No. 18-10545

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

STATE OF TEXAS; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF INDIANA; STATE OF WISCONSIN; STATE OF NEBRASKA,
Plaintiffs-Appellees-Cross-Appellants,

v.

CHARLES P. RETTIG, in his Official Capacity as Commissioner of Internal Revenue; UNITED STATES OF AMERICA; UNITED STATES DEPARTMENT OF HEALTH AND HUMAN SERVICES; UNITED STATES INTERNAL REVENUE SERVICE; ALEX M. AZAR, II, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,
Defendants-Appellants-Cross-Appellees.

On Appeal from the United States District Court
for the Northern District of Texas, Wichita Falls Division,
No. 7:15-cv-151
Hon. Reed O'Connor

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CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of Rule 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal.

Plaintiffs-Appellees-Cross-Appellants:

State of Texas
State of Kansas
State of Louisiana
State of Indiana
State of Wisconsin
State of Nebraska

Defendants-Appellants-Cross-Appellees:

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United States Department of Health and Human Services
United States Internal Revenue Service
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STATEMENT REGARDING ORAL ARGUMENT

The district court vacated a Department of Health and Human Services rule on constitutional grounds and ordered the United States to pay the plaintiff States $479 million. Pursuant to Fifth Circuit Rule 28.2.3 and Federal Rule of Appellate Procedure 34(a)(1), the United States respectfully requests oral argument given the importance of the issues in this case.

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INTRODUCTION

Through the Medicaid program, the federal government subsidizes States' provision of healthcare services to low-income individuals. The States typically contract with healthcare insurers known as managed-care organizations, which provide services to Medicaid-eligible individuals in exchange for receiving a fixed monthly payment from the State for each covered individual. Many of those managed-care organizations, like most other healthcare providers, pay the federal government a yearly Health Insurance Providers Fee (the "provider fee") required by the Patient Protection and Affordable Care Act (ACA).

To protect the integrity of the Medicaid reimbursement process, Congress has required that payments from States to managed-care organizations be actuarially sound. Since 2002, the Department of Health and Human Services (HHS) has implemented that command by requiring that States' payments be certified by an actuary, consistent with standards established by the Actuarial Standards Board (Board). And that Board has concluded that—like all other taxes and fees—the provider fee should be taken into account in determining the payments made to managed-care organizations.

This case concerns the efforts of six States to lower their payments to managed-care organizations. Relying on the fact that States and localities are exempt from provider fees when they provide services themselves, the States here argue that managed-care organizations with whom they contract should be exempt from the

provider fee as well. The text of the ACA does not permit this extrapolation. Congress dealt specifically with exemptions for Medicaid insurers, and exempted only certain nonprofit Medicaid insurers from the provider fee. The States' argument would impermissibly transform that limited exception into a blanket exemption.

The district court mistakenly analyzed plaintiffs' claim as if the scope of the statute were determined not by Congress and implementing regulations but by the Actuarial Standards Board, a private organization. And the district court accordingly declared that this exercise of authority violated the nondelegation doctrine. But the Board did not purport to have independent authority to require payment of provider fees. It simply articulated a basic actuarial principle that all taxes and fees must be included in setting and certifying capitation rates. The States' quarrel thus is not with the Board, but with Congress, which chose not to exempt the States' insurers from the provider fee. And, as the States have subsequently recognized, their asserted injury is not the result of any action by actuaries or by the Board. Subsequent to the district court's ruling, actuaries have continued to include provider fees as a condition of actuarial soundness because doing so reflects the state of the law. Accordingly, the States have filed a second suit, this time admitting that their injuries are unrelated to any actuarial decision.

Because the States' injury did not result from the Board's action and has not been redressed by the district court's injunction, they lack standing to challenge the HHS rule requiring certification by an actuary in compliance with Board guidelines.

And, because the States seek to challenge a rule that was promulgated in 2002, they fall outside of the statute of limitations and are barred from challenging the rule.

In any event, the States' nondelegation argument is foreclosed by Supreme Court precedents permitting the government to rely on disinterested private entities to determine interstitial, technical questions like accounting and actuarial best practices, particularly as a condition for government aid under the Spending Clause. Indeed, state statutes in each of the plaintiff States empower actuarial organizations identically to the regulation challenged here.

The district court was also gravely mistaken in concluding that its ruling entitled the States to $479 million in "equitable disgorgement" from the United States as compensation for provider fees paid to their Medicaid insurers. As an initial matter, because the States were required to account for the provider fee to fulfill congressional direction that rates be actuarially sound, not because of HHS's actuarial-certification requirement, no basis for the award exists. And even apart from the district court's fundamental misunderstanding of the role of the Board, the States identify no waiver of sovereign immunity that would permit them to recover from the United States monies paid to third parties. Accordingly, the district court's partial grant of summary judgment to the States should be reversed.

STATEMENT OF JURISDICTION

Plaintiffs assert claims against the United States under the Administrative Procedure Act (APA), 5 U.S.C. § 701 *et seq.*, the Declaratory Judgment Act, 28 U.S.C.

§§ 2201-2202, and the tax-refund statute, 26 U.S.C. § 7422. The district court had jurisdiction under 28 U.S.C. § 1331. The district court entered final judgment on July 30, 2019. The government filed a timely notice of appeal on September 26, 2019. ROA.4700. The States filed a timely notice of appeal on September 27, 2019. ROA.4703. This Court has jurisdiction under 28 U.S.C. § 1292.

STATEMENT OF THE ISSUES

1. Whether States' exemption from the health-insurance provider fee extends to the private insurers with whom the States contract for Medicaid services.

2. Whether the States have standing to challenge actions of the Board that did not cause their injuries and, if so, whether their nondelegation arguments are foreclosed by Supreme Court precedent.

3. Whether the district court erred in ordering the government to "equitably disgorge" the funds that States paid to managed-care organizations to account for the provider fee.

STATEMENT OF THE CASE

A. Statutory Background

1. The Patient Protection and Affordable Care Act

As part of the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119 (2010), Congress imposed an annual fee on health-insurance providers. *See id.* § 9010, 124 Stat. at 865 (reprinted *infra* A1). The statute imposes the provider fee on any "covered entity engaged in the business of providing health

insurance." *Id.* § 9010(a). It defines a covered entity as "any entity which provides health insurance for any United States health risk," *id.* § 9010(c)(1), subject to certain exceptions, *id.* § 9010(c)(2).

Notably, the statute excludes from the definition of "covered entity" "any governmental entity (except to the extent that such an entity provides health insurance coverage through the community health insurance option under section 1323)." ACA § 9010(c)(2)(B); *see* 26 C.F.R. § 57.2(b)(2)(ii). Congress subsequently amended the ACA to additionally exempt from the provider fee those nonprofit insurers that receive more than 80% of their gross revenue from "government programs that target low-income, elderly, or disabled populations." Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1406(a)(3), 124 Stat. 1029, 1066; *see* 26 C.F.R. § 57.2(b)(2)(iii).

