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

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs*, v. UNITED STATES OF AMERICA, UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES, 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, *Defendants*.	§	CIVIL ACTION NO. 7:15-CV-00151-O

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

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In accordance with LR 7.1(h), 56.5(a), and ECF No. 61, Plaintiffs provide this reply in support of their motion for summary judgment, ECF No. 53, and in opposition to Defendants' motion for summary judgment, ECF No. 62.

INTRODUCTION

In finally responding to Plaintiffs' motion for summary judgment, the federal Defendants offer the Court little beyond arguments already made and rejected. *See* ECF No. 34. And in responding to whether Plaintiffs should be saddled with the responsibility of the HIPF, Defendants summarily conclude that "basic concepts of both economics and actuarial science preclude virtually any other outcome." ECF No. 64 at 1. But basic concepts of economics do not force Plaintiffs to pay 100% of the HIPF—Defendants do. And therein lies the problem. While Defendants urge "basic concepts," they lose sight of the law. Not only did Congress exclude "governmental entit[ies]" from HIPF responsibility, 124 Stat. 865–66, but the HIPF exceeds the federal government's right to impose tax liability upon the States.

As the unrebutted expert testimony makes clear, the HIPF is not an incidental cost or tax that becomes part of the greater smögåsbord of factors composing capitation rates. Capitation rates are still calculated in a traditional sense, contemplating all of the *normal* factors systemic in the Medicaid MCO world. Then, after all the work is done, the declaration of a private organization—ASOP 49—mandates that the HIPF be *added* to the already-negotiated capitation rate. *See* ASOP 49 § 3.2.12(d) (Mar. 2015). If the components of a capitation rate are an ice cream sundae, the HIPF is no cherry on top; it is a watermelon. Not only is it out of place on an ice cream sundae, but its sheer weight and volume makes unrecognizable that which, since 1965, provided the States with a way to care for their most needy citizens. And if Plaintiffs are unwilling accept the watermelon on their sundae, they are ineligible for Medicaid altogether, removing their best method to pay for health

care primarily for low income families. That Plaintiffs continue to participate in Medicaid, instead of avoiding the HIPF by every theoretical means, does not create a self-inflicted injury. Rather, this conundrum represents the proverbial "gun to the head" that meets the Supreme Court's definition of unconstitutional coercion.

Defendants focus primarily on one step in their unconstitutional process, a 2002 regulation, in order to justify the end result of unlawfully taxing the States. But Defendants' analysis ignores Congress's creation of the actuarial soundness standard, the ACA itself, and its creation of the HIPF, as well as ASOP 49's imposition of the HIPF onto the States. But it is a culmination of factors that produce the unlawful result here, not just one. While Defendants focus single arguments on single occurrences, turning a blind eye to the toxic combination of all things put together does not circumvent the reality of the unlawful result.

As is clear from the Court's prior order denying Defendants' motion to dismiss, the issues presented are largely legal, with few factual disputes. ECF No. 34. As to the handful of factual questions that may have previously existed,[1] Plaintiffs' overwhelming factual and expert testimony leaves no genuine issue before the Court. Here, the undisputed facts demonstrate that every penny of the HIPF is imposed on the States. If the States refuse to pay the HIPF, they forfeit substantial funding for a critical sovereign mission—providing basic health care for underprivileged citizens, including children. Instead of disputing this impact, Defendants attempt to explain it. But this does not a genuine issue of material fact make. Accordingly, summary judgment for Plaintiffs is appropriate.

[1] That Defendants now move for summary judgment is significant. Defendants do not contend that a genuine issue exists, requiring the disposition of a fact-finder. Nor do Defendants plead affirmative defenses that turn on questions of fact. *See* ECF No. 43 at 16–17 (Defendants' five enumerated "DEFENSES").

ARGUMENT

I. PLAINTIFFS HAVE STANDING.

Plaintiffs' allegations establish Article III standing. ECF No. 34 at 12–18. Defendants do not challenge that Plaintiffs paid 100% of the HIPF. Even if Defendants were to question whether Plaintiffs pay 100% of the HIPF, there is no genuine issue as to this point. Thus, Plaintiffs have established "a 'concrete and particularized injury' by virtue of their having already paid, and their continuing obligation to pay in the future, the full HIPF amounts to MCOs." ECF No. 34 at 14. Moreover, Plaintiffs' injuries are redressable, as the Court has many options by which to alleviate Plaintiffs' injuries, past[2] and future.

Through expert testimony, Plaintiffs also establish the causal link between the actions complained of and their injuries, and that there is no genuine issue as to whether their injuries are self-inflicted. Plaintiffs' experts demonstrate intimate and unparalleled knowledge of their respective states, how the Medicaid program works, and the impact of the HIPF. Defendants offer no evidence to rebut or challenge Plaintiffs' expert testimony, but nonetheless argue that Plaintiffs' experts are incorrect. ECF No. 64 at 10–14. But declaring one to be wrong, and offering no evidence to explain why, does not manufacture a genuine issue of material fact.

A. Plaintiffs' Injuries Are Redressable.

Plaintiffs' claims are redressable by at least two remedies: (1) enjoining the collection of the portion of the HIPF attributable to MCOs' services rendered to states; and (2) enjoining the portion of Defendants' regulations that delegates the power to define "actuarially sound" to the ASB.[3] Contrary to Defendants assertions, ECF No.

[2] Plaintiffs maintain that a refund, restitution, or disgorgement of the HIPFs paid in past years will remedy past injuries. However, because the Court already dismissed those claims, ECF No. 34 at 21, Plaintiffs do not re-brief those arguments here, but will presumably be afforded the opportunity to further address those arguments on appeal.

[3] At the time this suit was filed, the delegation was found at 42 C.F.R. § 438.6(c)(1)(i)(C). Defendants have since recodified their regulations such that the delegation is found at 42 C.F.R. §§ 438.2, 438.4.

64 at 16, the first remedy redresses Plaintiffs' injuries if the Court agrees that application of the HIPF to the States violates the Tenth Amendment, the Spending Clause, Section 9010 of the ACA, or is otherwise arbitrary and capricious under the APA. *See* ECF No. 54 at 21–35, 40–42. The second remedy redresses Plaintiffs' injuries, additionally or alternatively, if the Court finds the legislative delegation to the ASB to be unlawful, arbitrary and capricious, or in violation of the notice and comment procedures of the APA. *See* ECF No. 54 at 35–42.

