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

REPLY BRIEF IN SUPPORT OF
DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

RULES

REGULATIONS

OTHER AUTHORITY

INTRODUCTION

This case concerns two unremarkable federal actions: the enactment of a tax, the HIPF[1], which applies to private entities that provide health coverage, and the issuance of a 2002 regulation implementing the statutory requirement that Medicaid managed care capitation rates be actuarially sound. From there, Plaintiffs pile unrelated, but fully lawful, statutory and regulatory provisions on top of each other to allege an unlawful whole. Plaintiffs' challenge confuses their remaining claims and the legal concepts that apply to them and fails at every turn, from subject matter jurisdiction to the merits.

First, the Court lacks subject matter jurisdiction. Plaintiffs lack standing. They offer no legal support for the theory that they have sustained an injury fairly traceable to the HIPF. Nor have they asserted an injury caused by the actuarial soundness regulation, much less that such injury is redressable. Moreover, the AIA deprives the Court of jurisdiction over Plaintiffs' claims challenging the HIPF. And because the statute of limitations has expired for Plaintiffs' claims challenging the 2002 regulation, those claims are barred by sovereign immunity.

Separate and apart from these threshold jurisdictional defects—each of which is independently fatal to Plaintiffs' action—every one of Plaintiffs' claims fails as a matter of law:

- The Spending Clause: The HIPF is a valid exercise of Congress's taxing power and so it does not—and cannot—violate the Spending Clause. Plaintiffs' Spending Clause claims are a veiled challenge to the actuarial soundness regulation, which is an unambiguous and non-coercive condition of Medicaid that clearly relates to the purposes of that program.
- The Tenth Amendment: The HIPF is a tax on MCOs, not on states, and the legal incidence of

[1] All abbreviations correspond to those in Defendants' Brief in Support of Defendants' Motion for Summary Judgment and in Opposition to Plaintiffs' Motion for Summary Judgment (Defs.' Br.), ECF No. 63.

the HIPF falls on MCOs, not on states. Plaintiffs have not shown that the HIPF (which is levied on virtually all healthcare plans, regardless of their customers' identities) is discriminatory or that it otherwise violates the intergovernmental tax immunity doctrine. Thus, the HIPF does not violate the Tenth Amendment either.

- The Delegation Doctrine: Congress's delegation to HHS of the regulatory authority to develop standards for assessing actuarial soundness does not implicate the delegation doctrine. Neither does the 2002 regulation's reference to ASB guidelines and principles for determining actuarial soundness. Indeed, Plaintiffs do not even try to explain why the actuarial soundness standard is supposedly an impermissible delegation of "legislative power" to the ASB.
- Statutory Interpretation: The enactment of the HIPF is irrelevant to Congress's delegation to HHS of authority to establish the actuarial soundness standard. Because Congress clearly ratified HHS's interpretive regulation in ACA § 2501, the regulation must be sustained under *Chevron* Step One. Moreover, because Plaintiffs failed to respond to Defendants' ratification argument, Defendants are entitled to summary judgment on Plaintiffs' claim that the regulation is not entitled to *Chevron* deference. Plaintiffs' *Chevron* Step Two argument must be rejected because Plaintiffs concede that the regulation was reasonable when issued and it is so today.

The jurisdictional and legal defects in Plaintiffs' claims are legion. There is no legal or factual basis for the action to proceed. Thus, the Court should grant summary judgment for Defendants.

ARGUMENT

I. THE COURT LACKS SUBJECT MATTER JURISDICTION.

A. Plaintiffs Have Not Demonstrated Standing.

1. Plaintiffs Have Not Shown That Their Claimed Injury is Fairly Traceable to the Federal Government.

To begin with, Plaintiffs' alleged injuries derive entirely from their own choices regarding

their Medicaid delivery model. Defs.' Br. 9-14. Plaintiffs do not contend that no alternative delivery model exists that would allow them to avoid all downstream costs of the HIPF; rather, they argue that choosing an alternative would not be "reasonable"—even though every Plaintiff state does so for at least some of their Medicaid population, *see* Golden Decl. ¶11, DA5-6, ECF No. 63-1—and that a provision of the Medicaid Act imposes some undefined standard of "reasonableness" that curtails the Plaintiffs' Medicaid policy choices. Pls.' Br. 7-11, ECF No. 66.[2] But Plaintiffs cite no caselaw recognizing this standard in this context or holding that their options for avoiding an avoidable injury (somehow) satisfy it. *See id.* Plaintiffs trace this "reasonableness" standard to the Medicaid Act's requirement that state plans "include reasonable standards . . . for determining eligibility for and the extent of medical assistance under the plan." 42 U.S.C. § 1396a(a)(17). But the statute's reference to "reasonable[ness]" is not so broad: it does not impose some imprecise "reasonableness" standard on every aspect of a state's management of its Medicaid program, *contra* Pls.' Br. 4; rather, it requires that a state's choices about what services it will cover and to whom it will furnish medical assistance be reasonable. *See Beal v. Doe*, 432 U.S. 438, 444-45 (1977) (holding that nothing in Medicaid Act, including § 1396a(a)(17), requires a state to provide medical assistance for nontherapeutic abortions).[3] As to delivery systems, the

[2] Plaintiffs' arguments that choosing a delivery model that avoids the downstream costs of the HIPF is not "reasonable" depend on their "expert testimony." Pls.' Br. 3. As argued in Defendants' motion to strike, Defendants object to Plaintiffs' designation of their witnesses as "experts." And contrary to Plaintiffs' assertion, Defendants do challenge Plaintiffs' testimony. *See* Defs.' Br. 10-13 (arguing that evidence Plaintiffs offer does not substantiate their contentions). Ultimately, however, any disputes between the parties' witnesses are not material to the Court's disposition of this case, because Plaintiffs have not identified any case supporting their standing theory and, even if they had, as explained *infra*, Plaintiffs' challenges to the HIPF are independently barred by the AIA.

[3] *Alexander v. Choate*, 469 U.S. 287 (1985), and *Ark. Dep't of Health & Human Servs. v. Ahlborn*, 547 U.S. 268 (2006), are equally inapposite. In discussing "reasonable Medicaid coverage rules," *Alexander* was referring to the "amount, scope, and duration limitations on services covered by state Medicaid," not the delivery model. 469 U.S. at 307 (citation omitted). The "reasonableness" inquiry in *Ahlborn* concerned the state's obligation to facilitate payment from liable third parties for care and services provided under Medicaid. 547 U.S. at 275-76. And *Schweiker v. Gray Panthers*, 453 U.S. 34 (1981), concerned the same

Medicaid Act explicitly provides for two options: FFS and managed care, with the latter provided for relatively recently. *See* 42 U.S.C. §§ 1396a, 1396b; *see also* Defs.' Br. 5-6.

