exaction is a tax . . . for constitutional purposes," it is within Congress's authority to decide whether an exaction is to be treated as a tax for purposes of the AIA. *Nat'l Fed'n of Indep. Bus. (NFIB), v. Sebelius*, 132 S. Ct. 2566, 2583 (2012); *id.* (the AIA and the Affordable Care Act "are creatures of Congress's own creation" and "[h]ow they relate to each other is up to Congress . . .").

In *NFIB*, the Supreme Court unequivocally confirmed that the AIA applies to exactions, regardless of their label, that are "treated as taxes under Title 26, which includes the Anti-Injunction Act." *Id.* at 2583. There, the Court found it significant that Congress chose to label the minimum coverage provision under the ACA as a "penalty," where it "describes many other exactions it creates as 'taxes.'" *Id.* at 2583 (citation omitted). Given the general presumption that Congress acts intentionally where it "uses certain language in one part of a statute and different language in another," *id.* (citing *Russello v. United* States, 464 U.S. 16, 23 (1983)), the Court

[12] Because the Declaratory Judgment Act is "at least as broad as the Anti-Injunction Act," *Bob Jones*, 416 U.S. at 732 n.7, we focus our discussion on the AIA, with the intention that the same reasoning be applied to the question of jurisdiction under the Declaratory Judgment Act.

rejected the argument that the minimum coverage provision should be treated as a tax that would be barred by the AIA. *Id.* at 2583. Unlike with other exactions, nothing in the Internal Revenue Code ("Code") or the ACA required that the minimum coverage provision "be treated as a tax for purposes of the Anti-Injunction Act." *Id.* at 2584.

Here, the plain language of the ACA establishes that the HIPF is the very type of exaction that *NFIB* recognized to be a "tax" for AIA purposes. In § 9010(f)(1), Congress deemed that the HIPF "shall be treated as [an] excise tax[]" for purposes of subtitle F of the Code, 26 U.S.C. Subt. F. Subtitle F, in turn, contains twenty chapters, *see* 26 U.S.C §§ 6001-7874, including Chapter 76, which addresses judicial proceedings and contains the AIA. *See* 26 U.S.C. § 7421. By expressly cross-referencing subtitle F in § 9010(f), Congress clearly expressed its intent that the AIA apply to any suit brought by "any person" for the purpose of challenging the HIPF. Consistent with the statutory text, *see* ACA § 9010(f)(1), the IRS regulation governing the tax treatment of the HIPF states that "[t]he fee is treated as an excise tax for purposes of subtitle F," 26 C.F.R. § 57.8(a), and that the references to "taxes" in subtitle F "are also references to the [HIPF]." *Id.* The regulation also confirms that § 9010(a)'s reference to subtitle F encompasses the AIA. *See id.* (broadly citing §§ 6001-7874).

The States previously argued that because Congress described the HIPF as a "fee," the AIA does not apply to the HIPF. But that argument cannot be squared with the States' new concession that "*Congress* recognized [the HIPF] as a 'tax.'" Pls. Br. at 3 (citing ACA, 124 Stat. at 867) (emphasis added). In any event, the Supreme Court has made it clear that Congress need not refer to an exaction as a "tax" for the AIA to apply; rather, Congress may describe the exaction with any label that it chooses "but direct that [the exaction] nonetheless be treated as a tax for purposes of the Anti-Injunction Act." *NFIB*, 132 S. Ct. at 2583. Plaintiffs concede that that is precisely

what Congress did here. *See* ECF No. 54, at 3 ("Though labeling it as a 'fee,' Congress recognized it as a 'tax.'"); *id.* ("Its label notwithstanding, the HIPF is a tax . . . ."). Given Congress's express command that the HIPF be treated as an excise tax for purposes of subtitle F, its description of the exaction imposed under § 9010 as a "fee" is of no consequence for purposes of the AIA. *See NFIB*, 132 S. Ct. at 2583; *see also Fla. Bankers Ass'n v. U.S. Dep't of the Treasury*, 799 F.3d 1065, 1068 (D.C. Cir. 2015), *cert. denied*, 136 S. Ct. 2429 (2016) (holding that suit challenging a penalty "treated as a tax for purposes of Title 26—including the Anti–Injunction Act" was barred where the suit "would have the effect of restraining . . . the assessment and collection of that tax"). The AIA thus bars any claim brought by the States—including their constitutional claims—that would restrain the collection of the HIPF from the MCOs.

2. The Jurisdictional Bar of the AIA Extends to the States, Regardless of Whether the States Are Subject to the HIPF.

Previously, in an attempt to evade the jurisdictional bar of the AIA, the States argued that they are beyond the reach of the AIA because States are exempted from the ACA's definition of "covered entities" subject to the HIPF. *See* 26 C.F.R. § 57.2(b)(2)(ii) (exempting governmental entities, including states and the United States, from payment of the HIPF).[13] The States are mistaken; because the Amended Complaint "leave[s] little doubt that a primary purpose of this lawsuit is to prevent the Service from assessing and collecting" the HIPF, *Bob Jones*, 416 U.S. at 738, the AIA bars them from seeking relief that would have the effect of restraining the assessment or collection of the HIPF, regardless of whether the States are subject to the HIPF.

By its terms, the AIA bars suits brought by "*any person, whether or not such person is the*

[13] Some non-state entities are also excluded from the definition of "covered entities" subject to the HIPF. *See id.* § 57.2(b)(2)(i) (self-insured employers); § 57.2(b)(2)(iii) (certain nonprofit organizations), § 57.2(b)(2)(iv) (certain voluntary employees' beneficiary associations).

person against whom such tax was assessed." 26 U.S.C. § 7421(a) (emphasis supplied). In the context of the Code, the Supreme Court has long held that "person" necessarily includes States. *Sims v. United States*, 359 U.S. 108 (1959); *Ohio v. Helvering*, 292 U.S. 360, 370 (1934). Further, the Supreme Court has held that the AIA applies even when a third party seeks to challenge only the regulatory impact of a tax, because "a suit to enjoin the assessment or collection of *anyone's* taxes triggers the literal terms of § 7421(a)." *Alexander*, 416 U.S. at 760 (emphasis added); *id.* ("Section 7421(a) does not bar merely a taxpayer's attempt to enjoin the collection of his own taxes."). Here, the States seek relief that would have the effect of restraining the assessment and collection of the HIPF from the MCOs that contract with the States. *See* Prayer for Relief, Am. Compl. at 27-29, ECF No. 19. Because the States' requested relief directly "triggers the literal terms of § 7421(a)," the AIA bars the claims. *See Alexander*, 416 U.S. at 760.

Moreover, the States do not contend that their claims fall into any of the AIA's statutory exceptions. *See* 26 U.S.C. § 7421(a). Nor are they "aggrieved parties" within the "extremely narrow" judicial exception recognized in *South Carolina v. Regan*, 465 U.S. 367, 378 (1984). *See Spencer v. Brady*, 700 F. Supp. 601, 604 (D.D.C. 1988); *see also Am. Soc'y of Ass'n Execs. v. Bentsen*, 848 F. Supp. 245, 250 (D.D.C. 1994) (noting that the exception "is a narrow one tailored to the unique factual pattern in that case"). In the rare instances in which courts have applied this exception, they have done so only where the plaintiffs were "aggrieved parties" lacking "an alternative legal avenue by which to contest the legality of a particular tax," *Regan*, 465 U.S. at 373, by virtue of the fact that they were challenging the tax liability of third parties.[14] *See, e.g.*,

[14] There, South Carolina challenged a federal statute that expressly taxed the interest on state-issued bearer bonds. Despite that Congress had directly legislated with respect to state-issued instruments, South Carolina, as a non-taxpayer, had no avenue to challenge the tax. The Court determined that the AIA did not preclude the State's suit, reasoning that if the AIA applied, South Carolina would need to persuade its citizen taxpayers to pursue court claims on its behalf, and that the AIA's "purposes and the circumstances

Leves v. I.R.S., 796 F.2d 1433, 1434 (11th Cir. 1986) (finding the exception inapplicable because *Regan* "involved the rights of third parties to litigate the tax liability of persons against whom the tax was assessed"). That is not the case here. The States do not purport to challenge the tax liability of the MCOs with whom they contract to deliver Medicaid healthcare services, but instead contend that the HIPF passes to the States as a result of those voluntary contracts.