B. Plaintiffs' Injuries Are Not Self-Inflicted.

"Title XIX [Medicaid] is a welfare assistance program with limited funding." *D.C. Podiatry Soc'y et al. v. District of Columbia et al.*, 407 F. Supp. 1259, 1264 (D.D.C. 1975). Thus, Medicaid is not inherently flexible, but "require[s] that state Medicaid plans establish '*reasonable standards* . . . for determining . . . the extent of medical assistance under the plan which . . . are consistent with the objectives of (Title XIX).'" *Beal v. Doe*, 432 U.S. 438, 441 (1977) (quoting 42 U.S.C. § 1396a(a)(17)). As healthcare expands towards the goal of universal coverage, and the resources available to each patient become smaller and smaller, the options available to Plaintiffs in *reasonably* managing their Medicaid programs become fewer and fewer.

Defendants argue from an unreasonable fantasy land where the Medicaid options for Plaintiffs are seemingly endless. For example, Defendants claim that "[n]o federal law requires the States to contract with MCOs subject to the fee." ECF No. 64 at 10. While this may be true, the reality of the circumstances presented to Plaintiffs requires them to contract with MCOs subject to the HIPF. While Defendants posture theoretical arguments based on alternatives supposedly available to Plaintiffs, they fail to counter the veracity of Plaintiffs' evidence and the lack of actual, reasonable choices. Defendants even suggest that Plaintiffs should talk their MCOs into transforming their business model and becoming non-profit, ECF No. 64 at 12, as if

the proper role of government is to drive for-profit entities from the private sector.

Defendants' self-infliction arguments are designed to shift the Court's focus away from Defendants' actions that prompted this dispute—violating the Constitution's prohibition against the federal taxation of state governments, the prohibition of delegation of legislative powers to private parties, and the maxim that the federal government may not abuse its spending power to coerce others into doing its bidding. "The fact that Texas sued in response to a significant change in the defendants' policies shows that its injury is not self-inflicted." *Texas v. United States*, 809 F.3d 134, 158 (5th Cir. 2015), *as revised* (Nov. 25, 2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016).

1. HIPF-Exempt MCOs Cannot Cover Plaintiffs' Medicaid Needs.

The unrebutted evidence, including factual and expert testimony submitted by Plaintiffs, demonstrates that HIPF-exempt MCO's are not an actual option for Plaintiffs to avoid the HIPF. As to this point, each Plaintiff presented their own evidence demonstrating that insufficient non-profit MCOs exist to permit the state to avoid the HIPF. Defendants seek to rebut this evidence with argument, not evidence. ECF No. 64 at 10–14.

Texas's expert testimony confirms that parts of Texas are not covered by *any* nonprofit MCOs. As Texas's expert explained, "[g]eographic areas that have no core hospital district around which to organize are clustered as regional Medicaid Rural Service Areas (MRSAs). To my knowledge, no non-profits plans have submitted a procurement response for these MRSAs." ECF No. 54-1 at A1043. And, "[N]o non-profit MCO plan covers more than its own geographic area." *Id.* at 1044. Further,

> Texas MCO model is an at risk model and while the state is required to provide adequate funding for the number of clients eligible and enrolled, the plans assume the risk of such care through a capitated payment. It is my opinion that non-profit and/or public plans will only accept risk and be willing/able to pay expenses that might exceed premiums if they

> are supported by public funds from hospital/health care districts. Not all of Texas's 254 counties are covered by such districts, so ultimately non-profit coverage of every county's population is not feasible."

Id. Thus, there is no genuine issue as to whether Texas may avoid the HIPF by merely contracting with non-profit MCOs.

This is true for all Plaintiffs. Indiana's unrebutted expert testimony confirms that it contracts with its two HIPF-exempt MCOs, ECF No. 54-1 at A0121–22 ¶¶ 6–10, although "they are not capable of handling all Indiana's Medicaid." *Id.* at A0129 ¶ 2. Wisconsin has the same problem, *id.* at A1163 ¶ 7, as does Kansas, *id.* at A133 ¶ 8, Louisiana, *id.* at A293 ¶ 9, and Nebraska, *id.* at A476 ¶ 18.

Defendants do not counter with competing evidence, but complain only about the amount of evidence submitted by Plaintiffs. *See, e.g.*, ECF No. 64 at 11 ("Plaintiffs have not established that in Texas, the necessary number of exempt MCOs does not exist."). And so as to contrive some form of genuine issue, Defendants present their complaint through the guise of expert testimony.[4] But experts are not the arbiters of the sufficiency of the evidence or whether a genuine issue exists—the Court is. Defendants cannot avoid summary judgment by securing an expert to declare that the Plaintiffs have not met their evidentiary burden.

Alternatively, Defendants' arguments regarding whether some of Plaintiffs' HIPF liability could be alleviated by greater usage of non-profit MCOs are actually mitigation arguments, which are not before the Court. Failure to mitigate damages is an affirmative defense that Defendants did not plead. ECF No. 43 at 16–17; *E.E.O.C. v. Serv. Temps Inc.*, 679 F.3d 323, 334 n.30 (5th Cir. 2012) (noting that

[4] The June 5, 2017 submission of the Declaration of James I. Golden, ECF No. 64-1 at 3–11; DA 1–11, and the Declaration of Christopher J. Truffer, ECF No. 64-1 at 148–65; DA 146–63, was the first time that any opinions or conclusions of these witnesses was disclosed to the Plaintiffs. While the identity of these two witnesses was previously disclosed to Plaintiffs, ECF No. 47, the entirety of that 17-page filing was devoid of any substance, opinions, or otherwise. Accordingly, Plaintiffs intend to move to exclude the testimony and all evidence related to Messers Golden and Truffer by the July 13, 2017 deadline.

failure to mitigate is an affirmative defense that must be included in defendant's answer). As an affirmative defense, Defendants have the burden of proof to show that Plaintiffs failed to mitigate. *NLRB v. Miami Coca-Cola Bottling Co.*, 360 F.2d 569, 575 (5th Cir. 1966). Even if Defendants did properly plead a mitigation defense, and properly move for summary judgment thereon, they have nonetheless failed to offer a scintilla of evidence for their claim that Plaintiffs can provide all necessary managed care via HIPF-exempt MCOs.