The only cases Plaintiffs cite that bear on traceability are *Clapper v. Amnesty Int'l USA*, 133 S. Ct. 1138 (2013), and *Texas v. United States*, 809 F.3d 134 (2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016). Neither supports Plaintiffs' assertion that a state has standing to sue the federal government when the federal government taxes a third-party with which the state contracts, resulting in a downstream cost increase to the state, where no law—state or federal—requires the state to enter the contract and no law—state or federal—precludes the state from avoiding the cost by making an alternate policy choice. *See Clapper*, 133 S. Ct. at 1151 (holding only that the plaintiff lacked standing because the harm it incurred costs to avoid was "not certainly impending"); *Texas*, 809 F.3d at 157 (holding that traceability prong was satisfied where state would have to change its own laws to avoid the complained-of injury caused by the challenged federal regulation, and not precluded simply because the state could raise taxes or fees to offset a financial loss). Plaintiffs offer no support for the boundless jurisdictional rule they advance, and none exists. The Court should reject Plaintiffs' invitation to upend the constitutional limits on federal court jurisdiction. *See* Defs.' Br. 9-10.

2. Plaintiffs Articulate No Redressable Injury From the Challenged Regulations.

The requirement that a state's actuary meet the AAA's qualification standards and follow the ASB's practice standards when certifying Medicaid MCO capitation rates causes no injury to Plaintiffs. *See* Defs.' Br. 15-17; Pls.' Br. 3-12. Plaintiffs tacitly agree. The only injury they claim

---

statutory provision invoking "reasonableness" as *Beal*, and Plaintiffs' parenthetical misstates the issue and holding in that case. Plaintiffs there challenged the validity of federal regulations that permitted states to consider an applicant's spouse's income in making eligibility determinations, and the Court upheld the federal regulations as "consistent with the statutory scheme and . . . *reasonable* exercises of the delegated power." *Schweiker*, 453 U.S. at 43 (emphasis added).

is "their having already paid, and their continuing obligation to pay in the future, the full HIPF amounts to MCOs [in the form of capitation rates that take account for such amounts]." *Id.* at 3 (quoting Mem. Op. 14, ECF No. 34).

Plaintiffs do not explain how "enjoining the portion of Defendants' regulations that delegates the power to define 'actuarially sound' to the ASB," Pls.' Br. 3, would even redress their purported injury. Assuming the court entered such an injunction, Plaintiffs would still have the statutory obligation under 42 U.S.C. § 1396b(m)(2)(A)(iii) to ensure that Medicaid MCO capitation payments be "made on an actuarially sound basis."[4] *See, e.g.*, Truffer Decl. ¶ 7, DA148, ECF No. 63-1; *id.* ¶ 17, DA156. Plaintiffs do not dispute this and their witnesses concede it. *See, e.g.*, A1103, ECF No. 54-1 (Wilkins Report) ("[T]he actuary is to . . . recognize all reasonable program expenditures in developing the capitation rates. . . . [I]t would be incorrect to say that, absent ASOP 49, Medicaid managed care rates would be actuarially sound if they excluded the HIPF."). Plaintiffs cannot obtain redress through an injunction aimed at regulatory requirements that implement an affirmative statutory command that they have not challenged. *Henderson v. Stalder*, 287 F.3d 374, 381 (5th Cir. 2002) (finding no standing because complained of injury would not be redressed by relief sought).

B. Plaintiffs' Claims Challenging the HIPF are Barred by the AIA.

Plaintiffs' claims challenging the HIPF fail due to an additional jurisdictional hurdle: the AIA. Plaintiffs do not dispute that the HIPF is a tax for purposes of the AIA. *See* Pls.' Br. 12-13;

[4] Under Plaintiffs' proposed remedy, they would also still be subject to 42 C.F.R. § 438.4(a) (2016), defining "[a]ctuarially sound capitation rates" as rates that "are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contact and for the operation of the MCO" (or, under 42 C.F.R. § 438.6(c)(2)(i) (2015), the requirement that "[a]ll payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound"), which they do not challenge. By the same reasoning applicable to the statute, the continued operation of this regulation means that Plaintiffs' proposed remedy would not redress their purported injury.

Defs' Br. 18-19 (explaining that Congress specified in ACA § 9010(f) that the HIPF "shall be treated as [an] excise tax[]" for purposes of subtitle F of the Internal Revenue Code). Instead, they argue that the AIA does not apply here, because states are not "person[s]" within the meaning of the AIA or, alternatively, this case fits within the exception to the AIA recognized in *South Carolina v. Regan*, 465 U.S. 367 (1984). *See* Pls.' Br. 12-13. Neither argument has any merit.

First, states are "person[s]" subject to the AIA. There is "no hard and fast rule" as to whether a state is a "person" for purposes of federal laws. *United States v. Cooper Corp.*, 312 U.S. 600, 604-05 (1941). In fact, "[i]t many times has been held that . . . a state is a 'person' within the meaning of statutory provisions applying only to persons." *Helvering v. Stockholms Enskilda*, 293 U.S. 84, 91-92 (1934). Whether a state is a "person" under a given statute depends on context.

For almost a century after its enactment, the AIA contained no reference to "person[s]." *See* 1867 Act § 10, 14 Stat. 475 ("And no suit for the purpose of restraining the assessment or collection of tax shall be maintained in any court."). And the Supreme Court's cases contained no suggestion that states were not subject to the AIA on the same terms as others. Indeed, in *Allen v. Regents of the University System*, 304 U.S. 439, 449 (1938), the Court declined to apply the AIA to a state, not because the state was excused from its restrictions, but on the different ground that the state's situation fell within then-existing precedent allowing suit in certain "exceptional cases."

The Supreme Court's cases have made clear, however, that states are "persons" to whom various other internal revenue laws apply. In *Ohio v. Helvering*, 292 U.S. 360, 368 (1934), the Court held that a tax on "person[s]" selling liquor in 26 U.S.C. § 205 (1925)—"person" being defined to "mean[] and include[e] a partnership, association, company, or corporation, as well as a natural person," in 26 U.S.C. § 11 (1925)[5]—applied to the State of Ohio as such a seller. The

[5] A similar definition appears in the current Internal Revenue Code. *See* 26 U.S.C. § 7421(a)(1).

Court found "no merit in the . . . contention that a state is not embraced within the meaning of the word 'person,' as used in" § 205. *Ohio*, 292 U.S. at 370. Similarly, in *Sims v. United States*, 359 U.S. 108, 112 (1959), the Court held that a state is a "person" that may be held liable for the value of levied property not surrendered under 26 U.S.C. § 6332(b) (Supp. V. 1957), even though the relevant definition of "person" did not refer to states. Observing that "[i]t is clear that § 6332 is stated in all-inclusive terms of general application," the Court concluded that it is "plain that Congress intended to and did include States within the term 'person' as used in § 6332." *Id*.