At bottom, Congress's decision to make "civil actions for refund" by covered MCOs the sole avenue for any party to challenge the HIPF, *see* ACA § 9010(f)(1) (referencing subtitle F of the Code), should be respected. *See NFIB*, 132 S. Ct. at 2583. This express restriction on judicial review gives effect to the "principal purpose" of the AIA: to protect "the Government's need to assess and collect taxes as expeditiously as possible," by requiring that any "legal right to the disputed sums be determined in a suit for refund.'" *Bob Jones*, 416 U.S. at 736 (quoting *Enochs*, 370 U.S. at 7). If the States could seek relief enjoining the collection of the HIPF against the MCOs, which are the States' contractual counterparties, that would mean that any non-taxpayer could haul the IRS into court anytime that he believed a tax to be wrongful simply by contracting with the taxpayer to cover any portion of the tax, even where the taxpayer itself would be prohibited from bringing such a claim. But controlling precedent from the Supreme Court precludes such a result, *Alexander*, 416 U.S. at 760-61 (holding that a third party's challenge was barred by the AIA where the requested relief would have the effect of reducing the taxes assessed and collected from a non-party taxpayer), which would constitute precisely the kind of judicial interference with the assessment and collection of taxes that the AIA was designed to prevent. *See Enochs*, 370 U.S. at 5 ("[T]he object of [the AIA] is to withdraw jurisdiction from the . . . courts to entertain suits seeking injunctions prohibiting the collection of federal taxes."); *see also Lange*

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of its enactment demonstrate that . . . the Act was intended to apply only when Congress has provided an alternative avenue for an aggrieved party to litigate its claims on its own behalf." *Id.* at 381.

v. Phinney, 507 F.2d 1000, 1003 (5th Cir. 1975).

II. DEFENDANTS ARE ENTITLED TO JUDGMENT AS TO PLAINTIFFS' CONSTITUTIONAL CLAIMS BECAUSE THE HIPF IS AN EXERCISE OF CONGRESS'S TAXING POWER, AND THE CLAIMS OTHERWISE LACK MERIT.

Even setting aside their jurisdictional defects, Plaintiffs' constitutional claims fail on their merits. First, because Congress had authority to impose the HIPF under its taxing power, and the HIPF does no more than impose a tax on covered entities, § 9010 must be sustained as a constitutional exercise of the taxing power. Similarly, that the HIPF represents an exercise of Congress's taxing power disposes of the States' Spending Clause claims, as well as the claim that the HIPF violates their Tenth Amendment immunity. While Plaintiffs assert a variety of theories, they fail to establish a claim under the Spending Clause or the Tenth Amendment.

A. The HIPF Is a Constitutional Exercise of Congress's Taxing Power.

In authorizing Congress to "lay and collect Taxes . . . for the . . . general Welfare of the United States," U.S. Const., Art. I, § 8, cl. 1, the Constitution permits Congress to require individuals to pay money into the Federal Treasury. "The power to tax is granted in broad and sweeping terms . . . . The authority thus granted 'is exhaustive and embraces every conceivable power of taxation.'" *Clark v. C.I.R.*, 41 T.C.M. (CCH) 618 (T.C. 1980) (quoting *Brushaber v. Union Pac. R.R.*, 240 U.S. 1, 12 (1915)). The Supreme Court has defined a tax as a "pecuniary burden laid upon individuals or property for the purpose of supporting the government." *United States v. New York* (*New York I*), 315 U.S. 510, 515 (1942).

An exaction need not be labeled as a tax to be authorized by Congress's taxing power; rather, the critical question is whether the exaction functions as a tax. *See NFIB*, 132 S. Ct. at 2595 (holding that the ACA's minimum coverage provision, 26 U.S.C. § 5000A, though not labeled a "tax," must be considered a tax for constitutional purposes); *id.* (citing *License Tax Cases*, 72 U.S.

462, 471 (1866) (holding that federal licenses to sell liquor and lottery tickets—for which the licensee had to pay a fee—could be sustained as exercises of the taxing power)). It is the practical operation of the provision, not its label, that controls, *see License Tax Cases*, 72 U.S. at 471, and a provision should be upheld as a valid exercise of the taxing power so long as it can reasonably be construed as an exercise of that power.

In *NFIB*, the Supreme Court held that the minimum coverage provision constituted a tax and that Congress acted within the scope of its constitutionally granted authority in imposing it. 132 S. Ct. at 2594–2600. The Court explained that the "essential feature" of any tax is that "[i]t produces at least some revenue for the Government." *Id.* at 2594. The fact that Congress "plainly designed" the ACA "to expand health insurance coverage" did not impact the Court's taxing power analysis under this "functional approach." *Id.* at 2596.

Supreme Court precedent thus makes clear that the HIPF possesses the "essential feature" of any tax: "it produces at least some revenue for the Government." *NFIB*, 132 S. Ct. at 2594. Further, it possesses the "functional" characteristics of a tax: Congress specifically directed that the HIPF "shall be treated as [an] excise tax[]" for purposes of the Internal Revenue Code, *see* 26 U.S.C. § 7421; the HIPF is embedded in the Code's tax system and assessed by the IRS, *see* 26 C.F.R. § 57.8; and it is paid into the Treasury by MCOs when they file their tax returns. Indeed, Plaintiffs admit that "[i]ts label notwithstanding, the HIPF is a tax"; that Congress and the Internal Revenue Service recognize the HIPF as a tax; and that "[t]he purpose of the HIPF is to generate revenue." ECF No. 54, at 3–4. And Plaintiffs' contention that the HIPF "functions as a federal tax on the States," ECF No. 54, at 4, even if true, only further confirms that the HIPF "may reasonably be characterized as a tax," *NFIB*, 132 S. Ct. at 2600, within the taxing power.[15]

[15] *See New York v. United States* (*New York III*), 505 U.S. 144, 171 (1992) (upholding as a tax a "surcharge"

Thus, the imposition of the HIPF on certain insurers is without question an exercise of Congress's authority under the Taxing Clause "to requir[e] an individual to pay money into the Federal Treasury." *Id*. "Because the Constitution permits such a tax, it is not [the Court's] role to forbid it, or to pass upon its wisdom or fairness." *Id.*

B. Plaintiffs Fail to Establish a Claim Under the Spending Clause.

Plaintiffs argue that § 9010 of the ACA exceeds Congress's power under the Spending Clause because it: (1) is unconstitutionally coercive of the States under the standard described in *NFIB*, Am. Compl. ¶ 59; Pls. Br. at 21-25; (2) violates the anti-retroactivity principle of *Pennhurst State School & Hospital v. Halderman*, 451 U.S. 1, 17, 25 (1981), by failing to provide the States with clear notice "on the conditions of accepting federal funding," Am. Compl. ¶ 49 (Count I); and (3) it is insufficiently related to Medicaid to be a legitimate exercise of Congress's spending power, (Count VIII). None of these claims have any merit.

1. Plaintiffs' Claims Do Not Implicate the Spending Clause Because § 9010 Does No More Than Impose a Tax Within the Taxing Power.

To begin, Plaintiffs' Spending Clause theories depend on the erroneous premise that the HIPF implicates Congress's spending power—it does not. "The Spending Clause grants Congress the power 'to pay the Debts and provide for the ... general Welfare of the United States.'" *NFIB*, 132 S. Ct. at 2601 (quoting U.S. Const. art. I, § 8, cl. 1). In exercising its spending power, Congress may offer funds to the States, and may, subject to certain restrictions, condition those offers on compliance with specified conditions. *See, e.g., Coll. Sav. Bank v. Florida Prepaid Postsecondary Educ. Expense Bd.*, 527 U.S. 666, 686 (1999).

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on out-of-state nuclear waste shipments, a portion of which was paid to the Federal Treasury, despite New York's claim that the surcharge violated state sovereignty reserved by the Tenth Amendment)); *cf. United States v. Sotelo*, 436 U.S. 268, 269 (1978) ("That the funds due are referred to as a 'penalty'. . . does not alter their essential character as taxes . . .").

Plaintiffs do not challenge any exercise by Congress of its Art. I, § 8 power to spend for the general welfare; § 9010 neither grants federal funds to states nor imposes a condition on the receipt of federal funds. As explained above, *see supra* Part II(A), the HIPF is a federal tax on private health insurance entities, including certain MCOs, levied by Congress under its taxing power. It was not enacted as a part of the Medicaid program any more than Congress's imposition of income taxes on individual Medicaid providers (*e.g.*, physicians) was. Tellingly, Plaintiffs do not dispute that § 9010 contains no grant of federal funds; and they admit that "the HIPF does not expressly impose a condition on the receipt of federal Medicaid funds. . . ." Pls. Br. at 23. Especially given their concessions that "the HIPF is a tax," Pls. Br. at 3, and that Congress expressly "recognized it as a 'tax'" in § 9010, *id*. (citing 124 Stat. 867), Plaintiffs' attempt to characterize the HIPF as a "condition" on federal funding, *see, e.g.*, Pls. Br. at 22, is unavailing.