2. Contracting Exclusively With HIPF-Exempt MCOs Is Unreasonable.

Because insufficient non-profit MCOs exist to service Plaintiffs' Medicaid beneficiaries, Plaintiffs need not make the decision whether to place all of their Medicaid eggs into the non-profit basket. But even if Plaintiffs were required to choose whether they would service their Medicaid population exclusively through non-profit providers, the unrebutted evidence demonstrates that choosing an exclusive non-profit path is imprudent, both factually and legally. Not only is reasonableness a hallmark of state decisions in managing Medicaid plans,[5] but it is significant to the self-infliction query. This is because the alternative available to Plaintiffs must be reasonable or "similar option[s]" for an injury to be self-inflicted. *Texas*, 809 F.3d at 159. But mere theoretical options, or the existence of a Hobson's Choice, is insufficient to declare an injury self-inflicted. *Id.* Therefore, using only non-profit MCOs is not a reasonable alternative to avoid the HIPF.

Plaintiffs' non-profit MCOs, as a group, do not deliver inherently superior care to Medicaid patients. ECF No. 54-1 at A0122 ¶ 9. Thus, there is nothing for states or

[5] *Cf. Alexander v. Choate*, 469 U.S. 287, 307 n.32 (1985) (discussing "a State's longstanding discretion to set otherwise reasonable Medicaid coverage rules"); *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268, 275–76 (2006) ("the state agency in charge of Medicaid (here, ADHS) [must] 'take all reasonable measures to ascertain the legal liability of third parties . . . to pay for care and services available under the plan.'" (quoting 42 U.S.C. § 1396a(a)(25)(A))).

patients to gain in terms of quality of care through non-profit service providers. More importantly, it is imprudent and dangerous to assign too many Medicaid clients to a single MCO. Since the passage of the ACA, the healthcare market has been in flux, with insurers leaving markets at unprecedented rates. *Id.* at A0122 ¶ 10.[6] And the nonprofit MCOs are generally willing to assume less risk than the for-profit MCOs, leaving them with insufficient scale to provide services to all recipients. *Id.* at A1044. "If a plan is acquired, goes out of business, or pulls out of a market, the state must then place its members in another MCO." *Id.* at A0122 ¶ 10. This is not an abstract concern. "Advantage Health Plan in Indiana recently exited the Medicare and Medicaid business [and] Centene's subsidiary in Kentucky exited the state Medicaid program during their contract period." *Id.*

Meeting the health care needs of underprivileged citizens is a priority of Plaintiffs. The percentage of Plaintiffs' budgets dedicated to Medicaid is more than adequate evidence of this priority. *See* ECF No. 54 at 19–20. And because those that benefit from Medicaid demonstrate a substantial need for the program, playing fast-and-loose with their Medicaid coverage is inappropriate. *See Schweiker v. Gray Panthers*, 453 U.S. 34, 43 (1981) (sustaining state programs that limit Medicaid availability based on spouse's income as "reasonable exercises").

Defendants ignore these admonitions and the level of prudence necessary to manage an entitlement program with limited resources. Moreover, Defendants offer no evidence to counter the lack of wisdom and unreasonable risk associated with placing the entirety of its Medicaid services with non-profit providers. That Defendants think less of these concerns than Plaintiffs does not rebut expert

[6] *See also* Tami Luhby, *More insurers abandon Obamacare. Who might be next?*, CNN MONEY, April 5, 2017, http://money.cnn.com/2017/04/05/news/economy/obamacare-insurers/index.html; Edmund Haislmaier, *Insurer ACA Exchange Participation Declines in 2016*, HERITAGE FOUNDATION, Mar. 14, 2016, http://www.heritage.org/health-care-reform/report/insurer-aca-exchange-participation-declines-2016.

testimony, nor does it create a genuine issue. *See Webster v. Offshore Food Serv., Inc.*, 434 F.2d 1191, 1193 (5th Cir. 1970) (finding summary judgment proper where movant offered "unequivocal, uncontradicted and unimpeached testimony of an expert witness"); *Dean v. Chrysler Corp.*, 38 F.3d 568, 1994 WL 574188 (5th Cir. 1994) (unpublished opinion) (finding summary judgment proper where movant offered expert testimony contradicted only by assertions of lay witness). To the contrary, the evidence proffered by Plaintiffs demonstrates that contracting exclusively with non-profit MCOs is not only a self-inflicted injury, but inconsistent with the reasonableness expectations of the Medicaid program as a whole.

3. Plaintiffs Possess No Reasonable Alternatives to Managed Care.

The Court has already rejected the argument that Plaintiffs may avoid injury by switching back to a fee-for-service model, noting "the possibility that a plaintiff could avoid injury by incurring other costs does not negate standing". ECF No. 34 at 15 (citing *Texas,* 809 F.3d at 156–57). Since that ruling, Plaintiffs submitted unrebutted expert evidence that significant costs are inevitable if Plaintiffs abandon managed care models. *See* ECF No. 54 at 16–19.

No credible alternative model for delivering Medicaid services exists, and abandoning managed care is more costly than paying the HIPF. *Id.* Defendants do not address the cost differences between managed care and fee-for-service as it is impossible for Defendants to argue the economic benefit of fee-for-service healthcare when they are transitioning to managed care, like Plaintiffs. *Id*. at 16–17. Thus, as in *Texas*, "treating the availability of changing state law as a bar to standing would deprive states of judicial recourse for many *bona fide* harms. . . . And states could offset almost any financial loss by raising taxes or fees. The existence of that alternative does not mean they lack standing." *Texas*, 809 F.3d at 157.

While Defendants attack the timing of some Plaintiffs' moves towards

managed care as unreasonable (because they began after enactment of the ACA), ECF No. 64 at 12–13, they do not dispute that such moves result in substantial and necessary savings. That Plaintiffs can avoid their injuries by choosing an even more costly option cannot negate the fact that Plaintiffs suffer an injury either way. Furthermore, Defendants mark time based only on when the ACA was enacted (2010) while ignoring when ASOP No. 49 became law (2015). All Plaintiffs began their managed care transition long before ASOP No. 49 existed,[7] so Defendants cannot argue that Plaintiffs began managed care transitions with the full knowledge of ASOP No. 49 in hand.[8] But even Plaintiffs chose to begin transitions to managed care after ASOP 49, that choice is insufficient to pose as a self-inflicted injury. By transitioning to managed care, Plaintiffs are not "manufactur[ing] standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending." *Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138, 1143 (2013). Instead, Plaintiffs are prudently avoiding the certain future harm of not transitioning to managed care. The overwhelming financial savings of managed care makes a non-transition a self-inflicted wound. That Plaintiffs' transition exposes them to the HIPF does not negate standing or resolve the HIPF's unlawfulness.