The AIA's reference to "any person" was added in 1966 in apparent response to questions that had arisen in suits brought by nontaxpayers whose property had been wrongfully levied upon. *Priority of Federal Tax Liens & Levies: Hearings on H.R. 11256 & H.R. 11290 Before the House Comm. on Ways & Means*, 89th Cong., 2d Sess. 58 (1966) (statement of Stanley S. Surrey, Ass't Sec'y of the Treas.). To provide a remedy to third parties in that situation, Congress created a suit for wrongful levy by "persons other than taxpayers." *Id*. at 57; Federal Tax Lien Act of 1966 ("FTLA"), Pub. L. No. 89-719, § 110(a), 80 Stat. 1142; *see* 26 U.S.C. § 7426. At the same time, Congress amended the AIA to emphasize that its bar applies to suits "by any person, whether or not such person is the person against whom such tax was assessed." FTLA § 110(c), 80 Stat. 1144. *See generally Regan*, 465 U.S. at 388-90 (O'Connor, J., concurring in the judgment). The Supreme Court has explained that the 1966 amendment was intended to "reaffirm[] the plain meaning of the original language of the Act." *Alexander v. Americans United, Inc.*, 416 U.S. 752, 760 & n.11 (1874); *see also Bob Jones Univ. v. Simon*, 416 U.S. 725, 732 n.6 (1974) (the change was "declaratory, not innovative"). Thus, the history of the 1966 amendment makes clear that Congress added the phrase beginning with "by any person" to make clear that it *extends* to third parties (such as the States here) and not to narrow the AIA to *exclude* states.

Second, the Supreme Court's decision in *Regan* provides no basis for allowing Plaintiffs' claims against the HIPF to proceed. *Regan*'s extremely narrow exception to the AIA applies only where plaintiffs are "aggrieved part[ies]" who lack "an alternative legal avenue by which to contest the legality of a particular tax" because they are challenging the tax liability of another. 465 U.S. at 373; *see Leves v. I.R.S.*, 796 F.2d 1433, 1434 (11th Cir. 1986). The plaintiff in *Regan* sought to challenge the tax liability of bondholders against whom a tax on bearer bonds was imposed. 465 U.S. at 372, 378. Here, in contrast, Plaintiffs do not challenge the tax liability of the MCOs with whom they contract to deliver Medicaid services. The *Regan* exception, therefore, does not apply.

Plaintiffs maintain that they "*do* challenge [a] portion of the MCOs' tax liability," but only to the extent that liability is passed to states through payment of Medicaid managed care capitation rates. Pls.' Br. 13. Plaintiffs, however, have "alternative legal way[s] to challenge" that purported pass-through, *Regan*, 465 U.S. at 373: they could have brought a timely challenge to the actuarial soundness regulation on the basis that it results in the pass-through to states of a portion of the MCOs' liability for the slew of taxes that already existed at that time, or, as described *infra*, they could petition HHS to amend the actuarial soundness regulation so that accounting for the HIPF in capitation rates is not required. The AIA, however, deprives this Court of subject matter jurisdiction over Plaintiffs' claims challenging the HIPF itself (Counts I, IV, VI, VIII, and X).

C. The Statute of Limitations Bars Plaintiffs' Challenges to the Regulation.

The six-year statute of limitations in 28 U.S.C. § 2401 applies to Plaintiffs' challenges to 42 C.F.R. § 438.6 and because Plaintiffs have not identified a "direct, final agency action involving [them] within six years of [their] filing suit," *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997), these challenges are time-barred.

Plaintiffs do not dispute that § 2401 applies to their challenges to the actuarial soundness

regulation. They do argue that Congress's enactment of the HIPF, together with the ASB's adoption of ASOP 49, constitutes "a substantive change that triggered a new statute of limitations period," Pls.' Br. 14. But even if either action actually effected any "substantive change" in the way the regulation operates—which neither did[6]—that would not be legally sufficient to trigger a new cause of action or a new limitations period for their challenges.

The Fifth Circuit has "made . . . clear" the limited circumstances in which a party may challenge the facial validity of a regulation more than six years after the regulation's promulgation. *P&V Enters. v. U.S. Army Corp. of Eng'rs*, 466 F. Supp. 2d 134, 143 (D.D.C. 2006) (citing *Dunn-McCampbell*, 112 F.3d at 1287), *aff'd*, 516 F.3d 1021 (D.C. Cir. 2008). On a "facial challenge to a regulation," the "general rule" is "that the limitations period begins to run from the date of publication in the Federal Register," but when "the ground for the challenge is that the issuing agency exceeded its constitutional or statutory authority[,] . . . the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit." *Dunn-McCampbell*, 112 F.3d at 1287. The *Dunn-McCampbell* court cited three cases "stand[ing] for the proposition that an agency's application of a rule to a party creates a new, six-year cause of action to challenge the agency's constitutional or statutory authority." *Id.* First, the court of appeals explained that in *Wind River Mining Corp. v. United States*, 946 F.2d 710 (9th Cir. 1991), the Ninth Circuit "held that a challenger may contest an agency decision as exceeding constitutional or statutory authority after the limitations period, but only by petitioning the agency to review the application of the regulation to that particular challenger." *Dunn-McCampbell*, 112 F.3d at 1287. Similarly, in *Public Citizen v. Nuclear Regulatory Commission*, 901 F.2d 147 (D.C. Cir. 1990),

[6] Notably, the regulation does not provide that actuarial soundness should be determined by reference to only those ASB practice standards that existed at the time of the rule's publication, and Plaintiffs do not—and cannot—claim to have been unaware that the ASB periodically publishes new guidance and ASOPs.

the D.C. Circuit "held that it had jurisdiction to hear a substantive challenge after the limitations period had run" because "the claimant filed a petition with the agency to rescind regulations, then challenged the agency's denial of the petition in federal court." *Dunn-McCampbell*, 112 F.3d at 1287. Finally, *Texas v. United States*, 749 F.2d 1144 (5th Cir. 1985), held "that when an agency *applies* a rule, the limitations period running from the rule's publication will not bar a claimant from challenging the agency's statutory authority." *Dunn-McCampbell*, 112 F.3d at 1287. Importantly, the agency act *applying* the rule was an order on a petition filed with the agency. The order required Texas to approve a tariff for intrastate contract carriage of wheat by rail, and in challenging that order, Texas argued that the Interstate Commerce Commission lacked statutory authority to adopt the contract rate rules undergirding the agency's order on the petition. *Tex. v. United States*, 730 F.2d 409, 411-12 (5th Cir. 1984), *withdrawn in other part*, 749 F.2d at 1146.

Together, these cases make clear what the Fifth Circuit meant by "an agency's application of a rule to a party," 112 F.3d at 1287, *viz.*, deciding a petition that affects the party's rights. The court of appeals makes this meaning plain elsewhere in its decision, when it explains that to sustain a challenge to a regulation more than six years after its publication, "the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit." *Id.* As Defendants argued, Defs.' Br. 41-43, Plaintiffs have articulated no such action[7] bringing them within the limitations period. Because "[f]ailure to file a timely suit against the United States . . . 'operates to deprive federal courts of jurisdiction,'" *Austral Oil Co. v. Nat'l Park Serv.*, 982 F. Supp. 1238, 1246 (N.D. Tex. 1997) (quoting *Dunn-McCampbell*, 112 F.3d at 1287), Plaintiffs' challenges to the regulation (Counts II, III, V, and IX) must be dismissed for lack of subject matter

[7] In this context, such an action might take the form of an agency decision on a petition by Plaintiffs to amend the regulation, were Plaintiffs to file one, or an agency decision refusing to approve a Plaintiff state's capitation rates if the state submitted for approval rates that did not account for the HIPF.

jurisdiction. *Gandy Nursery, Inc. v. United States*, 318 F.3d 631, 637 (5th Cir. 2003).