2. The States' Claim that the HIPF is "Unconstitutionally Coercive" Lacks Merit (Count IV).

Even if Plaintiffs' claim in Count IV were cognizable under the Spending Clause, it would fail under *NFIB*. There, the Supreme Court considered a constitutional challenge to a significant expansion of the Medicaid program, which required states to provide specified healthcare to *all* individuals with incomes below 133 percent of the poverty level as a condition of the state's continued participation in Medicaid. 132 S. Ct. at 2577, 2582. The Court held that the federal government could not condition the granting of *all* federal Medicaid funds on a state's participation in what the Court found to be a new expanded program. *Id.* at 2607.

Citing *NFIB*, the States contend that the HIPF "is a coercive condition on Plaintiffs' receipt of existing federal Medicaid funds. . . ." ECF No. 54, at 23. But Plaintiffs' reliance on *NFIB* is misplaced. Unlike the Medicaid expansion program at issue there, the HIPF is not, in any sense, a new spending program; it is a tax on certain entities. And § 9010 does not "expand" Medicaid

eligibility at all. It simply requires certain entities (but not the States) to pay the HIPF. It is true that states choosing to contract with MCOs subject to the HIPF may be required to account for the HIPF when formulating Medicaid capitation rates. But this is nothing new. As Plaintiffs concede, this merely reflects long-standing Medicaid requirements of actuarial soundness. *See* ECF No. 54, at 5 (acknowledging that ASOP 49 "is premised upon preexisting law requiring that the negotiated capitation rates . . . for Medicaid contracts be 'actuarially sound.'") (citing 42 U.S.C. § 1396b(m)). To the extent that ASOP 49 "newly" clarified that the States must account for the HIPF in the capitation rates, the application of ASOP 49 to the States falls comfortably within Congress's express reservation of power to "alter" or "amend" the terms of the Medicaid program. *See* 42 U.S.C. § 1304; *cf. Mayhew v. Burwell*, 772 F.3d 80, 85-88 (1st Cir. 2014) (rejecting Spending Clause claim in part because the challenged Medicaid provision did not create a "new program" under the meaning of *NFIB*).

Further, there is nothing coercive about the HIPF or ASOP 49. The coercion doctrine applies, if at all, where Congress compels "States to act in accordance with federal policies." *NFIB*, 132 S.Ct. at 2602. Much like the Medicaid statute considered in *Harris v. McRae*, 448 U.S. 297 (1980), the actuarial soundness requirement is part of "a cooperative program of shared . . . responsibilit[ies], not . . . a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund." *Id.* at 309. ASOP 49 merely elaborates on existing law requiring that Medicaid capitation rates be actuarially sound. Nothing in § 9010, its implementing regulations, or ASOP 49, purports to control how states regulate MCOs, or otherwise tells states how to conduct their own governments. No "federal policy" requires states to contract with for-profit MCOs to provide services to Medicaid beneficiaries, nor do States face any loss—much less a wholesale withdrawal of federal Medicaid funding—if they choose not to do so. Thus, even if

it is viewed as a challenge to an exercise of the spending power, Plaintiffs' claim that § 9010 is unconstitutionally coercive lacks merit.

3. The States' Other Spending Clause Theories Fail for Similar Reasons (Counts I & VIII).

Plaintiffs also base their requests for relief in Counts I and VIII on the incorrect premise that "the HIPF is not a valid use of the spending power." ECF No. 54, at 26; *id.* 27. But even if these claims can be treated as challenges to an exercise of the spending power, they fail for several additional reasons. Contrary to Plaintiffs' contention in Count VIII, Am. Compl. ¶¶ 72–75; ECF No. 54 at 26, the HIPF is "reasonably related to the purpose of the expenditure." *New York III*, 505 U.S. at 172. That is, one of the main purposes of the ACA is "to increase the number of Americans covered by health insurance[.]" *NFIB*, 132 S. Ct. at 2580. The HIPF, an excise tax imposed on "covered entities," including certain Medicaid MCOs, provides revenue that can be used by the federal government to fund ACA programs. Golden Decl. ¶ 19, DA10.

Plaintiffs insist, without citation, that the HIPF "pay[s] for subsidies on ACA exchanges for non-Medicaid recipients." Pls. Br. at 24. But nothing in the ACA or its implementing regulations directs the use of HIPF revenue in this manner. And even if the HIPF generated revenue to fund a new ACA program, that would be immaterial because Plaintiffs' claim is properly construed as a challenge to ASOP 49, not any provision of the ACA. *See* ECF No. 54 at 27–28 (admitting that "payment of the HIPF by Plaintiffs was not part of the ACA (or the Medicaid Act)," but resulted from the fact that "ASOP 49 confirmed the parameters of actuarial soundness regarding the HIPF"). There can be no doubt that the conditions that the States actually challenge[16]

[16] Remarkably, there is no nexus between the States' argument supporting this claim (that is, that *the actuarial soundness requirement* and *ASOP 49* impermissibly "condition Plaintiffs' receipt of federal funds on payment of the HIPF"), and the relief that Plaintiffs seek (a declaratory judgment that *the HIPF* is unconstitutional).

—that is, the requirements of actuarial soundness, clarified by ASOP 49—are meant to preserve the fiscal health of Medicaid programs, and thus are reasonably related to the purposes of Medicaid spending.

Similarly, there is no basis for concluding that Congress "surprised" the States with a retroactive condition when it enacted ACA § 9010, as Plaintiffs contend. ECF No. 54, at 27 (citing *Pennhurst*, 451 U.S. at 17, 25). As a preliminary matter, Plaintiffs' claim does not target any act of Congress in passing the ACA. *See* ECF No. 54, at 28 (challenging the effect of "a pre-ACA regulation (42 C.F.R. § 438.6), coupled with a post-ACA ASOP. . . ."). Further, as Plaintiffs concede, the requirement that states account for the HIPF in capitation rates merely reflects long-standing Medicaid requirements of actuarial soundness. *See* ECF No. 54, at 5 (acknowledging that ASOP 49 "is premised upon preexisting law requiring that the negotiated capitation rates (insurance premiums) for Medicaid contracts be 'actuarially sound.'") (citing 42 U.S.C. § 1396b(m)). For over a decade, states have had to comply with the requirement that capitation rates reflect taxes and fees imposed on MCOs as a precondition to receiving federal matching Medicaid funds.[17] To the extent that ASOP 49 "newly" clarified that the States must account for the HIPF in the capitation rates, it did not add any further conditions to the receipt of federal matching Medicaid funds. Instead, it merely confirmed that actuaries, applying existing principles

[17] *See, e.g.*, Actuarial Standards Board, The Redetermination (or Determination) of Non-Guaranteed Changes and/or Benefits of Life Insurance and Annuity Contracts (ASOP 1), at 6 (1990) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop001_020.pdf(including "tax rates" within the factors to be considered in the pricing of life insurance contracts); Actuarial Standards Board, Regulatory Filings for Health Plan Entities (ASOP 8), at 3-4 (2005) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop008_129.pdf (listing taxes within the assumptions to be included in regulatory filings for health plans); Actuarial Standards Board, Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans (ASOP 26), at 2 (1996) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop026_052.pdf (defining actuarially sound rates for small employer health benefit plan premiums as rates that "are adequate to provide for all expected costs").

of actuarial soundness, should not carve out a new exception for the HIPF.

C. The HIPF Does Not Violate the Tenth Amendment or the Intergovernmental Tax Immunity Doctrine (Count IV).

Defendants are entitled to judgment on the States' claim in Count IV that the HIPF "violates the States' constitutional immunity from federal taxation," ECF No. 54, at 30, for several reasons. At the outset, the fact that the HIPF is a valid exercise of Congress's taxing power, *see supra* Part II(A), precludes any claim under the Tenth Amendment. "If a power is delegated to Congress in the Constitution, the Tenth Amendment expressly disclaims any reservation of that power to the States; if a power is an attribute of state sovereignty reserved by the Tenth Amendment, it is necessarily a power the Constitution has not conferred on Congress." *New York III*, 505 U.S. at 156. As Plaintiffs do not dispute that the HIPF constitutes a constitutional exercise of Congress's taxing power, their resort to the Tenth Amendment does not avail. *Cf. id.* at 171 (upholding as a tax a "surcharge" on out-of-state nuclear waste shipments, despite New York's claim that the surcharge violated state sovereignty reserved by the Tenth Amendment).

Plaintiffs' Tenth Amendment claim, in any event, rests on the faulty premise that the HIPF is a tax imposed on the states. Plaintiffs are mistaken; the HIPF is a tax on certain private health insurance entities, and Congress expressly excluded Plaintiffs from any obligation to pay that tax.[18] While some of the economic burden of the HIPF may be passed on to the states (and the federal government)[19] through the States' Medicaid contracts with private MCOs subject to the HIPF, the

[18] Under the express terms of § 9010 of the ACA, the HIPF is an excise tax on "[e]ach covered entity engaged in the business of providing health insurance[.]" The term "covered entity" refers, with some exceptions, to certain health insurance issuers; certain health maintenance organizations; certain insurance companies; "entit[ies] that provide[] health insurance under Medicare Advantage, Medicare Part D, or Medicaid"; and a multiple employer welfare arrangement within the meaning of § 3(4) of ERISA. 26 C.F.R. § 57.2(b)(1)(iv).