Congress has determined the total amount of provider fees to be collected each year. *See* Health Care and Education Reconciliation Act of 2010, § 1406(a)(4), 124 Stat. at 1066. In 2014, the total amount was $8 billion, and in 2018 it was $14.3 billion.[1] *See id.*; 26 C.F.R. § 57.4(a)(3). Each covered provider pays a proportionate amount of the total, as calculated in accordance with a statutory formula. ACA

[1] Congress determined that the provider fee should not be collected for the 2017 and 2019 calendar years. *See* Consolidated Appropriations Act, 2018, Pub. L. No. 115-120, div. D, § 4001, 132 Stat. 28, 38; Consolidated Appropriations Act, 2016, Pub. L. No. 114-113, div. H, tit. II, § 201, 129 Stat. 2242, 3038 (2015).

§ 9010(b). To the extent that some providers are excused from payment, the burden on other providers is proportionally increased.

2. The Medicaid Program

a. Congress created the Medicaid program in 1965 "for the purpose of providing federal financial assistance to States that choose to reimburse certain costs of medical treatment for needy persons." *Harris v. McRae*, 448 U.S. 297, 301 (1980); *see* 42 U.S.C. § 1396 *et seq.* State participation in the Medicaid program is optional. *Harris*, 448 U.S. at 301. However, if a State elects to participate, it must comply with the requirements of the Medicaid statute. Since 1982, every State has participated in Medicaid.[2] *NFIB v. Sebelius*, 567 U.S. 519, 542 (2012).

b. For many years, States provided Medicaid health coverage exclusively through a "fee-for-service" model. *See Equal Access for El Paso, Inc. v. Hawkins*, 509 F.3d 697, 700 (5th Cir. 2007). Under this model, States pay healthcare providers directly for services rendered to Medicaid-eligible individuals. Under a fee-for-service model, the amount paid by each State is exactly equal to the Medicaid obligations incurred.

Every State continues to provide healthcare based on the fee-for-service model for at least some Medicaid beneficiaries. In recent years, however, States have

[2] The Children's Health Insurance Program (CHIP) was established in 1997 to provide healthcare to uninsured children who do not qualify for Medicaid. *See* Balanced Budget Act of 1997, Pub. L. No. 105-33, § 4901, 111 Stat. 251, 552-70. Medicaid and CHIP operate identically in all respects relevant to this litigation.

increasingly turned to a "managed-care" model to provide healthcare to Medicaid-eligible individuals. Under this model, States pay private managed-care organizations a fixed monthly fee per covered individual, called a "capitation rate," intended to approximate the costs of providing healthcare services to that individual. The managed-care organizations then establish and maintain networks of providers to deliver healthcare services to the covered individuals. The managed-care model increases the predictability of the Medicaid budgeting process and helps control Medicaid spending in some circumstances.

In 1981, Congress made it easier for States to offer Medicaid services through managed-care arrangements, and also set forth mandatory specifications for managed-care contracts between States and Medicaid managed-care organizations, as defined in the statute. Omnibus Budget Reconciliation Act of 1981, tit. XXI, § 2178, Pub. L. No. 97-35, 95 Stat. 357, 813-15. One such specification—a restriction at issue here—is that capitation payments to managed-care organizations must be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii) (reprinted *infra* A3). That requirement ensures that States do not underfinance managed-care organizations and thereby compromise enrollee access to care. *See* Aaron Mendelson et al., *New Rules for Medicaid Managed Care—Do They Undermine Payment Reform?*, 4 Healthcare 274, 274 (2016). It also guarantees that States do not overpay managed-care organizations and thereby needlessly expend federal funds.

c. Congress has entrusted HHS to implement the actuarial-soundness requirement pursuant to a broad grant of rulemaking authority. 42 U.S.C. § 1302(a). Initially, HHS determined that payments under a managed-care contract would not be actuarially sound unless it cost the State no more than it would have cost to provide the same set of services on a fee-for-service basis. 42 C.F.R. § 447.361 (repealed 2002). After States and other stakeholders objected that this rule limited state flexibility, *see* 67 Fed. Reg. 40,989, 40,996-97 (June 14, 2002), HHS issued the regulation challenged by the States.[3] 42 C.F.R. § 438.6(c)(1)(i) (2015) (reprinted *infra* A4).

HHS's rule established three principal requirements for determining whether rates are actuarially sound. The first two requirements are that the rates must (1) "[h]ave been developed in accordance with generally accepted actuarial principles and practices" and (2) be "appropriate for the populations to be covered, and the services to be furnished under the contract." 42 C.F.R. § 438.6(c)(1)(i)(A)-(B) (2015).

The third requirement is that rates must be "certified, as meeting the requirements of this [provision], by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards

[3] Effective 2016, HHS recodified the actuarial-soundness requirement, which is now contained in 42 C.F.R. § 438.2 (reprinted *infra* A5) and 42 C.F.R. § 438.4(a) and (b) (reprinted *infra* A6). Because the States challenge the version of the regulations in effect in 2015, and because the definitions relevant to the States' claims are unchanged, this brief follows the district court in discussing the 2015 version of the regulation. ROA.3967 & n.7.

established by the Actuarial Standards Board." 42 C.F.R. § 438.6(c)(1)(i)(C) (2015). The American Academy of Actuaries is a private, membership-based professional organization that sets qualification, practice, and professionalism standards for actuaries. ROA.159-160. The Actuarial Standards Board is an independent organization that aims to set appropriate standards for actuarial practice in the United States. ROA.160.

In the 2002 rulemaking, some commenters urged HHS to "establish prescriptive standards" for actuarial soundness rather than leaving the matter to generally accepted actuarial principles. 67 Fed. Reg. at 40,998. The agency explained that it preferred to "bas[e] the definition on a methodology that uses accepted actuarial principles and practices" so as to "give[] States and actuaries maximum flexibility while still ensuring that rates be certified as actuarially sound." *Id.*

d. As particularly relevant here, the Actuarial Standards Board in 2015 issued Actuarial Standard of Practice (ASOP) 49, which "provides guidance to actuaries when performing professional services related to Medicaid . . . managed care capitation rates, including a certification on behalf of a state." Actuarial Standards Board, ASOP No. 49, at 1, www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf. That standard explains that a managed-care capitation rate is "actuarially sound" only if it "provide[s] for all reasonable, appropriate, and attainable costs." *Id.* at 2. Those costs "include, but are not limited to, expected health benefits, health benefit settlement expenses,

administrative expenses, the cost of capital, and government-mandated assessments, fees, and taxes." *Id.*; *see id.* at 10 (similar). The standard advances Congress's goal of ensuring that States do not underfund managed-care organizations by paying them less than what is required to provide adequate care for Medicaid enrollees and to account for related administrative expenses. Similarly, it advances Congress's goal of avoiding overpayments to managed-care organizations by ensuring that the rates paid are tied to the costs of performing under the contract.

ASOP 49 aligned with HHS guidance documents that explained that the provider fee, "like other similar fees," should "be considered a business cost to health plans" and thus should be considered in capitation rates. HHS, *Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans* 1 (Oct. 2014), https://go.usa.gov/xVMgu; *see also id.* at 2 ("[T]he amount of the fee should be incorporated as an adjustment to the capitation rates and the resulting payments should be consistent with the actual or estimated amount of the fee."). That guidance reflected the common-sense proposition that actuarial soundness requires taking into account all of an insurer's costs, including taxes and fees like the provider fee. And it also reflected the economic reality that the provider fee, by increasing managed-care organizations' expenses, would ultimately lead to higher costs to the States, with whom the managed-care organizations contract to provide services.