II. DEFENDANTS ARE ENTITLED TO JUDGMENT ON PLAINTIFFS' CLAIMS.

A. The HIPF Is a Valid Exercise of Congress's Taxing Power, and Plaintiffs Have Failed to Establish a Claim Under the Spending Clause.

The HIPF is a constitutional exercise of Congress's taxing power. *See* Defs.' Br. 22-24. The HIPF possesses the "essential feature" of a tax, as it "produces at least some revenue for the Government." *Nat'l Fed'n of Indep. Bus. v. Sebelius* ("*NFIB*"), 567 U.S. 519, 564 (2012). And it has the functional characteristics of a tax. Congress directed that it "shall be treated as [an] excise tax;" it is assessed by the IRS pursuant to the Internal Revenue Code; and it is paid into the Treasury by MCOs when they file their tax returns. *See* 26 U.S.C. § 7421; 26 C.F.R. § 57.8. Plaintiffs do not dispute that the HIPF is a valid exercise of Congress's taxing power (other than to argue that it independently violates the intergovernmental tax immunity doctrine, which is wrong for the reasons discussed *infra*). This concession is fatal to Plaintiffs' Spending Clause challenge to the HIPF. The HIPF cannot violate the Spending Clause, because it is not an exercise of Congress' spending power. *See* Defs.' Br. 24-25.

Plaintiffs' challenge is really to the condition on Medicaid funding that requires states to pay actuarially sound capitation rates in their managed care contracts, and particularly, the governing actuarial standard that to be actuarially sound, capitation rates must account for all taxes, including the HIPF. *See* Pls.' Br. 15-16. This condition of the Medicaid program, however, does not violate the Spending Clause.

First, the condition that capitation rates be actuarially sound—including that they reflect taxes, like the HIPF, imposed on MCOs—is "reasonably related to" the Medicaid program. *N.Y. v. United States*, 505 U.S. 144, 172 (1992). Plaintiffs do not dispute that the actuarial soundness requirements, as clarified most recently by ASOP 49, are intended to preserve the fiscal health of

Medicaid managed care programs and that this goal is reasonably related to the purposes of Medicaid. *See* Pls.' Br. 17-18. Plaintiffs instead question whether the HIPF is reasonably related to Medicaid. *See id*. at 17. But the HIPF is not a "condition" on Medicaid; it is a broad-based tax on the majority of health insurance plans and MCOs. Thus, it is irrelevant whether the HIPF is reasonably related to Medicaid. *N.Y.*, 505 U.S. at 172 (asking whether the "condition[] imposed [is] reasonably related to the purpose of the expenditure" (citation omitted)). The relevant question is whether the actuarial soundness requirements are reasonably related to the purposes of Medicaid. Because Plaintiffs do not dispute that they are, the inquiry ends.[8]

Indeed, under Plaintiffs' novel theory, in assessing the constitutionality of the Medicaid program under the Spending Clause, courts would be required to consider whether other taxes and fees imposed on MCOs—which also must be accounted for in capitation rates—are related to the purposes of the program. For example, as employers, Medicaid MCOs are subject to the Federal Insurance Contributions Act ("FICA") tax. *See* Golden Decl. ¶ 22, DA11. FICA is a federal tax imposed on employers that is dedicated to funding Social Security and Medicare. *See id*. Because the FICA tax is a cost element for a Medicaid managed care contract, it—like the HIPF—must be accounted for in determining actuarially sound Medicaid capitation rates. *See id*. Plaintiffs do not argue that the requirement to account for the FICA tax in developing capitation rates renders the Medicaid program unconstitutional under the Spending Clause, even though the FICA tax is not related to Medicaid. But that would be the inevitable result of accepting Plaintiffs' theory. The same is true with respect to other taxes and fees imposed on MCOs (including taxes imposed by

[8] Even if the proper inquiry were whether the HIPF itself is reasonably related to the Medicaid program, it is for the reasons explained in Defendants' opening brief. *See* Defs.' Br. 27; Golden Decl. ¶ 19, DA10 (explaining that revenue from the HIPF "goes into the Treasury rather than directly to any particular government program or activity," and thus, it "go[es] in part to support the Medicaid program in the same way all other general revenue taxes do").

the Plaintiff states) that are unrelated to the Medicaid program itself.

Second, the requirement that capitation rates for Medicaid managed care contracts be actuarially sound—and thus reflect all taxes and fees imposed on MCOs—is "unambiguous." *N.Y.*, 505 U.S. at 172. For over a decade, as a condition to receiving federal matching Medicaid funds, states have had to comply with the actuarial soundness requirement by, *inter alia*, taking account of taxes and fees imposed on MCOs in their capitation rates. *See* Defs.' Br. 28 n.17. ASOP 49 merely clarified that Plaintiffs must account for all taxes in their capitation rates.

Plaintiffs suggest the HIPF is different from other taxes and fees previously accounted for in their rates. But many states—including Texas, Kansas, Louisiana, and Nebraska—impose a similar premium tax on health insurers, including MCOs. *See* Golden Decl. ¶ 6, DA3-4; Jaramillo Report 3-4, DA389-90. And, as with the HIPF, the cost of this tax is passed to the state as the purchaser of the MCO health care coverage for Medicaid.[9] *See* Golden Decl. ¶ 6, DA3-4; Jaramillo Report 3-4, DA389-90. Because states have been accounting for taxes and fees imposed on MCOs in their capitation rates for at least 15 years—including state taxes that are of the same kind as the HIPF—they had clear notice of this condition of Medicaid.

Finally, there is nothing coercive about requiring states, as a condition of participating in the cooperative federal-state Medicaid program, to set actuarially sound MCO capitation rates, so that the risk transferred to MCOs is priced appropriately and the fiscal integrity of Medicaid and of participating MCOs is preserved. *See NFIB*, 567 U.S. at 579 (explaining that the federal government retains the ability to "attach appropriate conditions to federal . . . spending programs to preserve its control over the use of federal funds"). Plaintiffs erroneously cite *NFIB* for the proposition that, to determine whether a funding condition is unconstitutionally coercive, courts

[9] The federal government also pays a share of the state premium tax (at least 50% and up to 100%) through its Federal Financial Participation ("FFP") payments on the state's capitation payments to Medicaid MCOs.

look solely to the magnitude of the "loss attached to the condition." Pls.' Br. 16. But if Plaintiffs were right, no condition of state participation in Medicaid (current or future) could withstand Spending Clause scrutiny because, as Plaintiffs note, federal Medicaid funds typically make up a large portion of states' budgets. To the extent *NFIB* discussed the size of the loss attached to a condition, it did so in the context of a condition that took "the form of [a] threat[] to terminate other significant *independent* grants." 567 U.S. at 580 (emphasis added). In particular, the Court found it was unconstitutionally coercive for Congress to condition Medicaid funding on states' acceptance of an entirely "new health care program," which constituted "a shift in kind" from the existing Medicaid program, "not merely" a shift in "degree." *Id*. at 583-84.