[19] Jaramillo Report at 3, DA389 (explaining that "the MCOs are jointly funded by the state and the federal government, with the federal government paying at least 50% of the cost, in accordance with the Federal

Supreme Court has "completely foreclosed any claim that the nondiscriminatory imposition of costs on private entities that pass them on to States or the Federal Government unconstitutionally burdens state or federal functions." *South Carolina v. Baker*, 485 U.S. 505, 521 (1988). In *Alabama v. King & Boozer*, 314 U.S. 1 (1941), the Supreme Court upheld a state sales tax imposed on a government contractor even though the economic burden of the tax was passed on, through a "cost-plus" contract, to the federal government. *Id.* at 8-9. "Subsequent cases have consistently reaffirmed the principle that a nondiscriminatory tax collected from private parties contracting with another government is constitutional even though part or all of the financial burden falls on the other government." *Baker*, 485 U.S. at 521 (citations omitted).

And while Plaintiffs devote much of their brief to the effects of ASOP 49, that ASOP announces no new principle regarding the determination of actuarially sound rates, which has always required accounting for costs and risks. Truffer Decl. ¶¶ 7, 11, DA148, DA152; Donna C. Novak, NovaRest Actuarial Consulting ("Novak Report") at 5-7 (Oct. 2016), DA400-02. Moreover, as a practical matter, MCOs will only contract with state governments if it is cost-effective to do so. Thus, in reiterating that Medicaid capitation rates paid by states be actuarially sound and "include an adjustment for any taxes, assessments, or fees that the MCOs are required to pay out of the capitation rates," ASOP 49 merely reflects a practical reality of the marketplace.[20]

Medical Assistance Percentage"); Golden Decl. ¶ 5, DA2-3.

[20] The Supreme Court has rejected any notion of reciprocal immunity. *See, e.g., N.Y. v. United States* (*New York II*), 326 U.S. 572, 577-78 (1946). The intergovernmental tax immunity doctrine comprises two distinct, judicially inferred immunities with different constitutional bases: "the state immunity arises from the constitutional structure and a concern for protecting state sovereignty whereas the federal immunity arises from the Supremacy Clause." *Baker*, 485 U.S. at 518 n.11. "The immunities have also differed somewhat in their underlying political theory and in their doctrinal contours. Many of this Court's opinions have suggested that the Constitution should be interpreted to confer a greater tax immunity on the Federal Government than on States because all the people of the States are represented in the Federal Government whereas all the people of the Federal Government are not represented in individual States." *Id.*

Nor does *United States v. Delaware*, 958 F. 2d 555, 556 (1992), have any bearing on Plaintiffs' claim. To begin, that case involved a state tax on the federal government, rather than a federal tax with an economic impact on the states (of which there are many). *See id*. Setting aside the fact that the federal government enjoys greater tax immunity than the states, the tax at issue in *Delaware* differs from the HIPF in many critical respects. There, while electricity distributors were to pay the state tax, the state law mandated that the tax be borne by the distributors' customers (meaning, the federal government), and provided that if customers failed to pay the tax to the distributors, the distributors would not be held liable. *Id*. at 562. Under those circumstances, the Third Circuit held that the *legal incidence* of the state tax law fell squarely on the federal government, rather than on the distributor.

Here, by marked contrast, the ACA does not mandate that states contract with entities that are subject to the HIPF or that states must pay the entirety of the HIPF; at most, ASOP 49 reflects the practical reality—and pre-existing statutory requirement—that capitation rates paid to an MCO (which are funded by both the state and federal governments) be actuarially sound. Nothing in the ACA or ASOP 49 requires that MCOs contract with the States to pay the HIPF, nor excuses the MCOs from paying the HIPF if capitation rates do not cover its full cost. Thus, while some of the *economic* burden of the HIPF may fall on the states (and on the federal government, which pays at least 50% and up to 100% of the cost of Medicaid covered services),[21] the analysis in *Delaware* makes it clear that the *legal* incidence of the HIPF plainly falls on the private MCOs.

Even accepting as true the States' claim that the HIPF can be construed as a direct tax on the States through Medicaid actuarial soundness requirements, that would not mean that § 9010 is unconstitutional. The intergovernmental tax immunity doctrine only prohibits discriminatory

[21] *See* Golden Decl. ¶ 6, DA3-4.

taxes imposed on states. And, as explained below, the HIPF is non-discriminatory.

To begin, the principle that states enjoy constitutional immunity from federal taxation "has been severely eroded with the passage of time." *Michigan v. United States*, 40 F.3d 817, 822–23 (6th Cir. 1994). That immunity now only prohibits the federal government from levying *discriminatory* taxes directly on states. *Ohio v. United States*, 849 F.3d 313, 324 (6th Cir. 2017) ("'[T]oday's Supreme Court would say that Congress is free to impose a nondiscriminatory tax' on a state government.") (quoting *Michigan*, 40 F.3d at 823). The Supreme Court has explained that this evolution "does not leave States unprotected from excessive federal taxation—it merely recognizes that the best safeguard against excessive taxation (and the most judicially manageable) is the requirement that the government tax in a nondiscriminatory fashion." *Baker*, 485 U.S. at 525 n.15. In *Baker*, on which Plaintiffs principally rely, the Supreme Court held a tax was not discriminatory as to states where it applied to all bonds "whether issued by state or local governments, the Federal Government, or private corporations." *Id.* at 526-27. Similarly, the Sixth Circuit recently upheld the ACA's Transitional Reinsurance Program as nondiscriminatory because it "applied evenly to public and private group health plans." *Ohio*, 849 F.3d at 324.

So too here. Under the ACA and the implementing regulations, the HIPF applies to all "covered entities"—a broad category that includes essentially all for-profit health insurance issuers and MCOs, "entit[ies] that provide[] health insurance under Medicare Advantage, Medicare Part D, or Medicaid," and a multiple employer welfare arrangement under § 3(4) of ERISA. 26 C.F.R. § 57.2(b). Thus, by its terms, the HIPF applies to these entities regardless of whether they contract with private corporations, individuals, states, or the federal government.

Plaintiffs nevertheless contend that the economic burden of the tax is discriminatorily passed on through capitation rates. In determining whether a tax is discriminatory, however, the

focus is on the "personality of the taxpayer," not the downstream economic effect of the tax. *See, e.g., California v. United States*, 441 F. Supp. 21, 24 (E.D. Cal. 1977) ("The air travel excise tax is imposed 'without regard to the personality of the taxpayer' and therefore does not discriminate against the State.") (quoting *New York II*, 326 U.S. at 587). In any event, under the Medicaid program, "MCOs are jointly funded by the state and the federal government, with the federal government paying at least 50% of the cost, in accordance with the Federal Medical Assistance Percentage. . . ." Jaramillo Report at 3, DA389. *See also* Golden Decl. ¶ 6, DA3-4. Thus, at most, Plaintiffs' theory shows that "the Federal Government has directly imposed the same . . . requirement on itself [and all other customers] that it has effectively imposed on States." *Baker*, 485 U.S. at 527. And in some cases, the federal governmental paid 100% of the cost in 2017. Golden Decl. ¶ 5, DA2-3.

Plaintiffs next contend that the intergovernmental tax immunity doctrine "protects against more than just 'discriminatory' taxes." Pls. Br. at 32. Specifically, Plaintiffs contend that it applies to taxes that infringe on State sovereignty and that do not represent a traditional source of federal revenue. But Plaintiffs have already litigated these legal questions and lost in other forums, and accordingly, are precluded from re-litigating them here. The doctrine of issue preclusion, or collateral estoppel, "bars successive litigation of an issue of fact or law actually litigated and resolved in a valid court determination essential to the prior judgment, even if the issue recurs in the context of a different claim." *Taylor v. Sturgell*, 553 U.S. 880, 892 (2008) (citation omitted).[22] In *Florida ex rel. McCollum v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120 (N.D.

[22] In the Fifth Circuit, issue preclusion has four elements, all satisfied here: "(1) the issue under consideration is identical to that litigated in the prior action; (2) the issue was fully and vigorously litigated in the prior action; (3) the issue was necessary to support the judgment in the prior case; and (4) there is no special circumstance that would make it unfair to apply the doctrine." *Winters v. Diamond Shamrock Chem. Co.*, 149 F.3d 387, 391 (5th Cir. 1998).