B. Factual Background and Prior Proceedings

1. Plaintiffs are the States of Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska. ROA.147. They filed this action against the United States in 2016, asserting a variety of challenges both to the provider fee and to the HHS rule requiring certification by an actuary. They did not contend that the insurers with whom they contract are exempt from the provider fee by statute. Instead, they alleged that, as applied to such insurers, the provider fee violates the Spending Clause, the Tenth Amendment, and principles of federalism, ROA.165-172, and that the actuarial-certification rule violates the Constitution's private nondelegation doctrine and the Administrative Procedure Act, ROA.166-169. The States sought an injunction, a declaratory judgment, and a "refund of the amounts the Plaintiff States have paid (or may pay during the course of this litigation) under the Health Insurance Providers Fee, including any prejudgment or post-judgment interest as allowed by law." ROA.173-175.

2. The district court granted the government's motion to dismiss as to two of the States' claims. ROA.371-372. After finding that the States had Article III standing, ROA.335-341, the district court concluded that it lacked authority to order a "refund" for amounts paid by States to managed-care organizations to account for the provider fee, ROA.342-344. That was so, the district court explained, because the States did not actually pay the provider fee to the government, and so could not invoke various provisions waiving the government's immunity for tax-refund suits.

ROA.344. The district court denied the remainder of the government's motion to dismiss, finding that the States stated a claim as to all merits counts. ROA.346-371.

3. On March 5, 2018, the district court partially granted the States' motion for summary judgment and partially granted the government's motion for summary judgment. ROA.3965-3966. As a threshold matter, the district court again determined that the States had Article III standing and that their suit was not barred by the Anti-Injunction Act or any statute of limitations. ROA.3974-3997. In reaching that holding, the court expressed its view—not urged by the States in their complaint—that the ACA exempts the States from being required to account for managed-care organizations' fee payments. The court opined that, because "Congress expressly exempted states from paying" the provider fee, ROA.3965, "condition[ing] Medicaid funds on whether" the States account for the provider fee would be "in defiance of Congressional intention," ROA.3984.

The court then turned to the merits of the States' claims, beginning with their challenges to the HHS actuarial-certification rule and concluding with their challenges to the provider fee itself.

First, the district court held that the HHS rule requiring an actuary to certify States' capitation rates violated the private nondelegation doctrine, which prohibits the delegation of legislative power to private entities. *See* ROA.4000-4010. The private nondelegation doctrine, the district court stated, prohibits "private lawmakers" from "alter[ing] the rights and duties of their fellow private citizens." ROA.4002.

The actuarial-certification rule violates that doctrine, the district court reasoned, because it allowed the Actuarial Standards Board to "prevent [HHS] from approving any . . . contract that deviates from its standards." ROA.4005. The district court acknowledged that the Supreme Court's decisions in *Currin v. Wallace*, 306 U.S. 1 (1939), and *United States v. Rock Royal Co-Op.*, 307 U.S. 533 (1939), held that nondelegation principles are not offended by a scheme that requires the approval of private parties. ROA.4006-4007. The district court nevertheless found *Currin* and *Rock Royal* distinguishable because those cases allowed private parties to approve government policy *after* the agency acted, while the rule challenged in this case prevents HHS from acting unless an actuary approves the States' contracts. *Id.*

Second, the district court rejected the States' other challenges to the actuarial-certification rule. The district court concluded that the actuarial-certification rule complied with the Administrative Procedure Act's notice-and-comment requirements, ROA.4014, and that it was not arbitrary and capricious, ROA.4015.

Third, the district court rejected plaintiffs' other challenges to the provider fee. ROA.4015-4024. The district court determined that the fee did not violate the Spending Clause because it was not "a coercive condition on spending," given the district court's view that Congress did not intend the States to pay the fee at all. ROA.4018. Likewise, the district court concluded that "[b]ecause the law exempts states from paying the" provider fee, the fee is a "constitutional tax and not a coercive, surprising, or unrelated condition on spending." ROA.4021. Similarly, the

court concluded that the fee was not an unconstitutional intergovernmental tax, because "it was the [Actuarial Standards Board's] imposition of the [provider fee] on Plaintiffs, not the [fee] itself," that caused the States' injury. ROA.4024.

4. The district court's summary-judgment order "set aside" the actuarial-certification rule as "contrary to constitutional right, power, privilege, or immunity." ROA.4025; *see* 5 U.S.C. § 706(2). The district court did not immediately enter final judgment, however, prompting both parties to file protective notices of appeal. ROA.4033, ROA.4038. Additionally, the plaintiff States filed a motion to reconsider on a variety of grounds. *See* ROA.4275-4302.

The district court partially granted the States' motion to reconsider. ROA.4402-4414. The district court rejected the States' request to find that the provider fee was a "tax" rather than a "fee." ROA.4402-4405. And it found that the States are not entitled to a permanent injunction preventing the government from imposing provider-fee liability on States. ROA.4412-4414.

The district court granted the States' motion to reconsider as to their argument that they are "entitled to equitable disgorgement of their [provider fee] payments under the APA, even if they are not entitled to a tax refund of those payments under 28 U.S.C. § 7422." ROA.4405. In reaching that ruling, the district court stated that the APA waives immunity for "relief other than money damages." ROA.4406 (quoting 5 U.S.C. § 702). It thought that equitable disgorgement was permitted by *Bowen v. Massachusetts*, 487 U.S. 879 (1988), in which the Supreme Court held that the

APA permits suits "seeking to enforce [a] statutory mandate itself, which happens to be one for the payment of money." *Id.* at 900; *see* ROA.4411. The district court believed that, because the ACA "explicitly prohibits Defendants from collecting the [provider fee] from the states in the first place," it could "exercise its inherent and broad jurisdiction to order Defendants to disgorge Plaintiffs' [provider-fee] monies." ROA.4411.

5. After issuing its reconsideration opinion, the court did not enter final judgment immediately, and the States filed another protective notice of appeal. *See* ROA.4551. Subsequently, the parties agreed on figures that represented "reasonable approximations of the amount each Plaintiff State paid to account for its [managed-care organizations'] [provider-fee] payments for Medicaid and CHIP premiums for 2014-2016." ROA.4626. Those figures totaled $479 million, $296 million of which was attributable to Texas and the remainder of which was attributable to the other States. *Id.*

The parties could not agree on whether interest was available on those figures. ROA.4626-4628. The district court subsequently ruled that interest was not available, ROA.4659-4663, and entered final judgment against the United States for $479 million. ROA.4677. The parties both filed notices of appeal. ROA.4700, ROA.4703. The government filed a motion urging that the final judgment be stayed pending appeal, and the district court administratively stayed its judgment pending consideration of that motion. ROA.4674.

6. After the district court's reconsideration order, the plaintiff States filed a separate action before the same district court.[4] *Texas v. United States* (*Texas II*), No. 4:18-cv-779 (N.D. Tex. filed September 20, 2018) (reprinted *infra* A7). The complaint stated that the district court's ruling in this case did not prevent States from being forced to account for the provider fee, because the "general principles of actuarial soundness[] nonetheless require that the 2018 [fee] still be added to the negotiated capitation rates of Plaintiffs' Medicaid and CHIP contracts." *Id.* ¶ 26; *see id.* ¶ 45 ("Plaintiffs' actuaries, employing their best judgment and discretion, [have] conclude[d] actuarial soundness in 2018 can only result from a full, dollar-for-dollar imposition upon Plaintiffs of any 2018 [provider fee] liability upon their Medicaid or CHIP [managed-care organizations]."). Accordingly, the State's second complaint seeks to enjoin the Internal Revenue Service from assessing the provider fee on managed-care organizations to the extent that they provide services under contract with States. *See id.* at 15. That case has been stayed pending this Court's resolution of this appeal.