Here, there is no new, independent program. States have had to comply with the Medicaid condition that MCO capitation rates be actuarially sound—including that they reflect fees and taxes imposed on MCOs—for over 15 years. Plaintiffs protest that the HIPF is "new," Pls.' Br. 16, but that does not render the HIPF, Plaintiffs' managed care programs, or the Medicaid program itself a "new health care program." *NFIB*, 567 U.S. at 580. In determining that the Medicaid expansion at issue in *NFIB* was in fact a new and independent program, the Court noted that the program was intended to "meet the health care needs of" an entirely new population; Congress created a new funding provision to cover this new population that was "separate" from existing Medicaid; and Congress imposed "conditions on the use of the[se] different funds" that were "distinct" from those imposed under existing Medicaid. *Id*. at 583-84. The same is not true with respect to the HIPF. There is no new or distinct population, funding provision, or coverage condition. Rather, the HIPF is simply one more tax imposed on MCOs that states must account for in developing actuarially sound capitation rates. At most, the HIPF is a shift in "degree," not in "kind." *Id*. at 583; *see also id*. at 583 (noting that Congress expressly reserved the right to

"alter" or "amend" the Medicaid program and states "might reasonably assume that Congress was entitled to make adjustments to the Medicaid program as it developed").[10] For all of these reasons, Defendants are entitled to judgment on Plaintiffs' Spending Clause claims (Counts I, IV, VIII).

B. The HIPF Does Not Violate the Tenth Amendment or the Intergovernmental Tax Immunity Doctrine.

Plaintiffs' Tenth Amendment claim fails for the simple reason, among others, that the HIPF is not a tax imposed on states. *See* Defs.' Br. 29-31. Instead, the HIPF is a tax on certain health insurance entities, and Congress expressly excluded states from any obligation to pay the tax. *See* ACA § 9010; 26 C.F.R. § 57.2(b)(2).

Plaintiffs do not dispute that "MCOs initially pay the tax," but argue that the intergovernmental tax immunity doctrine is in play because states "reimburse[]" MCOs with whom they contract for Medicaid services "for 100% of the cost" of the HIPF. Pls.' Br. 20. Plaintiffs suggest that the HIPF's constitutionality hinges on the magnitude of the downstream economic impact felt by a state, *see id*. at 21, while at the same time arguing that the mere existence of any downstream effect—no matter its size—is sufficient to render the HIPF unconstitutional, *see id*. at 26 n.13. Neither argument, however, has merit. Whether 100% of the financial burden of the HIPF is passed to the states (and it is not[11]) or some lesser amount, it would not transform the HIPF from a tax imposed on MCOs into one imposed on states. The Supreme Court has repeatedly affirmed "the principle that a nondiscriminatory tax collected from private parties

[10] There is no coercion for the additional reason that states are not required to contract with MCOs subject to the HIPF in order to provide services to Medicaid beneficiaries; nor will the states lose federal Medicaid funding if they choose not to contract with such MCOs. *See* Defs.' Br. 26-27.

[11] MCOs that participate in the Medicaid program are jointly funded by the state and federal governments, with the federal government paying 50 to 100% of the cost of Medicaid covered services. *See* Defs.' Br. 4 & n.2; Golden Decl. ¶ 5-6, DA3-4. Thus, Plaintiffs' repeated assertion that 100% of the HIPF imposed on MCOs is passed to the states, *see, e.g.*, Pls.' Br. 20-21, is incorrect. The federal government pays at least 50% (and, as to Plaintiffs, from 51.16 to 66.60%) of the cost. *See* Golden Decl. ¶ 5, DA3.

contracting with another government is constitutional even though *part or all* of the financial burden falls on the other government." *South Carolina v. Baker*, 485 U.S. 505, 521 (1988) (emphasis added) (citing cases).

Notably, Plaintiffs nowhere claim that the legal incidence of the HIPF falls on them, *see* Pls.' Br. 20-22; Pls.' MSJ 31-35, ECF No. 54, which was this Court's reasoning in denying Defendants' motion to dismiss Plaintiffs' tax immunity claim, *see* Mem. Op. 34-42, ECF No. 34. Plaintiffs' omission is an admission: the HIPF's legal incidence does not fall on them. Under the express terms of § 9010, the HIPF is imposed on "[e]ach covered entity engaged in the business of providing health insurance." MCOs pay the HIPF into the Treasury when they file their tax returns. *See* 26 C.F.R. § 57.8. And, if an MCO with whom Plaintiffs contract for Medicaid services fails to pay the HIPF, the MCO is held liable, not Plaintiffs. Thus, the legal incidence of the HIPF falls on MCOs. *Compare United States v. Delaware*, 958 F.2d 555, 562 (3d Cir. 1992). "The added circumstance that . . . the cost [of Medicaid managed-care services], including the tax," is passed to the states through payment of capitation rates does not shift the legal incidence of the HIPF to Plaintiffs.[12] *Alabama v. King & Boozer*, 314 U.S. 1, 14 (1941). Because the HIPF is not a tax imposed on the states, Plaintiffs' Tenth Amendment claim fails.

In any event, even assuming the HIPF could be construed as a direct tax on the states by virtue of the actuarial soundness requirements, it would not mean the HIPF is unconstitutional. The intergovernmental tax immunity doctrine prohibits only *discriminatory* taxes imposed on

[12] A contrary conclusion would mean that other federal taxes imposed on MCOs (like the FICA tax) would also implicate the tax immunity doctrine, because those taxes also must be accounted for by states in their Medicaid MCO capitation rates. Furthermore, a determination that the legal incidence of the HIPF falls on states would require the corresponding conclusion that the legal incidence of state premium taxes on health insurers (like those imposed by Texas, Kansas, Louisiana, and Nebraska) falls on the federal government and thus implicates the federal government's immunity from taxation by the states, because 50 to 100% of the cost of these state taxes are passed to the federal government when it pays FFP on the state's Medicaid capitation payments to MCOs. *See* Golden Decl. ¶ 6, DA3-4; Jaramillo Report 3-4, DA389-90.

states, and the HIPF is not discriminatory. *See* Defs' Br. 31-32. It applies to *all* "covered entit[ies]"—a broad category that includes nearly all for-profit health insurance issuers and MCOs, regardless of whether they contract with private corporations, individuals, states, or the federal government. *See, e.g.*, *Baker*, 485 U.S. at 526-27.