Fla. 2010), *rev'd in part on other grounds*, 132 S. Ct. 2566 (2012) ("Florida Litigation"), Plaintiffs here, along with other states, contended that the employer shared responsibility provision of the ACA, 26 U.S.C. § 4980H, violates the intergovernmental tax immunity doctrine. As they do in this case, Plaintiffs argued that the doctrine prohibits any taxes, discriminatory or not, that "interfere[] with the essential functions of State government and State sovereignty." Pls.' Mem. in Opp'n to Defs.' Mot. to Dismiss at 58-60, Florida Litigation 3:10-cv-91 (N.D. Fl. Aug. 27, 2010) (ECF No. 68). The court rejected this argument in dismissing the Tenth Amendment claim on its merits. *See Florida*, 716 F. Supp. 2d at 1154 n.14 (citing Reply in Supp. of Defs.' Mot. to Dismiss at 8-11, Florida Litigation, 3:10-cv-91 (N.D. Fl. Aug. 27, 2010) (ECF No. 74)).[23]

D. The Actuarial Soundness Requirement is Not an Unconstitutional Delegation

Plaintiffs next argue that 42 C.F.R. § 438.6—which requires that a state's managed-care contract be certified as actuarially sound "by actuaries who . . . follow the practice standards established by the Actuarial Standards Board"—unconstitutionally delegates legislative power to a private entity, the ASB. The delegation doctrine, as described in a handful of *Lochner*-era cases, bars Congress from delegating "its legislative authority to trade or industrial associations or groups so as to empower them to enact the laws they deem wise and beneficent." *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935); *see also Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936). However, the Supreme Court has invoked the non-delegation doctrine to

[23] In any event, there is no "traditional source of federal revenue" restriction on Congress's power to tax as Plaintiffs contend, *see* Pls. Br. at 32-35; if there were, that would mean that no new tax could be enacted. The Supreme Court has long deemed untenable the idea that the constitutionality of taxes could turn on distinctions between traditional and non-traditional governmental activities. *Massachusetts v. United States*, 435 U.S. 444, 457 & n.14, 460 (1978); *see Garcia v. San Antonio Metro. Transit Auth.*, 469 U.S. 528, 542, 546-47 (1985); *Baker*, 485 U.S. at 525 n.15; *Michigan*, 40 F.3d at 823. And, anyway, Plaintiffs' argument cannot be squared with the fact that the federal government has long imposed taxes, including but not limited to corporate income taxes, on companies in the health insurance industry, including MCOs. *See* Truffer Decl. ¶ 15, DA154.

invalidate federal laws only *twice* and has not done so for more than 80 years. *See Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 464-65 (2001) (unanimously reversing D.C. Circuit finding that non-delegation doctrine had been violated by Clean Air Act's delegation of authority to the EPA to set national ambient air quality standards at a level "requisite to protect the public health").[24]

The Supreme Court's decision in *Currin v. Wallace*, 306 U.S. 1 (1939), controls this case. In *Currin*, the Court considered a delegation challenge to the Tobacco Inspection Act, which permitted the Secretary of Agriculture to act only subject to certification by two-thirds of tobacco growers "voting at a prescribed referendum. . . ." *Id.* at 6. In rejecting the plaintiff's delegation claim, the Court noted that "[t]he Constitution has never been regarded as denying to the Congress the necessary resources of flexibility and practicality, which will enable it to perform its function in laying down policies and establishing standards." *Id.* at 15. The certification requirement, the Court held, was "not [a] delegation of legislative authority" but "a restriction upon [Congress's] own regulation by withholding its operation as to a given market unless two-thirds of the growers voting favor it." *Id*. Because the producers had the ability only to *block* government action, there was no risk of the harm the delegation doctrine was intended to prevent—that "a group of producers may make the law and force it upon a minority. . . ." *Id.*

[24] Moreover, even in "the furthest extension of [its] hostility to delegations of authority to nonpublic organizations," *see Cospito v. Heckler*, 742 F.2d 72, 87 n.25 (3d Cir. 1984), the Supreme Court nevertheless recognized Congress's authority to enlist private entities "in matters of a more or less technical nature, as in designating the standard height of drawbars." *Schechter Poultry*, 295 U.S. at 537. *See also Cospito*, 742 F.2d at 87 n.24 ("[W]e do not believe it constitutionally improper for Congress to delegate the general task of establishing the technical criteria by which a psychiatric hospital is to be judged. Congress' function in establishing federal policy does not impose upon it the responsibility to become professionally expert in every imaginable field in which the federal government has an interest.") Plaintiffs have cited no case holding to the contrary. *See* ECF No. 54, at 35-37 (quoting cases exhorting the value of the nondelegation doctrine generally but none actually striking down a delegation). And many have questioned whether the non-delegation doctrine endures. *See Nat'l Cable Television Ass'n, v. United States*, 415 U.S. 352, 353 (1974) (Marshall, J., concurring and dissenting) (calling the delegation doctrine "moribund"); *Cospito*, 742 F.2d at 87 n.25.

Here, there is actually no delegation of legislative authority to complain of, because Congress did not establish the actuarial soundness standard. Rather, the Secretary, in response to requests by the states for a standard by which the statutory requirement of actuarial soundness could be determined (and a replacement of the then-existing upper-payment-limit), proceeded through notice-and-comment rulemaking and chose the actuarial standards of practice option favored by many states. *See supra* n.10; *infra* 38, 47. And even if it did fall under the auspices of "delegation," the logic of *Currin*—that giving a private entity authority to block agency action is constitutional—requires that Plaintiffs' delegation claim be dismissed.[25] This is because the regulation provides only that a lack of certification of actuarial soundness by an actuary means only that one of the conditions for receipt of federal matching funds is not met, but otherwise affords neither the ASB nor the certifying actuary any influence on Medicaid policy.

Plaintiffs' argument that *Currin* is "inapposite" relies on a fundamental misunderstanding of the role ASB standards play in the agency's decision making. Here, the actuarial soundness regulation looks to the ASB to set technical standards that guide actuaries in pricing risks facing an insurance provider. But ASB standards do not, as Plaintiffs claim, "function as a discretionary veto" over state Medicaid programs. Although in implementing the actuarial soundness regulation, CMS will not approve a Medicaid managed care contract containing capitation rates that have not been "certified . . . by actuaries who meet the qualification standards established by the [AAA] and follow the practice standards established by the [ASB]," 42 C.F.R. § 438.6(c)(1)(i)(C) (2015), CMS maintains and exercises complete authority to review all such contracts and rates and the actuarial soundness thereof, and approves or denies contracts and rates

[25] Plaintiffs' suggestion that *Currin* somehow lacks precedential value cannot be seriously considered as Plaintiffs cite only a single concurring opinion in their support.

on the basis of its own review. *See* Truffer Decl. ¶¶ 16-21, DA154-59.[26]

By their terms, the ASB standards—including ASOPs 41 and 49—serve an advisory function; the agency considers and gives weight to the ASB standards but retains decision-making authority. And where, as here, an agency decision-maker considers the advice of a private party with expertise relevant to the agency decision, there is no unconstitutional delegation of authority. *See Cospito*, 742 F.2d at 88 (rejecting non-delegation claim where the Secretary, in deciding to decertify a hospital under Medicare following hospital's loss of accreditation by private accreditation commission, nonetheless retained "ultimate authority over decertification decision"); *Fischer v. Berwick*, 503 F. App'x 210, 214 (4th Cir. 2013) (finding non-delegation doctrine not implicated by HHS Secretary's reliance on private American Medical Association committee recommendations for setting Medicare payment amounts because Secretary retains authority to reject recommendations) (citing *Pittston Co. v. United States*, 368 F.3d 385, 395 (4th Cir. 2004) (adopting "standard that Congress may employ private entities for *ministerial* or *advisory* roles" when delegating authority)); *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1488 (9th Cir. 1992) (finding no unconstitutional delegation where "[a]lthough the Secretary [of Agriculture] normally follows the [private] NOAC's suggestions, he retains the authority to depart from or ignore them altogether").

Furthermore, the Supreme Court has applied the delegation doctrine only where Congress

[26] Further, the practice standards established by the ASB include ASOP 41, which provides that "[i]f, in the actuary's professional judgment, the actuary has deviated materially from the guidance set forth in an applicable ASOP, . . . the actuary can still comply with that ASOP by providing an appropriate statement in the actuarial communication with respect to the nature, rationale, and effect of such deviation." *See* Letter from Jen Steele. Therefore, in the event that an actuary certifying a state's Medicaid managed care capitation rates determined that such rates were actuarially sound even if such rates deviated from the requirements of ASOP 49, the actuary might nonetheless be able to certify the rates pursuant to 42 C.F.R. § 438.6(c)(1)(i)(C) (2015) if he provided an appropriate statement in the actuarial communication to CMS. Truffer Decl. ¶ 18b, DA157-58. The decision to approve the contract and rates would, again, be made by CMS. *Id.* ¶ 20b, DA159.

has delegated authority to *interested* private parties. The delegation doctrine is animated by the fear that industry groups might "regulate the affairs of an unwilling minority," *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936), but there is no risk of that here. The ASB has no financial interest in the outcome of capitation-rate negotiations. In enlisting guidance from the ASB, HHS gets expertise without bias, which raises no constitutional concerns.