At bottom, the evidence provided by Plaintiffs clearly shows that there is no

[7] Defendants unfairly label Louisiana's transition to managed care as supposedly beginning in 2016. ECF No. 64 at 12. They inappropriately presume that Director Steele's "February" in paragraph 4 of her report regards February 2016, but they're incorrect. As is made clear by the reports attached to Steele's Declaration, "Lousiana's Medicaid managed-care delivery system" was "[i]nitially implemented in February 2012." ECF No. 54-1 at A0300. Clearly, Director Steele inadvertently neglected to add a "2012" to her Declaration.

[8] Defendants' timing arguments presume that states can flip from fee-for-service to managed care, or vice versa, in the blink of an eye. But overhauling a Medicaid program is more akin to doing a 180-degree turn in an aircraft carrier. Texas's move to managed care began in the late 1990's. ECF No. 54-1 at A1006. By the end of 2005, 40% of Texas's Medicaid clients received managed care services. *Id*. at A1007. By 2012, Texas reached the 80% mark, and then 87% by 2015. *Id*. By the end of 2017, Texas expects 93% of its Medicaid clients to be part of a managed care network. *Id*. at A1007–A1008. Thus, even if Defendants were able to articulate a valid timing argument, that argument must be viewed through the lens of the unreasonable programmatic change that Defendants demand—another massive overhaul of a huge program that takes years, even decades.

genuine issue as to whether transitioning backwards, and returning to a fee-for-service model, is a reasonable or "similar" option for Plaintiffs. Defendants can extol this option only as a theoretical possibility. They offer no evidence that it is "similar."

C. Plaintiffs' Injuries Are Easily Traceable.

Plaintiffs' eleven experts confirm that Defendants' regulations pass the full HIPF to the States. ECF No. 54 at 13–14. This testimony is substantiated by Defendants' experts. ECF No. 54 at 14 n.40. If Plaintiffs fail to pay the HIPF, they are ineligible for federal Medicaid funding. *Id*. at 19, 23.

Defendants argue that Plaintiffs' injury is not fairly traceable to the federal government because the ACA imposes the HIPF on MCOs, not on the States. ECF No. 64 at 9–10. This Congress's reaffirmation of its "actuarial[] sound[ness]" requirement for Medicaid MCOs, 42 U.S.C. § 1396b(m), and that ASOP 49 substantively changed matters, contrary to Defendants' repeated assertions. ECF No. 64 at 3, 26, 28, 30, 31, 40, 41, 50. ASOP 49 removed actuarial discretion over the degree to which the HIPF must be included in capitation rates. Before ASOP 49, addressing the HIPF was at the discretion of the actuary. But ASOP 49 mandates that the actuary "should apply an adjustment to reflect the costs of the tax." ASOP 49 § 3.2.12(d) (Mar. 2015). Subsequent to this shift, Plaintiffs' experts are unware of circumstances in which ASOP 49 does not require full payment of the HIPF by Plaintiffs, and Defendants offer no examples of such a circumstance.

Before ASOP 49, Defendants declared that "[s]tates and their actuaries have flexibility in incorporating the [HIPF] into the state's managed care capitation rates" and that "[s]tates have the flexibility to account for the [HIPF] on a prospective or retroactive basis."[9] To be fair, some actuaries foresaw payment of the HIPF as an

[9] U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., MEDICAID AND CHIP FAQS: HEALTH INSURANCE PROVIDERS FEE FOR MEDICAID MANAGED CARE PLANS (Oct. 2014), *available at* https://www.medicaid.gov/federal-policy-guidance/downloads/faq-10-06-2014.pdf.

obligation before ASOP 49 existed. ECF No. 54-1 at A1103. However, even if the discretionary standard before ASOP 49 imputed most of the HIPF to the States, or even 99% of it, ASOP 49 unequivocally creates harm by guaranteeing, in every circumstance, a 100% imputation. Thus, the *de facto* removal of actuarial discretion is a substantive change that injures Plaintiffs. Thus, ASOP 49 injures Plaintiffs, and Defendants waived any argument as to the degree of injury. *See supra* Section I.B.

But even if Defendants' assertions are taken at face value, and the HIPF is merely just another "downstream costs increase for any entity with which the state or one of its instrumentalities does business," ECF No. 64 at 9–10, this only serves to substantiate Plaintiffs' Spending Clause arguments. *See* ECF No. 54 at 21–28; *infra* at Section III. For if it was clear to Defendants, or Congress, that the HIPF would ultimately become the sole responsibility of the States by virtue of the preexisting regulation, 42 C.F.R. § 438.6, then Congress's employment of a preexisting regulation to coerce the States into paying the HIPF, and Defendants' deliberate decision to leave 42 C.F.R. § 438.6 unamended, is unlawful.

II. THE COURT HAS SUBJECT MATTER JURISDICTION.

A. The Anti-Injunction Act Does not Bar Plaintiffs' Claims.

Whether the HIPF is labeled a "fee" or "tax" by Congress, the AIA does not bar jurisdiction. As the Court already held, if the HIPF is a "fee," then AIA prohibition does not apply. ECF No. 34 at 23. And if it is a "tax," it is not a tax on Plaintiffs, but one committed to Plaintiffs' MCOs. *Id*. Because the tax is textually committed to MCOs, the Court dismissed Plaintiffs' refund claims. *Id*. at 21. That leaves Plaintiffs without a remedy for being unlawfully taxed, triggering the exception to the AIA described in *South Carolina v. Regan*, 465 U.S. 367, 378 (1984).

In *Regan*, South Carolina challenged a federal tax on bearer bonds, which it issued. *Id*. at 379. Because of the tax, South Carolina paid a higher interest rate on

the bonds, causing South Carolina to bear part of the tax burden. *Id*. at 371. But because South Carolina did not directly pay the tax, it had no available remedy to challenge its lawfulness. The Supreme Court held that the AIA did not apply:

> In sum, the Act's purpose and the circumstances of its enactment indicate that Congress did not intend the Act to apply to actions brought by aggrieved parties for whom it has not provided an alternative remedy. . . . Under these circumstances, the State will be unable to utilize any statutory procedure to contest the constitutionality of [the provision]. Accordingly, the Act cannot bar this action.

Id. at 378–80 (footnotes omitted). Here, because the HIPF is initially paid by MCOs, Plaintiffs have no remedy, though they bear the full burden of the HIPF. ECF No. 34 at 21. Thus, the AIA does not bar Plaintiffs' claims. *See Regan*, 465 U.S. at 380.