Plaintiffs maintain that the HIPF "is discriminatory" because "other [customers] are not required to reimburse 100% of the HIPF to healthcare providers [with whom] they contract." Pls.' Br. 21. To determine whether a tax is discriminatory, however, courts consistently look at the "personality of the taxpayer," not the downstream economic effect of the tax. *See* Defs.' Br. 32-33; *N.Y. v. United States*, 326 U.S. 572, 587 (1946) (Stone, C.J., concurring) (stating that the "long accepted meaning" of "the phrase 'non-discriminatory tax'" is "a tax laid on a like subject matter, without regard to the personality of the taxpayer, whether a State, a corporation or a private individual); *Cal. v. United States*, 441 F. Supp. 21, 24 (E.D. Cal. 1977). Plaintiffs do not dispute or challenge this principle or even cite contrary authority. *See* Pls.' Br. 21. Accordingly, even if the HIPF were a tax imposed on states (and it is not), it would not violate the intergovernmental tax immunity doctrine because it is not discriminatory.

Plaintiffs further contend that a tax that is not discriminatory can nevertheless run afoul of the intergovernmental tax immunity doctrine if it "interfere[s] with state sovereignty." Pls.' Br. 21. But this argument is barred by issue preclusion, because it was raised and rejected in an earlier action brought by several Plaintiff states. Plaintiffs maintain that issue preclusion does not apply here because the earlier action involved a different ACA provision (*i.e.*, the employer shared responsibility provision) that is "not . . . analogous" to the HIPF. *Id.* Issue preclusion, however, bars successive litigation of "an issue of . . . law . . . , even if the issue recurs in the context of a different claim." *Taylor v. Sturgell*, 553 U.S. 880, 892 (2008) (citation omitted). That is what has

occurred here. In the earlier action, the plaintiff states argued, as they do here, that the intergovernmental tax immunity doctrine prohibits even nondiscriminatory taxes if they interfere with state sovereignty. *See* Defs.' Br. 34. The Florida district court's rejection of that legal argument thus precludes those plaintiff states from raising the same legal argument in this case.[13]

Furthermore, even if Plaintiffs' argument were not precluded, it fails on the merits for the same reason the Florida district court rejected the argument in the earlier action. Indeed, Plaintiffs do not challenge the reasoning underlying the Florida district court's decision. As that court recognized, the intergovernmental tax immunity doctrine simply does not prohibit non-discriminatory taxes imposed on states, whether they are alleged to interfere with state sovereignty or not. *See Florida ex rel. McCollum v. U.S. Dep't of Health & Human Servs.*, 716 F. Supp. 2d 1120, 1154 n.14 (N.D. Fla. 2010), *rev'd in part on other grounds*, 567 U.S. 519 (2012); *see also Baker*, 485 U.S. at 518 n.11 (declining to decide "the extent, *if any*, to which States are currently immune from direct nondiscriminatory federal taxation") (emphasis added); *id*. at 525 n.15; Defs.' Br. 34 n.23 (citing cases rejecting the notion that the constitutionality of a tax turns on distinctions between traditional and non-traditional governmental activities). For all of these reasons, Defendants are entitled to judgment on Plaintiffs' Tenth Amendment claim as well.

C. The Actuarial Soundness Requirement Is Not an Unconstitutional Delegation

The actuarial soundness regulation's reference to the ASB does not implicate the delegation doctrine because HHS, not Congress, created the standard that incorporates "generally accepted actuarial principles and practices," including "the practice standards established by the [ASB]." 42 C.F.R. § 438.6(c)(1)(i)(A), (C) (2015). Even if the regulation fell under the auspices

[13] Plaintiffs are correct that Kansas and Wisconsin were not plaintiffs in the earlier action at the time the court issued the relevant decision (although they did join the action later). *See* Pls.' Br. 21. But that fact does not impact whether issue preclusion applies as to the remaining plaintiff states. Those remaining states were parties to the earlier action, and thus, they are precluded from re-litigating the same issue here.

of "delegation," the logic of *Currin v. Wallace*, 306 U.S. 1 (1939)—that delegation to a private entity is constitutional so long as the entity is not given authority to both "make the law *and* force it upon a minority," *id.* at 15 (emphasis added)—requires rejection of Plaintiffs' delegation claim.

Instead of explaining how the actuarial soundness standard constitutes any delegation of "legislative power" to the ASB, Plaintiffs simply state that "the 'actuarial[] sound[ness]' standard of 42 U.S.C. § 1396b(m) speaks for itself." Pls.' Br. 22. But that provision makes clear that all Congress created was a requirement that Medicaid payments be "made on an actuarially sound basis." 42 U.S.C. § 1396b(m)(2)(A)(iii). Congress was silent as to how actuarial soundness was to be determined, "express[ly] delegati[ng] . . . authority to the agency to elucidate [this] provision of the statute by regulation." *Chevron*, 467 U.S. at 843-44. Congress's delegation of authority to HHS to define the actuarial soundness standard is routine and poses no constitutional problem.

Plaintiffs' contention that *Currin* does not control this case is wrong. While Plaintiffs correctly note that the tobacco growers "did not write the regulations and could only vote to block them," Pls.' Br. 22, they misconstrue the risk of harm that the Supreme Court sought to prevent through the delegation doctrine. That risk arises "where a group of producers may make the law *and* force it upon a minority." *Currin*, 306 U.S. at 15 (emphasis added). The Supreme Court's decision in *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935), makes clear that granting a private entity the authority to "write the regulations" is not sufficient alone to effect an unconstitutional delegation, and the doctrine is only implicated when a private entity is afforded both powers. In that case—one of only two in which the Supreme Court has invoked the unconstitutional delegation doctrine to invalidate federal law—the Court recognized Congress's authority to enlist private entities to define standards "in matters of a more or less technical nature, as in designating the standard height of drawbars." *Id.*

Further, despite Plaintiffs' contrary assertion, Defendants have cited support for the fact that the ASB standards serve an advisory function for the agency. CMS maintains and exercises complete authority to review for actuarial soundness all Medicaid managed care contracts, including all capitation rates, and approves or denies contracts and rates on the basis of its own actuarial review. *See* Truffer Decl. ¶¶ 16, 20, DA154-56, DA158-59 (cited in Defs.' Br. 37). And, as a letter from Plaintiffs' own witness confirms, the ASB standards themselves make clear that an actuary may be able to certify a state's Medicaid MCO capitation rates as actuarially sound even if those rates deviate from ASOP 49's requirements by providing an appropriate statement in the actuarial communication to CMS, and the decision to approve or deny that contract and those rates would, again, be made by CMS. Defs.' Br. 37 n.26.[14] Plaintiffs completely ignore this supporting authority.[15]

Plaintiffs contend that the mere fact that ASOPs are binding *on actuaries* renders the ASB's power "legislative" not advisory, but Plaintiffs offer no support for this contention. Pls.' Br. 23. In inquiries under the delegation doctrine, the relevant relationship is that between the federal government and the private entity to which it has purportedly delegated some authority, not that between the entity and its members. The question thus is not whether "ASOP 49 removed discretion" from actuaries but whether, both before and after ASOP 49, CMS has undertaken its

[14] Plaintiffs also are not injured by any reliance on the ASB. They do not dispute that to be "actuarially sound," MCO capitation rates would have to reflect taxes which MCOs must pay, and thus, that CMS would require the HIPF to be accounted for in Medicaid MCO capitation rates in its own review, *see* Pls.' Br. 22, as do the states themselves for state insurance or MCO contracts, *see* Defs.' Br. 15 n.10 (citing state laws).