[4] The plaintiff States initially sought to amend their complaint in this action to renew their claims. ROA.4438-4445. The district court denied that request due to the States' "significant delay" in filing their motion. ROA.4541. All of the allegations in the States' *Texas II* complaint are also contained in their proposed second amended complaint in this case. *See* ROA.4447-4480.

SUMMARY OF ARGUMENT

I. The district court's holdings rest on the premise that the Affordable Care Act does not require insurers to pay the statute's provider fee when they contract with state Medicaid programs. That statutory theory is inconsistent with the text of the Affordable Care Act, which exempts States from the provider fee when they provide health insurance directly. Congress specifically addressed the separate question of whether and when Medicaid insurers should also be exempt, and provided that the only Medicaid insurers that should be exempt from the fee are nonprofit insurers that receive more than eighty percent of their revenues from government programs targeting low-income, elderly, or disabled populations. Congress could have exempted all insurers from the fee when working under contract with State governments, but it chose not to do so. The States provide no reason to ignore that congressional choice.

II. The requirement that insurers under contract with States pay the provider fee is therefore not the product of any standard set by the Actuarial Standards Board. The Medicaid statute and implementing regulations require that the capitation rates paid by States to Medicaid managed-care organizations be actuarially sound. And the HHS rule challenged by the States requires that an actuary certify the States' contracts using guidelines developed by the Board. That rule ultimately has no bearing on the States' obligation to account for the provider fee in their Medicaid contracts. As the States explained in filing their second lawsuit, notwithstanding the district court's

order in this case, no actuary could certify that any contract is sound unless it accounts for the provider fee. Plaintiffs' alleged injury was not caused by the Board or by any actuary, and its alleged injury is not redressed by the district court's order vacating the requirement that an actuary certify each contract. The States thus lacked standing to challenge the HHS rule.

Even if plaintiffs could make out Article III standing, their challenge to the actuarial-certification rule is barred by the statute of limitations. The Administrative Procedure Act generally requires plaintiffs to sue within six years of the publication of a rule, unless the agency has sought to enforce the rule against plaintiffs or the plaintiffs have requested that the agency reconsider its rule. Here, the States can point to no governmental action applying the rule to them, and so filed this suit too late to challenge the rule.

Assuming that the Court were to conclude that the States had standing to pursue this claim and fall within the statute of limitations, the States' nondelegation challenge is foreclosed by Supreme Court precedent. The private nondelegation doctrine prohibits the government from allowing private parties to regulate the affairs of their competitors. But, under Supreme Court case law, the doctrine does not prohibit the government from conditioning governmental action on private-party approval or from involving disinterested private actors in matters of a technical nature, particularly as a condition for participation in a federal spending program. The actuarial-certification rule falls within both of these exceptions: HHS has

conditioned Medicaid funding on actuarial certification, and has involved the disinterested Actuarial Standards Board in a technical policy area.

III. The district court erred in awarding nearly $500 million in "equitable disgorgement" to the States. As a threshold matter, because the rule vacated here is not the cause of the States' monetary injury, it could not be the basis for any disgorgement.

In any event, the district court had no authority to enter an order of this kind. The Administrative Procedure Act does not waive the government's sovereign immunity for money damages. This is not the sort of case where plaintiffs sue to recover specific monies taken by the government under a forfeiture statute. Nor is it a case where there is a specific statute mandating that the government pay funds. Accordingly, the States' suit seeks a form of substitute relief that is not cognizable under the APA.

STANDARD OF REVIEW

"The district courts' orders granting summary judgment are subject to *de novo* review." *Van Houten v. City of Fort Worth*, 827 F.3d 530, 533 (5th Cir. 2016). This Court reviews a district court's disgorgement order for abuse of discretion. *SEC v. AMX, Int'l, Inc.*, 7 F.3d 71, 73 (5th Cir. 1993). "A decision premised on an error of law constitutes an abuse of discretion." *In re Deepwater Horizon*, 785 F.3d 986, 999 (5th Cir. 2015).

ARGUMENT

I. Insurers that contract with States are subject to the provider fee established by the Affordable Care Act

In the Affordable Care Act, Congress imposed an annual provider fee on all health-insurance providers. *See supra* pp. 4-6. The fee applies to all "covered entities"—a term generally defined to include "any entity which provides health insurance for any United States health risk." ACA § 9010(c)(1).

The ACA excludes from the definition of "covered entity" all "governmental entit[ies]," with an exception not relevant here. ACA § 9010(c)(2)(B). As a result, States do not owe the provider fee when they "provide[] health insurance," as they do when a "State health department or a State insurance commission" provides health insurance or healthcare services directly. 26 C.F.R. § 57.2(b)(1)(iv), (2)(ii)(B). The same is true when local governments provide healthcare insurance or services, such as county-run mental-health and behavioral-health organizations that pay directly for health services. *See id.*

The statutory text does not encompass private insurance providers simply because they do business with States. When Congress meant to exempt such entities, it did so explicitly. Congress carved out an exception to the provider fee requirement for nonprofit insurers if, and only if, more than eighty percent of their gross revenue comes from Medicare, Medicaid, and CHIP. Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1406(a)(3), 124 Stat. 1029, 1066;

see 26 C.F.R. § 57.2(b)(2)(iii). Thus, all for-profit insurers (and those nonprofit insurers that do not meet the other criteria) are subject to the provider fee, even when they provide services on behalf of States.

The provision regarding provider fees contrasts with those that apply to a different ACA fee that applies to health-insurance policies but that exempts all plans to the extent that they provide services under Medicaid or CHIP contracts. *See* 26 U.S.C. § 4377(b)(2) ("In the case of an exempt governmental program, no fee shall be imposed . . . ."); *id.* § 4377(b)(3) (defining government programs to include Medicaid and CHIP). As it did with respect to nonprofit providers for the provider fee, Congress in that context spoke explicitly when it meant to exempt entities because they were furnishing services in the Medicaid program.

The ACA neither requires nor prohibits private insurers from passing the cost of the provider fee to States. The requirement that contracts between insurers and States be "actuarially sound" long predates the enactment of the ACA. 42 U.S.C. § 1396b(m)(2)(A)(iii) (A2); *see* 42 C.F.R. 438.6(c)(2)(i) (2015). And the ACA itself added a requirement that Medicaid "capitation rates paid . . . shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates." ACA § 2501(c)(1)(C), 124 Stat. at 306 (amending 42 U.S.C. § 1396b(m)(2)(A)(xiii)). Therefore, to the extent that accounting for the provider fee is required by sound actuarial principles, it is mandated by the ACA.

Perhaps because the ACA would afford no basis for such an argument, the States did not assert in their complaint that they were statutorily exempt from accounting for the provider fee. That should have been the end of the matter. The provider fees were not imposed by actuaries, and actuaries cannot properly disregard fees imposed by Congress.