III. PLAINTIFFS' STATUTORY CLAIMS, WHICH ARE TIME-BARRED AND IGNORE THE PLAIN LANGUAGE OF THE ACA AND THE REGULATION, MUST BE REJECTED.

Two acts of Congress are relevant to Plaintiffs' statutory claims: 42 U.S.C. § 1396b and the ACA. First, Congress declared in 1981 that Medicaid MCO capitation rates be "actuarially sound." Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357, 814 (codified at 42 U.S.C. § 1396b(m)(2)(A) (1981)). By 42 U.S.C. § 1302(a), Congress authorized the Secretary to promulgate implementing "rules and regulations . . . as may be necessary to the efficient administration of the functions with which [the Secretary] is charged under this chapter." In 2002, after notice and comment,[27] the Secretary promulgated 42 C.F.R. § 438.6, which defined "[a]ctuarially sound capitation rates" as

> capitation rates that— . . . [h]ave been developed in accordance with generally accepted actuarial principles and practices; . . . and [h]ave been certified, as meeting the [regulatory] requirements . . . , by actuaries who meet the qualification standards established by the [AAA] and follow the practice standards established by the [ASB].

42 C.F.R. § 438.6(c)(1)(i) (2002).

In § 2501 of the ACA—separate from the enactment of the HIPF—Congress amended 42 U.S.C. § 1396b to provide that "capitation rates paid to [Medicaid MCOs] shall be based on actual cost experience related to rebates and *subject to the Federal regulations requiring actuarially*

[27] *See, e.g.*, AR0538-43, AR0576-87, AR0560-61, AR0562-74, AR0590-91, AR0806-07 (all comments from various states commending HHS's proposal to replace the upper-payment-limit).

sound rates." Pub. L. 111-148, § 2501, 124 Stat. at 308 (emphasis added) (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)). Although § 2501 of the ACA generally concerns the availability of drug rebates for drugs covered by Medicaid MCOs, Congress's pronouncement that "capitation rates paid to [Medicaid MCOs] shall be . . . subject to the Federal regulations requiring actuarially sound rates" is not limited to drug rebates, but applies to Medicaid MCO capitation rates in general. As noted, the Medicaid statute already required that MCO rates be actuarially sound, but Congress ratified the regulatory requirements in § 2501 and incorporated them into statute. Notably, Plaintiffs completely ignore this provision.

Rather than grapple with the statutory text, Plaintiffs instead assert, with no basis in either the statutory or regulatory text, that Defendants have "impose[d] the HIPF on the States." *See* ECF No. 54 at 29. But Defendants have done no such thing. To the contrary, Defendants have continued to apply a longstanding provision of the federal Medicaid statute providing that states' contracts with Medicaid MCOs will not be approved unless the contractual capitation rates are actuarially sound. An actuarially sound contract is one that is "developed in accordance with generally accepted actuarial principles and practices," and those general principles and practices have long provided that contract rates be sufficient to cover all expected costs under the contract. *See* Novak Report at 5-7, DA400-02. As a result, under 42 C.F.R. § 438.6 (2015), the capitation rates that a state pays for a Medicaid MCO contract must account for the monies that the MCO pays attributable to the HIPF, just as they must account for any other taxes or costs that the MCO expects to pay in its provision of Medicaid services. Viewed in light of the operative statutes and regulation, Plaintiffs' statutory claims must fail.

A. Plaintiffs' Challenges to the Regulation are Time-Barred.

First, Plaintiffs' challenge to 42 C.F.R. § 438.6 must be rejected as time-barred. Where,

as here, no other statute provides a limitations period, a plaintiff has six years to bring a civil action against the United States. 28 U.S.C. § 2401 ("[E]very civil action commenced against the United States shall be barred unless the complaint is filed within six years after the right of action first accrues."). For claims that an agency exceeded its constitutional or statutory authority, the statute of limitations runs from the time when the agency's rule was applied to the complaining party. *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997). Here, § 438.6(c)(1)(i)(C) went into effect in 2002, s*ee* 67 Fed. Reg. 40,989-01 (June 14, 2002) (to be codified 42 CFR pts. 400, 430, 431, 434, 435, 438, 440, and 447), and Plaintiffs have operated under its strictures ever since. The limitations period therefore lapsed in 2008, so the States' challenge to the regulation is barred.

Neither the fact that the HIPF was enacted in 2010 nor the fact that the ASB published ASOP 49 in 2015 makes any difference for purposes of applying the six-year statute of limitations. Since 2002, Plaintiffs operated under § 438.6's actuarial-soundness requirements including the requirement that all managed-care contracts must be certified by an actuary who follows the practice standards set forth by the Actuarial Standards Board. In the time before and since § 438.6 was promulgated, it has been standard practice for actuaries to account for all expected costs, including taxes and fees, when pricing insurance.[28] Moreover, an August 2005 practice note published by the AAA to provide guidance to actuaries certifying Medicaid rates defined actuarially sound Medicaid benefit plan premium rates as rates that "provide for all reasonable,

[28] *See* Novak Report at 5-6 (citing ASOP 26 (1996)); ASOP 1, at 6 (1990) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/07/asop001_020.pdf (including "tax rates" within the factors to be considered in the pricing of life insurance contracts); ASOP 8, at 3-4 (2005) (superseded), http://www.actuarialstandardsboard.org/wp-content/uploads/2014/02/asop008_129.pdf (listing taxes within the assumptions to be included in regulatory filings for health plans).

appropriate and attainable costs, including health benefits, health benefit settlement expenses, marketing and administrative expenses, *any state-mandated assessments and taxes*, and the cost of capital."[29] AAA practice notes are part of the "generally accepted actuarial principles and practices."[30] 42 C.F.R. § 438.6(c)(1)(i)(A) (2015). For at least a decade, the actuarial soundness regulation has operated to obligate actuaries working on behalf of states to ensure that capitation rates reflected taxes and fees imposed on MCOs, including federal corporate income and payroll taxes and any *state* taxes. Then and now, states had to comply with these standards for an actuary to certify that the rates are actuarially sound, a precondition to federal matching Medicaid funds. Plaintiffs have no excuse for bringing these claims more than seven years after the statute of limitations expired.

Plaintiffs argue that "their clock began running" on their APA claims concerning the regulation no earlier than the 2010 enactment of the HIPF, by virtue of Defendants' "application of ASOP 49, beginning in 2015." But even apart from the fact that ASOP 49 announced no new requirement and merely clarified how *preexisting* standards should apply to a specific factual context—*see* Novak Report 7, DA402; Truffer Decl. ¶¶ 13-15, DA152-54. And Plaintiffs can

[29] *See* AAA, *Actuarial Certification of Rates for Medicaid Managed Care Programs* at 8-9 (Aug. 2005), http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf (emphasis added) ("AAA 2005 Practice Note"); *see also* Novak Report at 6. Plaintiffs' suggestion that "state-mandated assessments and taxes," ECF No. 54, at 42 n.64 in the 2005 Practice Note was understood to exclude federal assessments and taxes is baseless, contrary to common sense usage and definitions, and more importantly, not a distinction intended by the ASOP 49 Task Force. *See, e.g.*, Truffer Decl. ¶ 11, DA152; Black's Law Dictionary (10th ed. 2014) (defining "state action" as "anything done by a government"; defining "state" as "[t]he political system of a body of people who are politically organized; the system of rules by which jurisdiction and authority are exercised over such a body of people"). Even if AAA did intend "state" to refer only to one of the 50 U.S. states and commonwealths, Plaintiffs have presented no evidence that "state-mandated" was intended to modify "taxes" in addition to "assessments." Plaintiffs also offer no reason why federal taxes would or should be treated any differently than state taxes for actuarial purposes.