Defendants assert that *Regan* does not apply because Plaintiffs do not challenge the tax liability of the MCOs. ECF No. 64 at 21. But Plaintiffs *do* challenge the portion of the MCOs' tax liability that is attributable to providing Medicaid services to the States. *See supra* at Section I.A. Thus, *Regan* provides an exception.

Further, the AIA bars suits by "any person," 26 U.S.C. § 7421(a), and States are not defined as "persons" for purposes of that Act. A person is "an individual, a trust, estate, partnership, association, company or corporation." 26 U.S.C. § 7701(1). A company or corporation "includes associations, joint-stock companies, and insurance companies," 26 U.S.C. § 7701(3), and does not include Plaintiff States as the term "State" is defined separately. 26 U.S.C. § 7701(10). Thus, the AIA does not apply to Plaintiffs even if the HIPF is considered a "tax" for purposes of the AIA.

B. The Plaintiffs' Claims Are Not Time-Barred.

Since the HIPF was created in 2010, and ASOP 49 was adopted in 2015, Plaintiffs filed this suit well within the statute of limitations. Defendants cling to the 2002 promulgation of 42 C.F.R. § 438.6. ECF No. 64 at 39–43. Though Defendants cite *Dunn-McCampbell Royalty Interest, Inc. v. National Park Service*, to support their argument, ECF No. 64 at 40, Defendants omit the most significant part.

> It is possible, however, 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. To sustain such a challenge, however, the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit.
>
> . . .
>
> [A]n agency's application of a rule to a party creates a new, six-year cause of action to challenge to the agency's constitutional or statutory authority.

112 F.3d 1283, 1287 (5th Cir. 1997). "When an agency applies a previously adopted rule in a particular case, the [limitations period] does not bar later judicial review of the substantive statutory authority for their enactment or of their applicability to a particular situation." *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985).

The ACA changed things, creating the HIPF. ASOP 49 also changed things. Unlike prior ASOPs,[10] where taxes *could* impact an actuary's judgment, ASOP 49 removed discretion regarding the HIPF. *See* ECF No. 29 at 11–12. While Defendants call this change a "clarifi[cation]," ECF No. 64 at 41, they cannot circumvent the fact that it is a substantive change that triggered a new statute of limitations period.

The Court has already found that Defendants' application of the actuarial soundness requirement to the HIPF is a new application that begins a new statute of limitations period. ECF No. 34 at 25–26. In 2010, Congress imposed the HIPF on Medicaid MCOs. Knowing the HIPF imposed a massive new financial requirement, Congress simultaneously amended the law to maintain an "actuarially sound[ness]" requirement for Medicaid MCOs subject to the HIPF. 42 U.S.C. § 1396b(m); 124 Stat. 308. Defendant agencies (by inaction)[11] maintained the delegation of authority to ASB, which provided ASOP 49, re-altering the concept of "actuarial[] sound[ness]" by

[10] In the original ASOP 1, "tax rates" are one of over 13 different factors, in two different categories, that *could* factor into an actuary's "sound professional judgment."

[11] Under the APA, a claim may proceed "where a plaintiff asserts that an agency failed to take a discrete agency action that it is required to take." *Norton v. S. Utah Wilderness Alliance*, 542 U.S. 55, 64 (2004). Government is always required to take action necessary to comply with the Constitution.

removing preexisting discretion regarding the HIPF. And once ASOP 49 appeared, Defendants did not disavow ASOP 49 in any way. A multitude of federal actions justifying litigation have occurred since 2010. By any measurement or standard, Plaintiffs' brought their lawsuit well within the time period of 28 U.S.C. § 2401.

III. THE HIPF VIOLATES THE SPENDING CLAUSE.

As to their Spending Clause claims, Plaintiffs challenge *Congressional* action. ECF No. 19 at ¶¶ 46–49, 58–59, 72–75. The HIPF violates the Spending Clause because it threatens to remove Medicaid funds if Plaintiffs fail to fully reimburse MCOs for HIPF payments. Defendants' assertion that the HIPF is an exercise of the taxing power, ECF No. 64 at 22–24,[12] disregards the separate question as to whether the HIPF is a valid condition of the Medicaid program under the Spending Clause.

Indeed, governmental action cannot be partially constitutional, as governmental action must survive scrutiny under all portions of the Constitution, both facially and as applied, in order to warrant sustainer by the Court. *Cf. Texas Democratic Party v. Benkiser*, 459 F.3d 582, 588 n.8 (5th Cir. 2006) (citing *Women's Medical Prof. Corp. v. Voinovich*, 130 F.3d 187, 193 (6th Cir. 1997)). As the Court has already recognized, the HIPF's role as a condition on states receiving Medicaid funds from the federal government implicates the spending power. ECF No. 34 at 29.

Defendants declare that the HIPF does not implicate the Spending Clause because it is a tax, not an expenditure program. ECF No. 64 at 24–25. Wearing blinders, one can take this narrow view—that the HIPF merely imposes a tax, and nothing more. But the HIPF cannot be viewed as a narrow enactment that raises revenue and nothing else. Rather, the HIPF is inextricably intertwined with Medicaid and, by Congress's hand, the HIPF imposes unconstitutional conditions on Medicaid.

[12] In this context, the parties disagree as to whether this exercise of the federal taxing power is valid. *See infra* Section V.

Congress imposed the HIPF on Medicaid MCOs, among others, and Congress requires that Medicaid contracts be "actuarially sound," 42 U.S.C. § 1396b(m). Moreover, Congress decided that the HIPF should be an excise tax, ECF No. 54-1 at A0047, and thus non-deductible, *id.* at A0049, which impacts any analysis of Congress's "actuarial[] sound[ness]" requirement. *See, e.g.*, ECF No. 54-1 at A0199, A0994, A1000, A1049, A1091, A1103, A1148, A1156, A1158. Congress violated the Spending Clause, and Defendants failed to regulatorily remedy that violation.

A. The HIPF Unconstitutionally Coerces States to Pay for Costs of Those Not Covered by Medicaid.

It is coercive for Defendants to condition otherwise qualifying Medicaid funds on participation in new ACA programs. *Nat'l Fed'n of Indep. Bus. v. Sebelius*, 132 S. Ct. 2566, 2606 (2012) ("*NFIB*"). Notably, Defendants abandon prior arguments about the threatened of loss of funds to Plaintiffs being insignificant. The penalty for noncompliance makes a provision coercive. The penalty here—loss of Medicaid funds—is identical to that in *NFIB*. *See* ECF No. 54 at 24–25. Plaintiffs demonstrate that the impact on their budgets is constitutionally significant. ECF No. 54 at 19–21.