The district court thus erred in ascribing the applicability of the provider fee not to Congress but to the Actuarial Standards Board. For the reasons discussed, the court was wrong to declare that the ACA "expressly excluded states from paying" the provider fee. ROA.4005. And it similarly erred in declaring that the Actuarial Standards Board "effectively rewr[o]te[] the ACA" by "forcing the states to pay a tax when Congress has expressly forbidden the federal government to collect it from them." ROA.4005-4006. The district court did not, and could not, reconcile its conclusion with the legislative text of the exclusion for States and of the limited exclusion for certain nonprofit Medicaid insurers.

II. The actuarial-certification rule does not violate nondelegation principles.

Correcting the district court's statutory misunderstanding fully resolves this case. Once it is clear that the ACA requires managed-care organizations generally to pay the provider fee, the rest of the States' arguments collapse. The States' attack on the actuarial-certification rule fails at the outset because their alleged injury is not redressable by vacating that rule: even if that rule were vacated, the States have

confirmed that they would still be required to pay the same amounts to managed-care organizations.

In any event, the States' constitutional attack on the actuarial-certification rule is foreclosed by precedent. The Supreme Court has held that the government does not impermissibly delegate power whenever it conditions government action on a private party's approval. And the Court also has allowed the government to entrust disinterested private entities with decisions of a technical nature, particularly as a condition for government funding under the Spending Clause. The actuarial-certification rule, which conditions government funds on a technical certification by a disinterested actuary, is permissible under these precedents.

A. The States lack standing to challenge the actuarial-certification rule.

The court's holding vacating the HHS actuarial certification rule rested entirely on the mistaken premise that the Actuarial Standards Board "effectively rewr[o]te[] the ACA" by "forcing the states to pay a tax when Congress has expressly forbidden the federal government to collect it from them." ROA.4005-4006. Once that premise is corrected, it is clear that the States suffered no injury as a result of the rule and that an order setting aside the rule does not redress their asserted injuries. They can thus satisfy neither the causation nor the redressability requirements of standing. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560-61 (1992) (noting that there "must be a

causal connection between the injury and the conduct complained of" and that it must be "likely" that an injury will be "redressed by a favorable decision").

The district court believed that the States could challenge the actuarial-certification rule on the grounds that vacating the rule "would give [the States] freedom to negotiate to exclude the [provider fee] from their rates and give [HHS] freedom to approve those rates." ROA.3983. But because the Board was not the source of the provider fee or the requirement that contracts be actuarially sound, the court's order could have no effect, as events immediately demonstrated.

As the States alleged in filing their second suit, "the actuarial soundness requirement of 42 U.S.C. § 1396b(m)(2)(A)(iii) has caused Plaintiffs' actuaries, employing their best judgment and discretion, to conclude that actuarial soundness in 2018 can only result from a full, dollar-for-dollar imposition upon Plaintiffs of any 2018 [provider fee] liability upon their Medicaid or CHIP [managed-care organizations]." Complaint ¶ 45, *Texas II*; *see supra* p. 16. They further acknowledge that,

> [f]ollowing the removal of ASOP 49 as a legal requirement, actuaries for Plaintiffs assessed the impact of the 2018 [provider fee] upon their respective jurisdictions' contracts with [managed-care organizations] for Medicaid and CHIP. In sum, given the nature and size of the 2018 [provider fee], when it comes to the 2018 [provider-fee] liability, Congress's admonition of "actuarial sound[ness]," *see* 42 U.S.C. § 1396b(m)(2)(A)(iii), and *the general principles of actuarial soundness, nonetheless require that the 2018 [provider fee] still be added to the negotiated capitation rates of Plaintiffs' Medicaid and CHIP contracts.*

Id. ¶ 26 (emphasis added).

In other words, the States and their actuaries all agree that "the general principles of actuarial soundness" require taking the provider fee into account. And they concede that no actuary, if left to his or her discretion, would develop or approve a rate that does not include the fee. The States cannot take a different position in this appeal, *see Brandon v. Interfirst Corp.*, 858 F.2d 266, 268 (5th Cir. 1988), and there would be no plausible basis for doing so.

Accordingly, because the States' injury is caused by Congress, not by HHS' actuarial-certification requirement or by the actions of the Board, and because the court's order does not redress that injury, the States lack standing to challenge the HHS rule.

B. The statute of limitations bars the States' challenge to the actuarial-certification rule.

Even if the States had standing, their challenges to HHS's actuarial-certification rule still fails at the threshold. The regulation at issue was published in 2002. ROA.3991. The Administrative Procedure Act's six-year statute of limitations therefore lapsed in 2008, seven years before the States filed this suit. 28 U.S.C. § 2401(a). That time limit "function[s] as [a] condition[] on the Government's waiver of sovereign immunity." *United States v. Kwai Fun Wong*, 135 S. Ct. 1625, 1636 (2015).

In *Dunn-McCampbell Royalty Interest, Inc. v. National Park Service*, 112 F.3d 1283, 1287 (5th Cir. 1997), this Court held that it is "possible" to "challenge a regulation after the limitations period has expired" on constitutional or statutory grounds. 112

F.3d at 1287. To do so, however, the plaintiff must "show some direct, final agency action involving the particular plaintiff within six years of filing suit." *Id.* For example, if a plaintiff petitions the government to review the application of its regulation, then the agency's denial of that petition would restart the statute of limitations. *Id.* (citing *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991)). Likewise, when an agency "*applies* a rule, the limitations period running from the rule's publication will not bar a claimant from challenging" that rule. *Id.* (citing *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985)). Those circumstances "do not create an exception from the general rule that the limitations period begins to run from the date of publication in the Federal Register." *Id.* "They merely stand for the proposition that an 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." *Id.*

Here, the States failed to challenge the actuarial-certification rule within six years of its publication. And they cannot identify a "direct, final agency action" involving them. The States never petitioned HHS to alter or forbear enforcement of its regulations. Nor can they point to any agency order that requires them to take a particular action. Accordingly, they cannot establish that their APA claims are timely under the reasoning of *Dunn-McCampbell*.

The district court purported to identify three "direct, final agency actions" taken by HHS against the States. *See* ROA.3995-3997. But none of those actions

satisfy the *Dunn-McCampbell* test. First, the district court pointed to a "letter" sent by HHS to the Texas Medicaid Director approving Texas's contract with insurers. ROA.3995. But that letter is not an order requiring any State to take a particular action—nor have the States ever challenged HHS's approval of Texas's contracts. Accordingly, the letter is hardly a "direct, final agency action involving the particular plaintiff within six years of filing suit." *Dunn-McCampbell*, 112 F.3d at 1287.

Second, the district court thought that the government's collection of the provider fee from insurers could satisfy the *Dunn-McCampell* standard. ROA.3995-3996. But the government's decision to collect funds from third parties is not a "direct, final agency action involving the" States. The proper plaintiffs to challenge that collection would be the insurers themselves (although such a challenge would fail on the merits, for the reasons described above).