[15] To the extent Plaintiffs seek to exclude Mr. Truffer's testimony and evidence on the basis that Defendants somehow failed to file a proper or timely disclosure for him as an expert witness under Fed. R. Civ. P. 26(a)(2)(C), Defendants note that they designated him as both an expert witness and a fact witness. *See* ECF No. 47. The vast majority—if not all—of the content of Mr. Truffer's Declaration, DA146-63, is either fact testimony or permissible lay opinion and, therefore, even if the Court agreed with Plaintiffs that Defendants should be procedurally barred from designating Mr. Truffer as an "expert," that would not preclude admitting his testimony or evidence. The same is true for Dr. Golden. *See* ECF No. 47; DA1-11.

own actuarial review of Medicaid capitation rates and "render[ed] its own actuarial opinion as to whether the rates are actuarially sound." Truffer Decl. ¶ 20(b), DA159. It has. Therefore, the ASB must be understood to have purely advisory power, and the regulation's reference to the ASB does not implicate the delegation doctrine. *See* Defs.' Br. 37 (citing cases).

D. Plaintiffs Offer No Legal Basis for Rejecting the Agency's Interpretation.

Plaintiffs' *Chevron* arguments depend entirely on their misunderstanding of the APA and thus must be rejected. Plaintiffs assert that the actuarial soundness regulation "fail[s] *Chevron* Step Zero" because "there is no clear statement from Congress that the States are to be taxed" and Congress excluded states from "covered entities" subject to the HIPF. Pls.' Br. 23-24. But the regulation's reasonableness is independent of Congress's enactment of the HIPF. HHS's authority to promulgate the regulation derives from Congress's authorization to the Secretary to promulgate rules for the efficient administration of the Medicaid Act, *see* 42 U.S.C. § 1302(a), and Congress's requirement that capitation rates be actuarially sound, *see id.* § 1396b(m)(2)(A), which together constitute an "express delegation." *Chevron*, 467 U.S. at 843-44. Because "[t]he grounds upon which an administrative order must be judged are those upon which the record discloses that its action was based," *SEC v. Chenery Corp.*, 318 U.S. 80, 87 (1943), it is to these provisions—not the HIPF (which did not even exist when HHS promulgated the regulation)—that the Court must look. [16] And as the agency made clear in the rulemaking, 42 C.F.R. pt. 438 (which includes the actuarial soundness regulations) "implement[s] authority in sections 1902(a)(4), 1903(m), 1905(t), and 1932 of the [Social Security Act]." Medicaid Program; Medicaid Managed Care: New

[16] Even if Plaintiffs were correct (which they are not) that this Court should look to the ACA to discern the scope of any Congressional delegation by ACA § 2501, Congress ratified the actuarial soundness regulation HHS promulgated, thereby making it "absolutely certain that Congress intended such an exercise." *Gregory v. Ashcroft*, 501 U.S. 452, 464 (1991) (cited in Pls.' Br. 24).

Provisions, 67 Fed. Reg. 40,989-01, 40,994 (June 14, 2002). Section 1903(m), in turn, was codified at 42 U.S.C. § 1396b(m). Accordingly, Plaintiffs' arguments about "*Chevron* Step Zero," which concern the HIPF rather than § 1396b(m), are wholly inapposite.

Plaintiffs' arguments that "the agency actions (and inactions) here survive neither Step One nor Step Two" of *Chevron* are similarly unavailing. As to *Chevron* Step One, Congress's intent is clear because, in ACA § 2501, Congress ratified HHS's actuarial soundness regulation and incorporated it into the statutory scheme. *See N. Haven Bd. of Educ. v. Bell*, 456 U.S. 512, 535 (1982) ("Where an agency's statutory construction has been fully brought to the attention of the public and the Congress, and the latter has not sought to alter that interpretation although it has amended the statute in other respects, then presumably the legislative intent has been correctly discerned." (citations omitted)). Moreover, when Congress enacted the ACA, "generally accepted actuarial principles and practices"—the regulatory standard that was codified by ACA § 2501—already defined "actuarially sound" rates for Medicaid MCOs as rates that "provide for all reasonable, appropriate and attainable costs, including . . . any . . . taxes." *See* AAA 2005 Practice Note 8-9, DA269-70; *see also* Novak Report 6, 14, DA401, DA409. By this endorsement of the regulation, Congress made clear its intent that capitation rates paid by states to Medicaid MCOs would provide for all of the MCOs' costs, including the HIPF.[17]

[17] Even if such a clear statement of Congressional intent were absent, Plaintiffs cite no authority that one is required for the regulations at issue here. Plaintiffs cite three cases which they assert hold that "[t]o ensure that Congress intended to raid State coffers, the Constitution requires a 'clear statement from Congress.'" Pls.' Br. 24. But each actually stands for the proposition that courts require a clear statement from Congress "where the [challenged] administrative interpretation alters the federal-state framework by permitting federal encroachment upon a traditional state power." *See Solid Waste Agency of N. Cook Cty. v. U.S. Army Corps of Eng'rs*, 531 U.S. 159, 173 (2001) (requiring clear statement where interpretation regulated "nonnavigable, isolated, intrastate waters," a realm of traditional state power); *see also Bond v. United States*, 134 S. Ct. 2077, 2088-90 (2014) (requiring clear statement where interpretation "would dramatically intrude[] upon traditional state criminal jurisdiction" (citation omitted)); *Gregory*, 501 U.S. at 464 (requiring clear statement where interpretation would intrude upon state's power to determine qualifications of state government officials). None concerns Congressional action that had some downstream effect on a state's budget (let alone was a "raid [on] State coffers"). And because Medicaid has always been a

While conceding for other purposes that Congress "reaffirm[ed]" HHS's actuarial soundness standard when it revised § 1396(m) in ACA § 2501, *see* Pls.' Br. 11, Plaintiffs fully ignore that revision in their *Chevron* arguments. *See generally* Pls.' Br. 19-20, 23-25. As Defendants argued, ACA § 2501 is a clear statement of "the unambiguously expressed intent of Congress" to which the Court "must give effect" at *Chevron*'s first step. 467 U.S. at 842-43; Defs.' Br. 43-45, 48. But Plaintiffs failed to respond to Defendants' argument, and the Fifth Circuit "has consistently held that arguments not raised in response to a motion for summary judgment are waived." *Hensley v. Wal-Mart Stores Inc.*, 290 F. App'x 742, 743 (5th Cir. 2008) (citing *Keenan v. Tejeda*, 290 F.3d 252, 262 (5th Cir. 2002)). Accordingly, Defendants are entitled to summary judgment on Plaintiffs' claim that the regulation is not entitled to *Chevron* deference.