Defendants now try a different argument—to distinguish *NFIB* based on the nature of the condition. ECF No. 64 at 25–27. Unlike the "new expanded program" in *NFIB*, Defendants contend "the HIPF is not, in any sense a new spending program." *Id.* at 25. But this is not the test for coerciveness—whether the new condition is, in fact, "new" or "expanded." It is the threat of loss attached to the condition that controls. Nonetheless, even if novelty were a factor, the HIPF more than qualifies.

As far as Medicaid capitation rates are concerned, the HIPF is both "new" and "expanded." Experts agree that "there are aspects of the HIPF which do make it a[n] unusual concept." ECF No. 54-1 at A1156. Federal premium taxes on Medicaid plans are unique, *id.*, and the HIPF's non-deductibility sets it apart. Indeed, "[t]he HIPF is a somewhat unique element in capitation rate development." ECF No. 54-1 at A0199.

B. The HIPF Is Insufficiently Related to Medicaid to Be a Legitimate Exercise of Congress's Spending Power.

Conditioning Medicaid spending on the payment of the HIPF is unconstitutional because, as Defendants concede, the HIPF "provides revenue that can be used by the federal government to fund ACA programs." ECF No. 64 at 27. Thus, the HIPF funds the ACA, which is "in reality a new program," not a "mere alteration of existing Medicaid." *NFIB*, 123 S. Ct. at 2605–06. The Court already found that the HIPF is not sufficiently related to Medicaid spending to serve as a valid use of the Spending Clause. ECF No. 34 at 31. Because Medicaid is not an ACA program, the HIPF is unconstitutional. *See NFIB*, 132 S. Ct. at 2605–06.

Defendants concede that the HIPF itself does not expand Medicaid, ECF No 64 at 26–27, and this is the point. The HIPF has nothing to do with Medicaid, yet is a significant Medicaid liability. And though the ACA exists "to increase the number of Americans covered by health insurance," *NFIB*, 132 S. Ct. at 2580, Medicaid exists for a different purpose—"to assist pregnant women, children, needy families, the blind, the elderly, and the disabled in obtaining medical care." *Id*. at 2581. Thus, neither the HIPF nor its purposes are sufficiently related to Medicaid to justify the condition. *NFIB*, 132 S. Ct. at 2605–06.

That the proceeds from the HIPF go to the Treasury does not negate the incongruent purposes of the HIPF and Medicaid. Virtually all taxes go to the treasury. Were Plaintiffs required to draw a dollar-for-dollar line from the HIPF to the ACA, ECF No. 64 at 27, Congress could circumvent almost any Spending Clause challenge. Because the HIPF goes to the Treasury, some of it must inevitably end up in Medicaid and other federal programs, as Defendants contend. ECF No. 64-1 at DA 10. But by this reasoning, *no* tax or fee is related to Medicaid, as the majority of federal funding does not go to Medicaid. Defendants' standard must be rejected.

That Plaintiffs could theoretically avoid the HIPF by moving away from

managed care agreements does not negate the coercive nature of the condition. Rather, as Plaintiffs demonstrate, *supra* at Section I.B.; ECF No. 54 at 16–19, such a drastic overhaul of Plaintiffs' healthcare system would cause greater harm, which only enhances the coercive nature of the condition. Indeed, a required reversion to a fee-for-service model for Plaintiffs' Medicaid programs would be such a substantial change to the existing practice of Medicaid that it would itself constitute "a new program." *NFIB*, 132 S. Ct. at 2605.

C. The HIPF Violates Standards of Clear Notice.

Clear notice must be given, by Congress, of spending conditions. Defendants aver that Congress left a gap for the agency to fill, but any gap left by the "actuarial[] sound[ness]" requirement of 42 U.S.C. § 1396b(m) is too narrow for the HIPF. If section 1396b is a garden hose designed to maintain the health of the Medicaid program, the HIPF is a golf ball. It not only doesn't fit, but has no capacity to strengthen Medicaid program by siphoning money from the States. But because Congress pre-placed an "actuarial[] sound[ness]" requirement into the law, Defendants argue that Congress gave clear notice of *any* subsequent burden. By Defendants' rationale, Congress can quadruple the HIPF. Since Medicaid contracts must be "actuarially sound," clear notice of the quadrupled burden was given long ago. The potential for abuse from Defendants' argument is limitless.

But "the power to attach conditions to grants to the States has limits." *NFIB*, 132 S. Ct. at 2659. If the "actuarial[] sound[ness]" requirement of 42 U.S.C. § 1396b(m) is "wielded without concern for the federal balance," as it is here with the HIPF, it "has the potential to obliterate distinctions between national and local spheres of interest and power . . . ." *Id.* Concluding that 42 U.S.C. § 1396b(m) provided clear notice of the HIPF—or whatever else Congress does in the future—is unconscionable. The Constitution demands more. For if clear notice exists for any

future liability Congress may place upon Medicaid, the "actuarial[] sound[ness]" requirement permits Congress to regularly raid state coffers to fund any program or deficit, all while holding hostage Plaintiffs' policy to care for its most needy citizens.

IV. DEFENDANTS LACK STATUTORY AUTHORITY TO IMPOSE THE HIPF ON THE STATES.

The HIPF does not apply to "government entities," ECF No. 54-1 at A0045–46, yet Defendants claim power to make Plaintiffs pay the HIPF via delegation and statutory ambiguity. ECF No. 64 at 45–49. But agency interpretations are given no weight if they are "manifestly contrary to the statute." *Chevron U.S.A. v. Nat. Res. Def. Council*, 467 U.S. 837, 844 (1984). While Defendants argue that their authority stems from an "express delegation" to define "actuarial soundness," ECF. No. 64 at 46, any delegated authority is cabined by other statutory provisions, such as Section 9010, which exempts the States from the HIPF. ECF No. 54-1 at A0045–46.

The unlawful effects of Defendants' regulations result from three primary decisions. First, the HIPF is applied to MCOs doing business with the States. Second, delegating the power to define actuarial soundness to the ASB. Third, adopting (by silence) ASOP 49, which results in 100% of the HIPF being paid by the States. Even if these steps were lawful individually, their combined effect is contrary to the ACA provision that exempts the States from paying the HIPF. The government cannot accomplish piecemeal what is unlawful if taken as a single action. Because this combination of decisions contradicts the ACA, Defendants actions are unlawful.