Third, the district court pointed to an HHS guidance document that emphasizes that actuaries must follow all the practice standards established by the Actuarial Standards Board. *See* ROA.3996. That guidance document is not a "final" action, because it "merely restate[s]" the HHS rule rather than "creat[ing] new legal consequences." *National Pork Producers Council v. U.S. EPA*, 635 F.3d 738, 756 (5th Cir. 2011). And it does not "direct[ly] . . . involve" the States, because it does not require any State to undertake a particular action. *Dunn-McCampbell*, 112 F.3d at 1287. It cannot be that, every time an agency reminds regulated individuals to follow the

law, it creates a new opportunity to challenge that law outside of the ordinary statute of limitations. The States' challenge to the HHS rule therefore cannot proceed.

C. The actuarial-certification rule does not delegate legislative power impermissibly.

Assuming the Court does reach the merits, binding precedent forecloses the States' challenge to the actuarial-certification rule under the private nondelegation doctrine.

1. Similar to the broader nondelegation doctrine, which concerns the transfer of power from Congress to the executive branch, the private nondelegation doctrine seeks to ensure that legislative power is not impermissibly devolved to private entities. Such delegations may violate both the Vesting Clause, U.S. Const. art. I, § 1, and the Due Process Clauses, *id.* amends. V, XIV. *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936); *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935); *see Boerschig v. Trans-Pecos Pipeline, L.L.C.*, 872 F.3d 701, 707 (5th Cir. 2017).

The private nondelegation doctrine's earliest applications concerned ordinances that allowed homeowners to set zoning requirements for their neighborhoods. *Washington ex rel. Seattle Trust Co. v. Roberge*, 278 U.S. 116, 121-22 (1928); *Thomas Cusack Co. v. City of Chicago*, 242 U.S. 526, 530 (1917); *Eubank v. City of Richmond*, 226 U.S. 137, 143-44 (1912). Such ordinances, the Supreme Court explained, were generally unconstitutional because they "confer[red] the power on some property holders to virtually control and dispose of the property rights of others," without setting any

standard to prevent the property owners from making policy "solely for their own interest, or even capriciously." *Eubank*, 226 U.S. at 143-44.

In *Schechter Poultry*, 295 U.S. 495, the Supreme Court first considered the application of this doctrine to the federal government. That case invalidated the New Deal-era National Industrial Recovery Act as unlawfully delegating to the President authority to enact "codes of fair competition." *Id.* at 531. In holding that delegation unconstitutional, the Court observed that it would not solve the problem if the President turned to "representative members" of "each industry" to develop the codes. *Id.* at 537. Although Congress could "avail[] itself of such [private] assistance . . . in the exercise of its authority over the public domain . . . or in matters of a more or less technical nature, as in designating the standard height of drawbars," the Court observed that delegating core legislative power to private industry would be "utterly inconsistent with the constitutional prerogatives and duties of Congress." *Id.*

That reasoning was confirmed in *Carter Coal*, 298 U.S. 238, which invalidated a federal statute that allowed the producers of two-thirds of the coal in any given district to set wages and hours for all the producers in that district. *Id.* at 283-84. That delegation "to private persons whose interests may be and often are adverse to the interests of others in the same business," the Court held, was "so clearly arbitrary, and so clearly a denial of rights safeguarded by the due process clause of the Fifth Amendment, that it is unnecessary to do more than refer to decisions of this court

which foreclose the question." *Id.* at 311 (citing *Schechter Poultry*, 295 U.S. at 537, *Eubank*, 226 U.S. at 143, and *Roberge*, 278 U.S. at 122).

Since *Carter Coal*, neither the Supreme Court nor this Court have held that a federal or state statute violates the private nondelegation doctrine. And in *Currin v. Wallace*, 306 U.S. 1 (1939), the Supreme Court upheld a statute that provided that the Secretary of Agriculture could not designate a tobacco market for regulation unless two-thirds of tobacco growers approved the designation in a referendum. *Id.* at 15. That referendum requirement, the Court held, did not present a "delegation of legislative authority" because "Congress has merely placed a restriction upon its own regulation by withholding its operation as to a given market 'unless two-thirds of the growers voting favor it.'" *Id.* Thus, unlike *Carter Coal*, this is "not a case where a group of producers may make the law and force it upon a minority," because "it is Congress that exercises its legislative authority in making the regulation and in prescribing the conditions of its application." *Id.* at 15-16. Instead, the required actuarial certification, like "[t]he required favorable vote upon the referendum" in *Currin*, "is one of these conditions." *Id.* at 16.

Finally, in *United States v. Rock Royal Co-Op.*, 307 U.S. 533 (1939), the Court upheld a similar statute that allowed milk producers to veto certain milk-pricing orders. *Id.* at 545. Such a statute was not "an unlawful delegation to producers of the legislative power to put an order into effect in a market," the Court ruled, because

"the Congress had the power to put this Order into effect without the approval of anyone." *Id.* at 577.

2. The actuarial-certification rule is constitutional under these precedents. As in *Currin* and *Rock Royal*, HHS "exercise[d] its [rulemaking] authority in making the regulation and in prescribing the conditions of its application," *Currin*, 306 U.S. at 16, and no delegation occurred because HHS "ha[s] the power to" determine actuarial soundness "without the approval of anyone," *Rock Royal*, 307 U.S. at 577. Notably, HHS could achieve *exactly the same result* by promulgating regulations that adopted the substance of the Actuarial Safety Board's standards. There can be no dispute that such an approach would be permissible under Supreme Court precedent. And, in reality, that approach is almost identical to what HHS did here: it announced that the standards it will require actuaries to follow align with what a professional organization in the field already requires of actuaries. If HHS disagreed with the Actuarial Standard Board's guidance, it was free to amend its regulation at any time. HHS thus did not delegate any power to any private entity—instead, it simply "prescrib[ed] the conditions" necessary to receive federal funds. *Currin*, 306 U.S. at 16. The actuarial-certification rule, by imposing a condition on the exercise of government power, does not implicate the private nondelegation doctrine under *Currin* and *Rock Royal*.

Those decisions are dispositive. And if anything, the HHS regulation challenged here is less problematic than the statutes considered by the Supreme Court in its relevant precedents for at least three reasons.

First, unlike the private entities in *Carter Coal* and its predecessors, there is no claim that the Actuarial Standards Board and the American Academy of Actuaries are self-interested actors empowered to regulate their competitors. The private nondelegation doctrine is animated by the concern that private persons' "interests may be and often are adverse to the interests of others in the same business." *Carter Coal*, 298 U.S. at 311; *see Eubank*, 226 U.S. at 144 (noting concern that private parties may act "solely for their own interest, or even capriciously"). Accordingly, it appears that neither the Supreme Court nor any court of appeals has struck down a law that assigned limited power to a disinterested, expert private entity. *Cf. Association of Am. R.Rs. v. U.S. Dep't of Transp.*, 821 F.3d 19, 29 (D.C. Cir. 2016) ("Delegating legislative authority to official bodies is inoffensive because we presume those bodies are *disinterested*, that their loyalties lie with the public good, not their private gain."). Here, the States do not contend that the actuarial organizations are self-interested (and for good reason, given that the States empower those entities in their own laws, *see infra* pp. 39-40).