[30] Although practice notes "are not binding on actuaries" they do "define current [actuarial] practice," and "actuaries are generally knowledgeable about and consider practice notes as well as the ASOPs." Novak Report 14.

point to no *agency* action applying this ASOP. In *Dunn-McCampbell*, the Fifth Circuit described how the statute of limitations for APA claims operates. *See generally* 112 F.3d at 1287. As that court explained, the United States has consented to suit for civil claims only when brought within six years of accrual and, as to "a facial challenge to a regulation, the limitations period begins to run when the agency publishes the regulation in the Federal Register." *Id.* However, the court noted that "[i]t is possible . . . to challenge a regulation after the limitations period has expired, provided that the ground for the challenge is that the issuing agency exceeded its constitutional or statutory authority," but, "[t]o sustain such a challenge . . . the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit." *Id.*

But Plaintiffs point to no "direct, final agency action" applying ASOP 49 to them. In support of their argument that their claim is not time-barred, Plaintiffs cite a letter from CMS to the State of Texas approving the State's proposed amendment "to include payments for the Health Insurance Providers Fee into the capitation rates" for Texas's Medicaid managed care program. A0513 (Brooks Report), ECF No. 54-1. But neither this letter nor the State's proposed amendment makes any mention of ASOP 49; both refer only to the actuarial soundness regulation itself. *Id.* at A0514 ("This contract is subject to the managed care requirements in 42 Code of Federal Regulations 438 Subpart A through J."); *Id.* at A0577-78 (noting that "[i]n order to satisfy the requirement for actuarial soundness set forth in 42 C.F.R. § 438.6(c) . . . [the State] will make a retroactive adjustment to capitation to the MCO for the full amount of the HIP Fee").

Moreover, the letter Plaintiffs point to—which approved Texas's proposed capitation rates—is not comparable to the types of "direct, final agency actions" that the Fifth Circuit cited as examples of "an agency's application of a rule to a party [that] creates a new, six-year cause of action," *Dunn-McCampbell*, 112 F.3d at 1287: an agency's denial of a petition to review the

application of a regulation to the challenger, *id.* (citing *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); an agency's denial of the claimant's petition to rescind the regulations, *id.* (citing *Public Citizen v. Nuclear Regulatory Comm'n*, 901 F.2d 147, 152 (D.C. Cir. 1990); or a challenge to the Park Service's denial of a proposed plan of operations or an action by the Park Service to block a party's access to its own mineral estate. *Id.* at 1288. Even more to the point, Plaintiffs do not challenge CMS's approval of the proposed amendment Texas submitted. Because Plaintiffs have not identified a direct, final agency action triggering a new cause of action, "the limitations period beg[an] to run when the agency publishe[d] the regulation in the Federal Register." *Id.* at 1287. Plaintiffs are simply too late.

B. HHS's Continued Application of the Actuarial Soundness Regulation After Enactment of the HIPF Gives Effect to The Unambiguously Expressed Intent of Congress.

In *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837 (1984), the Supreme Court articulated the principle of judicial deference to an agency's "permissible" construction of its statute and adopted a two-step inquiry. At the first step, a court determines whether "the intent of Congress is clear," and, if it is "that is the end of the matter; for the court, as well as the agency, must give effect to the unambiguously expressed intent of Congress." *Id*. at 842-43. If, by contrast, "the court determines Congress has not directly addressed the precise question at issue," but rather the statute is "silent or ambiguous on the specific issue," the court "does not simply impose its own construction on the statute, as would be necessary in the absence of an administrative interpretation," but instead, in the second step, asks "whether the agency's answer is based on a permissible construction of the statute." *Id.* at 843.

Here, Congress's intent is clear. In § 2501 of the ACA, Congress provided strong evidence that it endorses the HHS regulation's reliance on the ASB, amending 42 U.S.C. § 1396b to provide

that "capitation rates paid to [Medicaid managed care organizations] shall be based on actual cost experience related to rebates and *subject to the Federal regulations requiring actuarially sound rates*." 124 Stat. at 308 (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)). In other words, Congress ratified the actuarial soundness regulation HHS promulgated, including its reference to the ASB. Moreover, by the time Congress did so, "generally accepted actuarial principles and practices" already defined "actuarially sound" rates in the context of Medicaid managed care program as rates that "provide for all reasonable, appropriate and attainable costs, including . . . any state-mandated assessments and taxes . . ." *See* AAA 2005 Practice Note; *see also* Novak Report 6, 14, DA401, DA409. As a result of § 2501, the ACA provides a clear Congressional expression of intent that the downstream economic effects of the HIPF would be felt in the capitation rates paid by States to Medicaid MCOs.

It is well established that "an agency's interpretation of a statute may be confirmed or ratified by subsequent congressional failure to change that interpretation. . . ." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto Ins. Co.*, 463 U.S. 29, 45 (1983). As the Fifth Circuit has noted, "[i]t has been oft-stated that 'a consistent administrative interpretation of a statute, shown clearly to have been brought to the attention of Congress and not changed by it, is almost conclusive evidence that the interpretation has congressional approval.'" *J.H. Rutter Rex Mfg. Co. v. United States*, 706 F.2d 702, 711 (5th Cir. 1983) (quoting *Kay v. FCC*, 443 F.2d 638, 646-47 (D.C. Cir. 1970)). For example, where Congress amends a statute fully aware of agency action, but takes no steps to halt the agency action, then "presumably the legislative intent has been correctly discerned." *N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982). The presumption applies with great force where the interpretation "has been brought to the attention of Congress, and Congress has not sought to alter that interpretation although it has amended the statute in other

respects. . . ." *United States v. Colahan*, 635 F.2d 564, 568 (6th Cir. 1980) (citing *United States v. Rutherford*, 442 U.S. 544, 554, n.10 (1979)); *see also J.H. Rutter Rex*, 706 F.2d at 711). Here, Congress was not only aware of HHS's regulatory interpretation, it affirmatively ratified it and incorporated it into the statute itself.

Congress expressly referenced 42 C.F.R. § 438.6 (2015)—*the* "Federal regulation[] requiring actuarially sound rates" at the time the ACA was enacted —and the definition of "actuarially sound capitation rates" within it, which provides, in pertinent part, that such rates "[h]ave been developed in accordance with generally accepted actuarial principles and practices." 42 C.F.R. § 438.6(c)(1)(i)(A) (2015). When Congress enacted the ACA, including § 2501, in 2010, "generally accepted actuarial principles and practices" already defined "actuarially sound" rates in the context of Medicaid managed care program as rates that "provide for all reasonable, appropriate and attainable costs, including . . . any state-mandated assessments and taxes." *See* AAA 2005 Practice Note at 8-9; *see also* Novak Report at 6, 14, DA401, DA409. Congress thus understood that the practical effect of the regulation would be that the HIPF would be accounted for in States' Medicaid MCO capitation rates. It is therefore apparent that the HHS actuarial soundness regulation "has congressional approval." *J.H. Rutter Rex*, 706 F.2d at 711. Plaintiffs are thus wrong to argue that HHS lacks statutory authority to interpret the actuarial soundness regulations to require accounting for the HIPF in Medicaid MCO capitation rates. *See* ECF No. 54, at 29.

C. Congress Has Expressly Delegated Authority to HHS to Establish Standards for Actuarial Soundness and Those Regulations Are Entitled to *Chevron* Deference.

Even if the Court disagrees that Congress's express reference to the Medicaid actuarial soundness regulations reflects Congress's ratification, that same language makes clear that the agency is entitled to deference in its application of 42 C.F.R. § 438.6 to treatment of the HIPF.

Under *Chevron*'s second step, if "Congress has explicitly left a gap for the agency to fill, [then] there is an express delegation of authority to the agency to elucidate a specific provision of the statute by regulation." *Chevron*, 467 U.S. at 843-44. In such cases, agency interpretations are given "controlling weight unless they are arbitrary, capricious, or manifestly contrary to the statute." *Id.* at 844; *see also* 5 U.S.C. § 706(2)(A), (D). The "question for the court is whether the agency's [interpretation] is based on a permissible construction of the statute," *see Chevron*, 467 U.S. at 843; or "has stayed within the bounds of its statutory authority," *City of Arlington v. FCC*, 133 S. Ct. 1863, 1868 (2013). The court "may not substitute its own construction of [the] statutory provision for a reasonable interpretation made by [the] agency." *Chevron*, 467 U.S. at 844.

Even assuming that 42 U.S.C. § 1396b(m)(2)(A) and § 2501 of the ACA were unclear (and they are not), that would only show that Congress "explicitly left a gap for the agency to fill," thereby expressly delegating "authority to the agency to elucidate a specific provision of the statute by regulation." *Chevron*, 467 U.S. at 843-44. Together with Congress's authorization to the HHS Secretary to promulgate rules and regulations for the efficient administration of the Medicaid Act,[31] Congress's requirement that capitation rates be actuarially sound, *Omnibus Budget Reconciliation Act of 1981*, Pub. L. No. 97-35, 95 Stat. 357, 814 (codified at 42 U.S.C. § 1396b(m)(2)(A) (1981)), constitutes an "express delegation." *Chevron*, 467 U.S. at 843-44. When combined with Congress's delegation in ACA § 2501, amending 42 U.S.C. § 1396b to provide that "Federal regulations requiring actuarially sound rates" are to govern Medicaid MCO capitation rates, *ACA*, 124 Stat. at 308, there is no question that the actuarial soundness regulations

[31] *See* 42 U.S.C. § 1302(a) (authorizing the HHS Secretary to promulgate implementing "rules and regulations not inconsistent with [Title 42, Chapter 7 of the U.S. Code, codified at 42 U.S.C. §§ 1301–1397mm], as may be necessary to the efficient administration of the functions with which [the Secretary] is charged under this chapter").

are Congressionally authorized and entitled to *Chevron* deference.