The *ultra vires* nature of these decisions is especially evident given that *Chevron* does not apply, *i.e.*, *Chevron* Step Zero. *See infra* Section VII. That is so for three reasons, each of which precludes *Chevron's* application. First, *Chevron* is inapplicable when agency action contradicts Congress. *See City of Arlington, Texas v. FCC*, 133 S. Ct. 1863, 1874 (2013). As explained above, that is the case here.

Second, *Chevron* deference is not proper when interpreting a statutory

provision raises a "question of deep 'economic and political significance' that is central to th[e] statutory scheme." *King v. Burwell*, 135 S. Ct. 2480, 2489 (2015) (citation omitted). Defendants argue that the monetary value of the HIPF, approximately $14 billion/year nationwide, is insignificant and, thus, delegable. But the value of the subsidies in *King* also involved "billions of dollars" and too significant to be delegated. *Id.* However, the Court looked beyond the value of the subsidies to their effects on the broader healthcare market to determine their "deep economic and political significance." *Id.* Here too, the significance of the HIPF as a condition on Medicaid funds is greater than its dollar value. If the States do not pay—just as in *King*—millions of people will lose their healthcare. *Id.* Whether the focus is on the dollar value of the HIPF, or its significance as a condition of Medicaid funding, its application to the States is too significant to be delegated via ambiguity.

Third, Congress cannot delegate the creation of spending conditions to an agency under *Chevron*. While *Chevron* is triggered by ambiguity, spending conditions require "clear notice." These requirements are mutually exclusive and unfulfilled in this instance. *See infra* Section VII.

V. THE HIPF UNCONSTITUTIONALLY TAXES THE STATES IN VIOLATION OF THE TENTH AMENDMENT.

The taxing power does not extend to taxing the States. Defendants go to some length to demonstrate that the federal government has a taxing power. ECF No. 64 at 22–24. But as with any power, the federal government's taxing authority is not limitless. The question is not whether a taxing power exists, but whether that power extends to imposing a tax that is 100% paid by the States.

The HIPF is a pass-through tax on the States. While MCOs initially pay the tax, the Court has acknowledged they are then reimbursed for 100% of the cost by the States. *See* ECF No. 34 at 40; ECF No. 54 at 12–21. Defendants acknowledge that "the economic burden of the HIPF may be passed on to the states . . . ." ECF No. 64

at 29.[13] And because the States assume 100% of the liability of the HIPF, the issue presented does not involve a "downstream economic effect of the tax." ECF No. 64 at 33. There is nothing attenuated or "downstream" about Plaintiffs assuming 100% of the HIPF, and this distinguishes the cases argued by Defendants.

That the States reimburse the full amount of the HIPF is discriminatory, and Defendants do not dispute that the HIPF is functionally imposed on the States. Nor do they dispute that other entities are not required to reimburse 100% of the HIPF to healthcare providers they contract with. While Defendants note that other healthcare providers aside from MCOs pay the HIPF, they offer no suggestion that their customers are require to reimburse the fees paid. ECF No. 64 at 31–33.

The argument that the Constitution bars federal taxes that interfere with state sovereignty is not barred by issue preclusion.[14] Here, the issue is not even analogous to *Florida ex rel. McCollum*. Plaintiffs in that case challenged the "Employer Mandate" of the ACA, not the HIPF. *Florida ex rel. McCollum v. U.S. Dept. of Health & Human Svcs.*, 716 F. Supp. 2d 1120, 1153 (N.D. Fla. 2010). And the Court rejected their argument by analogizing the mandate to other conditions of employment—reasoning inapplicable to the HIPF. *Id.* Further, Plaintiffs Kansas and Wisconsin were not parties to that litigation. *Id.* at 1127 n.1. Thus, the Florida litigation is no basis for issue preclusion or even persuasive authority on this issue.

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[13] Defendants contend that because the federal government supplies Medicaid funding, it also pays a portion of the HIPF. ECF No. 64 at 29. But this red herring ignores that the HIPF is paid *to Defendants*. To the extent Defendants pay the HIPF, it is akin to taking money out of their wallet only to put it back in again. What Defendants cannot refute is that 100% of the HIPF is removed from the coffers of Plaintiffs, and 100% of the net HIPF payments come from the States. Even if Defendants committed to reimbursing the States for all but $100 of the HIPF, this commitment would only mitigate the harm to Plaintiffs. The pass through tax would still be unconstitutionally discriminatory and an unconstitutional tax on the States; but the harm would merely be reduced.

[14] For issue preclusion to apply, "(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." *Copeland, et al. v. Merrill Lynch & Co., et al.*, 47 F.3d 1415, 1422 (5th Cir. 1995) (citing *United States v. Shanbaum*, 10 F.3d 305, 311 (5th Cir. 1994)).

That the federal government has long imposed taxes on healthcare providers, including corporate income taxes is inapposite. ECF No. 64 at 34 n.23. Plaintiffs do not dispute that the federal government has a taxing power, or that it can tax MCOs. But the HIPF doesn't stop with the MCOs. Per Congress, *see* 42 U.S.C. § 1396b(m), the HIPF is routed to the States. This makes the HIPF an unconstitutionally discriminatory tax that interferes with state sovereignty and must be enjoined.

VI. ASB IS EXERCISING UNLAWFULLY DELEGATED LEGISLATIVE POWER.

Currin does not control this case. The Tobacco growers did not write the regulations and could only vote to block them. *Currin v. Wallace*, 306 U.S. 1, 15–16 (1939). ASB is writing law that the States must follow to receive funding. Thus, a private organization is making law—a clear example of unconstitutional delegation.

While Defendants contend that "Congress did not establish the actuarial soundness standard," ECF No. 64 at 36, though the "actuarial[] sound[ness]" standard of 42 U.S.C. § 1396b(m) speaks for itself. Moreover, Defendants cite no support for their assertion that the ASOPs are merely advisory and not binding. ECF No. 64 at 37. This comprises yet another theoretical argument, detached from reality. Defendants' own regulation requires that MCO contracts

> [h]ave been certified, as meeting the requirements of this paragraph (c), 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.*

42 C.F.R. § 438.6(c)(1)(i)(C) (2015) (emphasis added).[15] Moreover, only actuaries can declare contracts "actuarially sound." Actuaries are governed by the Actuarial Board for Counseling and Discipline ("ABCD"), which enforces the Code of Professional Conduct. ECF No. 54 at 10. Actuaries conclude that ASOP 49 must be followed, ECF

[15] Defendants have amended their regulations since this litigation began, but as they note in their brief, they have not changed the relevant definition of "actuarially sound." ECF No. 64 at 7 n.4. The new regulations are codified at 42 C.F.R. §§ 438.2, 438.4.