Second, the HHS rule challenged here gives the Actuarial Standards Board power only "of a more or less technical nature." *Schechter Poultry*, 295 U.S. at 537. This is not a case where a private entity is entrusted to set prices, wages, or labor standards for an entire industry. Rather, the Actuarial Standards Board determines only which "actuarial principles and practices" are "generally accepted" in the field. 42 C.F.R. § 438.6(c)(1)(i)(A) (2015). In that respect, the regulation is analogous to the

law empowering private entities to "designate[] the standard height of drawbars" that the *Schechter Poultry* Court indicated would be permissible. 295 U.S. at 537; *see St. Louis, Iron Mountain & S. Ry. Co. v. Taylor*, 210 U.S. 281, 286 (1908) (upholding law that allowed the American Railway Administration to set the height of drawbars); *Cospito v. Heckler*, 742 F.2d 72, 86-87 & nn.24-25 (3d Cir. 1984) (upholding statute that required psychiatric hospitals to be "accredited by the Joint Commission on Accreditation of Hospitals" in order to participate in Medicare and Medicaid).

Third, the actuarial-certification rule does not result in any private actor actually "regulat[ing] the business of another." *Carter Coal*, 298 U.S. at 311. Indeed, there is no coercive regulation at issue here at all. Unlike the statute struck down in *Carter Coal*, the actuarial-soundness statute was not enacted pursuant to Congress's power to "regulate Commerce," U.S. Const. art. I, § 8, cl. 3, but rather as a condition for state participation in the Medicaid program. When acting pursuant to the Spending Clause, U.S. Const. art. I, § 8, cl. 1, Congress has "broad power to set the terms on which it disburses federal money to the States," as long as it sets forth those conditions "unambiguously." *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006); *see Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981) ("[I]n return for federal funds, the States agree to comply with federally imposed conditions."). Many of those conditions involve accreditation, certification, or compliance with state law, and no court has ever held that those conditions are unconstitutional. *See infra* pp. 37-38 (describing those conditions).

Indeed, it is not even clear that States can invoke the doctrine in this Spending Clause context. As this Court has recognized, the private nondelegation doctrine stems, at least partly, from the Due Process Clauses. *Boerschig*, 872 F.3d at 707; *see Carter Coal*, 298 U.S. at 311. Here, the States cannot allege that the actuarial-certification rule deprives them of "life, liberty, or property, without due process of law," U.S. Const. amend. V, because the States "are not the intended beneficiaries of the federal health care programs," *Shah v. Azar*, 920 F.3d 987, 998 (5th Cir. 2019). This case is therefore doctrinally dissimilar from cases of direct economic regulation (as under the Commerce Clause), where a property interest would be affected.

In short, many of the factors that the Supreme Court has treated as relevant—the disinterested nature of the private body, the technical nature of the question, the fact that Congress and HHS had the power to make these decisions without any actuarial approval, and so on—confirm that the challenged rule is permissible under *Currin* and *Royal Rock*.

3. Although the district court sought to distinguish *Currin* and *Rock Royal* on their facts, its ruling cannot be reconciled with the Supreme Court's holdings.

The district court found significance in the fact that the private actors in those cases could veto the Secretary's actions, whereas here the actuaries certify (or decline to certify) capitation rates before HHS acts. ROA.4006. But that is a distinction without a difference. Nothing in *Currin* or *Rock Royal* suggests that the chronology of the private action matters; on the contrary, *Currin* spoke broadly of Congress's

authority to "prescrib[e] the conditions of . . . application." 306 U.S. at 16; *see Cook v. Ochsner Found. Hosp.*, 559 F.2d 968, 975 (5th Cir. 1977) (suggesting that *Currin* permits any "condition *precedent* to the operative effect of the Secretary's regulations" (emphasis added)). Moreover, it is unclear why such temporal differences would matter: on the district court's theory, if HHS had chosen to declare all contracts actuarially sound, but given actuaries authority to subsequently veto any contract, then the delegation would survive. It is hard to imagine a rationale for the private nondelegation doctrine in which that scenario is meaningfully distinct from the actuarial-certification rule.

For that reason, the only court of appeals to consider the district court's timing theory has rejected it. In *Confederated Tribes of Siletz Indians of Or. v. United States*, 110 F.3d 688, 696 (9th Cir. 1997), the Ninth Circuit upheld a provision of the Indian Gaming Regulatory Act that required a State's governor to consent before the Secretary of the Interior could take lands in trust for the benefit of Indian tribes. *Id.*; *see* 25 U.S.C. § 2719(b)(1)(A). Responding to a similar timing argument, the court of appeals held that "the formality of which official acts first should not be determinative"—rather, "[t]he important consideration is that both officials must act." 110 F.3d at 696. In a footnote, the court observed that "the statutes at issue in *Currin* and *Rock Royal* do not specify whether the individual farmers or the Secretary of Agriculture should decide first," and that "the order of the decisions" was "irrelevant" to those case's holdings. *Id.* at 696 n.5.

Further underscoring the weakness of its distinction, the district court indicated that even if the order of decisions were inverted—that is, if HHS had declared all contracts actuarially sound, but had authorized actuaries to subsequently veto any contract—that arrangement would likewise constitute an impermissible delegation of the "legislative power" "to veto executive action." *See* ROA.4004. In doing so, the court expressed doubt that *Currin* and *Rock Royal* remain good law following *INS v. Chadha*, 462 U.S. 919 (1983). ROA.4007 n.44. Although jurists have split on whether the holding of *Chadha* diminishes the force of *Currin* and *Rock Royal*,[5] the district court was not free to disregard Supreme Court precedents. The Supreme Court "has admonished the lower federal courts to follow its directly applicable precedent, even if that precedent appears weakened by pronouncements in its subsequent decisions, and to leave to the Court 'the prerogative of overruling its own decisions.'" *Randell v. Johnson*, 227 F.3d 300, 301 (5th Cir. 2000) (per curiam) (quoting *Agostini v. Felton*, 521 U.S. 203, 237 (1997)). To the extent that the district court's holding rests on a skepticism of the Supreme Court's precedents, the court misapplied the law.

Moreover, the district court was mistaken to conclude that the Actuarial Standards Board is acting contrary to the will of Congress. *See* ROA.4004-4006. As discussed above, the Board was correct to determine that States should account for

[5] *Compare Department of Transp. v. Association of Am. R.Rs.*, 135 S. Ct. 1225, 1253-54 (2015) (Thomas, J., concurring in the judgment), *with Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wis. v. United States*, 367 F.3d 650, 655-58 (7th Cir. 2004).

the provider fee when contracting with managed-care organizations. *Supra* pp. 9-10, 24-25. That decision does not conflict with any statute because, again, the ACA does not exempt most managed-care organizations from the fee. *Supra* Part I. Contrary to the district court's fears, therefore, HHS is not "obey[ing] the [Actuarial Standards Board] even over the express commands of Congress." ROA.4006.

4. Federal and state law regularly assigns limited authority to private parties, and there is nothing particularly novel about the actuarial-certification rule. And indeed, many laws would be unconstitutional under the district court's theory.

a. Numerous federal statutes require private parties to comply with "generally accepted accounting principles." *E.g.*, 15 U.S.C. § 78m(b)(2)(B); 25 U.S.C. § 3304(c)(2)(A); 42 U.S.C. § 300ee-15(b)(4); 42 U.S.C. § 11360a(g)(2)(A); *see Owens v. Jastrow*, 789 F.3d 529, 534 (5th Cir. 2015). Those generally accepted accounting principles are not set by the government, but rather "are the official standards adopted by the American Institute of Certified Public Accountants . . . , a private professional association, through three successor groups it established." *Ganino v. Citizens Utilities Co.*, 228 F.3d 154, 159 n.4 (2d Cir. 2000). There is no principled distinction between those accounting principles and the actuarial standards at issue in this case.