Even if "the court determines that Congress has not directly addressed the precise question at issue," under *Chevron* Step Two, the court defers to the agency's interpretation if it "is based on a permissible construction of the statute," "within the bounds of its statutory authority," and not "arbitrary" and "capricious." *Id.* at 843-44. Plaintiffs admit that they "don't challenge whether 42 C.F.R. § 438.6 was reasonable in 2002." Pls.' Br. 25. Rather, they plainly argue that Defendants acted arbitrarily and capriciously based entirely on some alleged "inaction." *See id.* at 14-15, 23.

Plaintiffs, complaining that "Defendants assess only whether the initial promulgation of 42 C.F.R. § 438.6 in 2002 was reasonable at the time," argue that "[l]aws once reasonable may prove unreasonable over time as circumstances change." Pls.' Br. 25.[18] But this argument completely

---

cooperative federal-state program, *see* Defs.' Br. 4, federal regulation thereof is hardly "federal encroachment upon a traditional state power." *Solid Waste*, 531 U.S. at 173. Moreover, even if the Court finds that Congress "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," that does not mean Congress has "surprised . . . States with post acceptance . . . conditions," *Pennhurst*, 451 U.S. at 25. *See* Defs.' Br. at 49.

[18] Thus, Plaintiffs do not assert that this is a case where the agency "has given its regulation a definitive interpretation, and later significantly revise[d] that interpretation." *Shell Offshore Inc. v. Babbitt*, 238 F.3d 622, 629 (5th Cir. 2001). Rather, as Plaintiffs' brief makes clear, Plaintiffs complain that the agency failed

misapprehends the nature of APA review. It is well-established that "[r]eview of agency action under [5 U.S.C.] § 706(2)'s 'arbitrary or capricious' standard is limited to the record before the agency *at the time of its decision*." *Luminant Generation Co. v. U.S.E.P.A.*, 675 F.3d 917, 925 (5th Cir. 2012) (emphasis added) (citation omitted).[19] Accordingly, the Court is bound to—as Defendants did—"assess only whether the initial promulgation of 42 C.F.R. § 438.6 was reasonable at the time [it was promulgated]." Pls.' Br. 25. And for the reasons Defendants previously explained, Defs.' Br. 47, and nowhere disputed by Plaintiffs, Pls.' Br. 23-25, the regulation's definition of "actuarial soundness"—which the agency adopted following notice-and-comment procedures—is entirely reasonable and surely "within the bounds of reasoned decisionmaking." *Balt. Gas & Elec. Co. v. Nat. Res. Def. Council, Inc.*, 462 U.S. 87, 104 (1983).[20]

Moreover, to the extent Plaintiffs argue that applying the extant regulatory scheme to Medicaid managed care capitation rates following enactment of the ACA is unreasonable,[21] the Court should reject that argument for two reasons. First, Plaintiffs cannot argue that subsequent events—in this case, enactment of the HIPF—gave rise to a duty to amend the regulation, and that such failure to amend the regulation is reviewable here. *Auer v. Robbins*, 519 U.S. 452 (1997)—where the Supreme Court held that failure to initiate rulemaking to amend a rule is not a reviewable

---

to revise its regulatory interpretation in the face of subsequent events that allegedly rendered continued application of that interpretation newly unreasonable. *See* Pls.' Br. 14-15, 25.

[19] *See also Banner Health v. Burwell*, 126 F. Supp. 3d 28, 81 (D.D.C. 2015) (holding that because "review is limited to . . . the information that was before an agency at the time of the . . . rulemaking[]" a court "cannot invalidate a rulemaking" even if "it subsequently becomes clear that a rulemaking was unwise.")

[20] Indeed, as Defendants noted, every one of the Plaintiffs has expressly incorporated the ASB's standards into their own regulation of intra-state insurance contracts. *See* Defs.' Br. 15, 15 n.10 & 47 n.32.

[21] Plaintiffs offer no support for their contention that notice-and-comment procedures were required for ASOP 49, nor do they even respond to Defendants' argument that even if ASOP 49 represented some change to "generally accepted actuarial standards and practices," it would constitute an "interpretive rule," and thus be exempt from such procedures. *See* Defs.' Br. 49-50 & n.36; Pls.' Br. 23. Even if they were correct that ASOP 49 "removed discretion," they do not argue or explain why that would render it anything other than an interpretive rule exempt from notice-and-comment rulemaking.

action under the standards of the APA unless the plaintiff has filed a formal petition for rulemaking under 5 U.S.C. § 553(e)—forecloses that argument. *See Auer*, 519 U.S. at 459; *Biggerstaff v. FCC*, 511 F.3d 178, 184 (D.C. Cir. 2007) (noting that a petition for rulemaking "'ordinarily' is 'the appropriate way in which to challenge a longstanding regulation on the ground that it is "violative of statute"'"). Here, Plaintiffs never filed a petition for rulemaking.

Second, even if Plaintiffs' failure to petition the agency to amend the regulation did not preclude their claim, it would be outside the scope of this case because Plaintiffs have not pleaded a claim under 5 U.S.C. § 706(1) to "compel agency action unlawfully withheld." *See generally* Am. Compl.; *see id.* ¶¶ 47, 51, 54, 61 & 67 (all citing only 5 U.S.C. § 706(2)). A theory or "claim which is not raised in the complaint but, rather, is raised only in response to a motion for summary judgment is not properly before the court." *Cutrera v. Bd. of Sup'rs of La. State Univ.*, 429 F.3d 108, 113 (5th Cir. 2005). And as the Supreme Court has explained, while the APA authorizes suit by "[a] person suffering legal wrong because of agency action," which is defined to include "failure to act," relief for failure to act is provided in § 706(1). *See Norton v. S. Utah Wilderness All.*, 542 U.S. 55, 61-62 (2004). Accordingly, Plaintiffs—having conceded that the actuarial soundness regulation was reasonable when promulgated, and being precluded from arguing that Defendants' continued application of the extant actuarial soundness regulation following enactment of the ACA is unreasonable—raise no meritorious claim under the APA. Defendants are therefore entitled to summary judgment on these claims (Counts I, II, III, V, and VI).

CONCLUSION

For the foregoing reasons, and for the reasons explained in Defendants' opening brief, Defendants respectfully request that the Court enter summary judgment for Defendants.

Dated: July 13, 2017

Respectfully submitted,

CHAD A. READLER
Acting Assistant Attorney General

JOHN R. PARKER
United States Attorney

SHEILA M. LIEBER
Deputy Director

/s/ Julie Straus Harris
JULIE STRAUS HARRIS
DC Bar No. 1021928
MICHELLE R. BENNETT
CO Bar No. 37050
Trial Attorneys
United States Department of Justice
Civil Division, Federal Programs Branch
20 Massachusetts Avenue N.W., Room 6118
Washington, DC 20530
Tel: (202) 353-7633
Fax: (202) 616-8470
Email: Julie.StrausHarris@usdoj.gov

Counsel for Defendants