No. 54 at 13–14, and a "[f]ailure to satisfy ASOP 49 . . . could result in suspension or expulsion from the Academy," ECF No. 54-1 at A0197, A1102. Thus, Defendants' assertion that ASOP 49 isn't binding are without merit. And because ASOP 49 is binding, the delegation to ASB is one of legislative power rather than advisory power.

The Court has already held that Plaintiffs stated a claim that the Defendants had delegated legislative authority to the ASB. ECF No. 34 at 43–44. It did so based on four factual propositions, *id*. at 43–44, for which Plaintiffs have since offered substantial evidence. ECF No. 54 at 9–11, 35–37. Defendants dispute none of it. Therefore, there is no genuine issue of fact on Plaintiffs' delegation claim, and Court should therefore enjoin the Defendants' delegation of legislative power to the ASB.

VII. THE IMPOSITION OF THE HIPF ON THE STATES VIOLATES THE ADMINISTRATIVE PROCEDURE ACT.

By action and inaction, Defendants changed the rules applicable to capitation rates to guarantee the imposition of a multibillion dollar tax on the States, though (1) Congress committed the tax to non-governmental entities, and (2) the Constitution prohibits the taxation of the States. These decisions were made without notice and comment, are unlawful, and arbitrary and capricious. *See* ECF No. 54 at 40–42.

ASOP 49 was imposed without Notice and Comment. Defendants' sole claim that notice and comment was unnecessary is that ASOP 49 "changes nothing." ECF No. 64 at 50. But ASOP 49 removed discretion. *See supra* Sections I.C. and II.B. Thus, notice and comment was required.

While Defendants leap headlong into a *Chevron*-based defense, ECF No. 64 at 43, Defendants' regulations fail at each *Chevron* stage. *See Chevron,* 467 U.S. at 842–43. They fail *Chevron* Step Zero, the threshold inquiry of whether agency deference is warranted in the first place. This step cannot be overlooked, as delegation is antecedent to deference, and "there may be reason to hesitate before concluding that Congress" intended to delegate rulemaking authority to a federal agency. *King*, 135

S. Ct. at 2488–89. It fails at *Chevron* Step One, regarding whether "actuarially sound" regarding the HIPF is ambiguous. And it fails again at *Chevron* Step Two, where the inquiry turns on the reasonableness of the interpretation.

Chevron Step Zero is "'the initial inquiry into whether the *Chevron* framework applies at all.'" *ClearCorrect Operating, LLC v. Int'l Trade Comm'n*, 810 F.3d 1283, 1303 n.1 (Fed. Cir. 2015) (O'Malley, J., concurring) (quoting Cass R. Sunstein, *Chevron Step Zero*, 92 Va. L. Rev. 187, 191 (2006)). It "asks whether Congress delegated authority to make interpretations carrying the force of law." *Exelon Wind 1, L.L.C. v. Nelson*, 766 F.3d 380, 406 (5th Cir. 2014). That the case concerns a "major question" makes the *Chevron* framework inapplicable. *See supra* Section IV.

Moreover, under Step Zero, there is no clear statement from Congress that the States are to be taxed, and it can never be presumed that Congress delegated the authority to act unconstitutionally (taxing the States). Here, Congress said the opposite. ECF No. 54-1 at 45–46. Thus, while Defendants urge "delegation," they do not reconcile Congress's language to the contrary, representing the opposite of *Chevron's* "express delegation." *Chevron*, 467 U.S. at 843–44. Congress cannot simultaneously exempt States from a tax and then delegate authority to exact that same tax on the States. Nor do Defendants explain how an agency delegation, allowing it to unilaterally change the terms of the "contract" inherent in Spending Clause legislation, simultaneously complies with the "clear notice" requirement.

Contrary to Defendants' demands of deference, Courts "must be absolutely certain that Congress intended such an exercise" before they will uphold it. *Gregory v. Ashcroft*, 501 U.S. 452, 464 (1991). To ensure that Congress intended to raid State coffers, the Constitution requires a "clear statement from Congress." *Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 174 (2001); *Bond v. United States*, 134 S. Ct. 2077, 2088–90 (2014); *Gregory*, 501 U.S. at 460, 464. "If

Congress intends to alter the usual constitutional balance between the States and the Federal Government, it must make its intention to do so unmistakably clear in the language of the statute." *Gregory*, 501 U.S. at 460 (citation and quotation marks omitted). Because Congress's clear statement demonstrates the opposite of what Defendants urge, the *Chevron* inquiry ends with Step Zero—there is no delegation.

Even if *Chevron* applies, the agency actions (and inactions) here survive neither Step One nor Step Two. Step One asks whether the agency's answer is based on a permissible construction of the statute. *Chevron*, 467 U.S. at 842–43. Defendants contend that Congress left a gap to be filled, making an "express delegation" consistent with the right of HHS to promulgate rules for Medicaid. ECF No. 64 at 46. Defendants' argument surveys every related statute, except the one where Congress excluded "governmental entities" from the HIPF. ECF No. 54-1 at 45–46.

Step Two asks whether the regulatory actions (and inactions) are arbitrary and capricious. But Defendants assess only whether the initial promulgation of 42 C.F.R. § 438.6 in 2002 was reasonable at the time. ECF No. 64 at 47. But Plaintiffs don't challenge whether 42 C.F.R. § 438.6 was reasonable in 2002. Laws once reasonable may prove unreasonable over time as circumstances change. Plaintiffs re-urge their arguments as to why the complained of regulatory action and inaction is arbitrary and capricious. ECF No. 29 at 24–25; ECF No. 54 at 40–42.

CONCLUSION

For all the reasons stated herein, in the Court's Order Denying Partially Defendants' Motion to Dismiss, Plaintiffs' pleadings and briefs, and as supported by the evidence contained in Plaintiffs' Appendix, the Court should enter summary judgment in Plaintiffs' favor, permanently enjoin Defendants from enforcing the HIPF against Plaintiffs, and grant Plaintiffs all other relief, in law or in equity, to which they are justly entitled.

Respectfully submitted this the 23rd day of June 2017,

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CERTIFICATE OF SERVICE

I certify that on the 23rd day of June, 2017, the foregoing was electronically filed with the Clerk of Court using the CM/ECF system, which will send notification of such filing to all counsel of record.

/s/ Joel Stonedale
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