The regulations are also entirely reasonable under *Chevron*. *Chevron*, 467 U.S. at 844; *Mayo Found. for Med. Educ. & Research v. United States*, 562 U.S. 44, 53 (2011) (noting that under *Chevron* step two, "we may not disturb an agency rule unless it is arbitrary, capricious, or manifestly contrary to the statute" (internal quotations and citations omitted)); *Coastal Conservation Ass'n v. U.S. Dep't of Commerce*, 846 F.3d 99, 106-09 (5th Cir. 2017). As the administrative record reveals, the agency's process of promulgating 42 C.F.R. § 438.6 was lengthy and included several notice-and-comment periods. *See* AR 939-40. The agency explained that it "considered various approaches in defining actuarial soundness," ranging from "establish[ing] prescriptive standards" to "requiring that rates be developed using accepted actuarial principles and practices," in choosing an approach that "gives States and actuaries maximum flexibility while still ensuring that rates be certified as actuarially sound." *Id.* at 946. Further, the agency explained that it "sought to strike a balance between merely accepting State assurances on capitation rates in risk contracts on one hand, and requiring that the amounts of the capitation rates paid in each contract meet specific requirements for reasonableness and adequacy on the other." *Id.* As the agency concluded in 2002, "[w]e believe that by reviewing the process used in setting the rates under a risk contract, we will fulfill our regulatory responsibilities to the fiscal integrity of the Medicaid program and will assure that States have considered all relevant factors in this process." *Id.* Moreover, turning to the premier actuarial standards-setting organization to help define "actuarial soundness" is surely "within the bounds of reasoned decisionmaking." *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council, Inc.*, 462 U.S. 87, 104 (1983).[32]

Although Plaintiffs briefly assert several arguments that *Chevron* deference should not

[32] Plaintiffs recognize as much in their own regulation of intra-state insurance contracts. *See supra* note 10.

apply here, none has merit. First, Plaintiffs argue that *Chevron* deference is not appropriate when an agency adopts "an interpretation at odds with Congress's language." ECF No. 54, at 30 (citing *City of Arlington*, 133 S. Ct. at 1874). That principle is not relevant where, as here, the agency's interpretation is entirely consistent with Congress's language in the ACA, which includes § 2501, as explained *supra*.[33] To the contrary, Congress has provided clear evidence that it does sanction—indeed, *requires*—the continued use of existing actuarial soundness standards.

Plaintiffs additionally argue that the narrow exception to *Chevron* deference when an agency interpretation involves a question of "vast economic and political significance" applies here. *Util. Air Regulatory Grp. v. EPA*, 134 S. Ct. 2427, 2444 (2014) (citation omitted); *see also King v. Burwell*, 135 S. Ct. 2480, 2488 (2015). But this economic-and-political-significance exception is strictly reserved for questions of historic importance, *see, e.g., FDA v. Brown & Williamson Tobacco Corp.*, 529 U.S. 120, 159 (2000) (involving an agency interpretation that would have effectively banned tobacco in the United States), and here, all that is at stake is a fee imposed on private entities that may cause the States to pay slightly more for contracts they choose to enter. Considering that Plaintiffs themselves predict that the HIPF will impact a mere fraction of 1 percent of their budgets,[34] this is far from the "extraordinary" circumstance, *see King*, 135 S. Ct. at 2488, that would warrant an exception to *Chevron* deference.

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[33] Additionally, rather than grapple with the language of the Final Rule, which ineluctably demonstrates the reasonableness of the agency's interpretation, Plaintiffs rely entirely on an agency statement in the first notice of proposed rulemaking in support of its argument that the agency's decision was arbitrary and capricious. And Plaintiffs offer nothing more than a "conclusory statement" that the agency's continued application of the existing actuarial soundness regulation to Medicaid managed care contracts following enactment of the HIPF, rather than by creating a new regulatory scheme "addressing [the HIPF] separately" is "arbitrary and capricious." ECF No. 54, at 40-41.

[34] Plaintiffs have only presented evidence showing the total impact of the HIPF on Plaintiff States' budgets for Kansas and Texas, which shows that it represents 0.37 percent of Kansas's budget, *see* Randol Decl., A0135-39, and 0.11 percent of Texas's budget, *compare* A1172 (Parks Decl.) *with* Texas Comptroller, Certifying the 2016-2017 Texas State Budget, https://comptroller.texas.gov/transparency/budget/docs/BudgetCertification-Infographic.pdf17.

At the summary judgment stage, mere allegations or conclusory statements are not sufficient. *See Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248-49 (1986). Because Plaintiffs present no argument that the agency's *final* decision was anything other than a "reasonable interpretation" of the enacted text which was "committed to the agency's care by statute," and "one that Congress would have sanctioned,'" the agency's decision must be upheld under *Chevron*. 467 U.S. at 844.

Finally, Plaintiffs argue that by virtue of the clear notice requirement, *Chevron* deference cannot apply where a Congressional action implicates the Spending Clause. But this argument confuses two distinct legal concepts governed by distinct principles. Just because Congress has "explicitly left a gap for the agency to fill" via an "express delegation of authority to the agency to elucidate a specific provision of the statute by regulation" does not mean that Congress has created the type of ambiguity that would not satisfy clear notice. In particular, as discussed *supra* Part II (B)(3), clear notice requires only that when "Congress intends to impose a condition on the grant of federal moneys, it must do so unambiguously," and may not "surpris[e] participating States with post acceptance or 'retroactive' conditions," *Pennhurst*, 451 U.S. at 17, 25. This is not inconsistent with Congress explicitly creating a gap in which the agency may regulate. Plaintiffs identify no authority to the contrary, and this argument must be rejected.

D. HHS's Continued Application of 42 C.F.R. § 438.6 Following Enactment of the ACA and the ASB's Issuance of ASOP 49 Did Not Require Notice-and-Comment Procedures.

Even if it were not time-barred, Plaintiffs' claim that HHS's continued delegation to the ASB following enactment of the HIPF without notice and comment violates the APA is baseless. Pls.' Br. 37-40. The APA does not require notice and comment rulemaking in this circumstance.

HHS already undertook notice-and-comment procedures in adopting the standard it would

consider as part of its evaluation of the actuarial soundness of Medicaid MCO capitation rates. *See supra* Part III, at 38, 47. ASOP 49 changes nothing about that standard, and ASOP 49's express application of pre-existing actuarial principles (e.g., ASOP 26) that the agency had long considered as part of its evaluation as applied to another cost incurred by certain Medicaid MCOs called for no new agency rulemaking. ASOP 49 "did not change the requirements of 42 CFR § 438.6(c)," Novak Report 4, DA399, since well before ASOP 49, "generally accepted actuarial principles and practices" already defined "actuarially sound" rates in the context of Medicaid managed care program as rates that "provide for all reasonable, appropriate and attainable costs, including . . . any state-mandated assessments and taxes . . ."[35] *See* AAA Practice Note 8-9; *see also* Novak Report 6, DA401.[36]

CONCLUSION

For the foregoing reasons, Defendants respectfully request that the court enter summary judgment for Defendants and deny Plaintiffs' motion for summary judgment.

Dated: June 5, 2017

Respectfully submitted,

CHAD A. READLER

[35] *See supra* note 17.

[36] Although practice notes are not "binding" on actuaries, they are understood in the actuarial profession to "define current practice" and "actuaries are generally knowledgeable about and consider practice notes as well as the ASOPs." Novak Report 14. And even if ASOP 49 does add to "generally accepted actuarial principles and practices," it does so in a way that merely interprets the term "actuarially sound" in the statutory and regulatory text, making it "the quintessential example of an interpretive rule," *Orengo Caraballo v. Reich,* 11 F.3d 186, 195 (D.C. Cir. 1993) (citation omitted), which is exempt from notice-and-comment rulemaking. *See also* Novak Report at 4 & 7 (explaining that ASOP 49 "interpreted [the regulation] in actuarial terms" in a manner "consistent with longstanding general actuarial soundness principles"). Because ASOP 49 interprets the statutory and regulatory language as applied to the particular circumstance of Medicaid managed care contracts and "creates no new law," notice-and-comment rulemaking was not required. *Friedrich v Sec'y of Health & Human Servs.*, 894 F.2d 829, 837 (6th Cir. 1990) (holding "national coverage determination" was interpretive rule for which notice-and-comment rulemaking was unnecessary because it only "interprets the statutory language 'reasonable and necessary' as applied to a particular medical service or method of treatment.").

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