Similar grants of authority occur in many other contexts. As the D.C. Circuit recently observed, "[a]cross a diverse array of commercial and industrial endeavors, from paving roads to building the Internet of Things, private organizations have

developed written standards to resolve technical problems, ensure compatibility across products, and promote public safety." *American Soc'y for Testing & Materials v. Public.Resource.Org, Inc.*, 896 F.3d 437, 440 (D.C. Cir. 2018). "Federal, state, and local governments, however, have incorporated by reference thousands of these standards into law." *Id.* Indeed, Congress encourages that practice with respect to federal agencies. *See* 15 U.S.C. § 272(b)(3) (urging agencies to use "where possible the use of standards developed by private, consensus organizations"). For example, statutes require that smoke detectors in places of public accommodation be "installed in accordance with National Fire Protection Association Standard 74," 15 U.S.C. § 2225(a)(1), and that toys meet a safety standard set by the American Society of Testing and Materials, 15 U.S.C. § 2056b(a). All of those statutes could be unconstitutional on the district court's theory.

Finally, various federal statutes require compliance with state law or delegate power to States. *E.g.*, 15 U.S.C. § 2645(b) (requiring state governors to approve asbestos-management plans); 42 U.S.C. § 10705 (requiring state courts to approve grant applications). One such law, the Indian Gaming Regulatory Act, has been challenged as violating the private nondelegation doctrine; those challenges have failed in every circuit in which they have been brought. 25 U.S.C. § 2719(b)(1)(A); *see Lac Courte Oreilles Band of Lake Superior Chippewa Indians of Wis. v. United States*, 367 F.3d 650, 656-57 (7th Cir. 2004); *Confederated Tribes of Siletz Indians*, 110 F.3d at 696. States, just like the Actuarial Standards Board, are not Article I or Article II constitutional

actors—but no court has held it unconstitutional to allow the States to approve or veto planned federal actions.

b. Federal statutes would not be the only laws affected by the district court's capacious reasoning. The Supreme Court and this Court have both explained that the private nondelegation doctrine sounds in due process. *Carter Coal*, 298 U.S. at 311 (delegation was "clearly a denial of rights safeguarded by the due process clause"; *Boerschig*, 872 F.3d at 707 ("Boerschig's nondelegation claim arises from a constitutional provision that does apply to states: the Due Process Clause."). Therefore, if the States succeed in this suit, any state law that devolved power to a private entity would also be suspect.

Many state statutes, like the federal laws discussed above, entrust private actors to impose or implement technical conditions as part of a regulatory scheme. *See, e.g.*, Tex. Tax Code Ann. § 11.1826(b)(1) (property may not be exempted for tax purposes unless the organization "has an audit prepared by an independent auditor" that is "conducted in accordance with generally accepted accounting principles").[6] All of the plaintiff States, like the federal government, require private actors to comply with private safety standards set by disinterested organizations. *See, e.g.*, Tex. Health & Safety Code Ann. § 247.0273(a) ("The executive commissioner by rule shall specify an

[6] *See also, e.g.*, Ind. Code Ann. § 27-16-8-4(3); Kan. Stat. Ann. § 9-2211(b)(2); La. Stat. Ann. § 22:461(D); Neb. Rev. Stat. Ann. § 76-1302(17); Wis. Stat. Ann. § 65.90(6).

edition of the Life Safety Code of the National Fire Protection Association to be used in establishing the life safety requirements for an assisted living facility licensed under this chapter.").[7] And—notably—all of the plaintiff States, like the federal government, empower the Actuarial Standards Board to set technical standards. *E.g.*, Tex. Ins. Code Ann. § 425.0545(a), (c)(4) (requiring every company that holds life-insurance contracts to submit each year an "opinion of [an] appointed actuary" that is "based on standards adopted from time to time by the Actuarial Standards Board or its successor").[8] It is difficult to understand how these States can contend that the actuarial-certification rule violates the Constitution when all of them maintain similar laws that would be unconstitutional under their own theory.

III. The States are not entitled to any monetary relief.

The district court's choice of remedy—awarding the States $479 million in "equitable disgorgement," ROA.4405-4412—was plainly incorrect for two reasons. First and foremost, the alleged infirmity in the actuarial-certification rule did not cost the States any money. And, in any event, the "equitable disgorgement" ordered by the court is not permissible under the Administrative Procedure Act, which does not waive the government's sovereign immunity against monetary relief.

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[7] *See also, e.g.*, Ind. Code Ann. § 16-21-1-7(b)(2); Kan. Stat. Ann. § 31-132(b); La. Stat. Ann. § 40:1578.7(A); Neb. Rev. Stat. Ann. § 66-1623; Wis. Stat. Ann. § 101.14(1)(c).

[8] *See also, e.g.*, Ind. Code Ann. § 27-1-12.8-23(d)(4); Kan. Stat. Ann. § 40-409(b)(5)(C); La. Stat. Ann. § 22:752(D)(3); Neb. Rev. Stat. Ann. § 44-424(3); Wis. Stat. Ann. § 623.06(1m)(c)(2).

A. Because plaintiffs' asserted injuries were not the result of the rule vacated by the district court, there can be no basis for any award of monetary relief, even assuming that any such award would be permissible. Indeed, the States have acknowledged that, without the actuarial-certification rule, "the general principles of actuarial soundness" would "nonetheless require" that the provider fee "still be added to the negotiated capitation rates of Plaintiffs' Medicaid and CHIP contracts." Complaint ¶ 26, *Texas II*; *see supra* pp. 16, 24-25. Accordingly, even if HHS had never enacted the actuarial-certification rule, insurers still would still have owed the same provider-fee payments and would still have priced those payments into their contracts with the States. And Congress's actuarial-soundness requirement still would have required the States to account for those payments in their capitation rates. *See supra* Part I.

There was therefore no basis for the district court's disgorgement award. "Disgorgement wrests ill-gotten gains from the hands of a wrongdoer." *Allstate Ins. Co. v. Receivable Fin. Co.*, 501 F.3d 398, 413 (5th Cir. 2007). Because "disgorgement is meant to be remedial and not punitive," it is "limited to 'property causally related to the wrongdoing' at issue." *Id.* (quoting *SEC v. First City Fin. Corp.*, 890 F.2d 1215, 1231 (D.C. Cir. 1989)). The "party seeking disgorgement must distinguish between that which has been legally and illegally obtained." *Id.*; *see United States v. Search of Law Office, Residence, and Storage Unit Alan Brown*, 341 F.3d 404, 410 (5th Cir. 2003) (plaintiffs seeking equitable remedies are "not entitled to be any better off" than they

would be notwithstanding the allegedly illegal conduct). Here, where the States' monetary losses are unrelated to the HHS rule that the district court found unconstitutional, there is no cause for awarding any disgorgement on the basis of the nondelegation holding.

B. Even if the States had suffered monetary harm resulting from the actuarial-certification rule, the district court had no authority to order monetary relief. "Absent a waiver, sovereign immunity shields the Federal Government and its agencies from suit." *FDIC v. Meyer*, 510 U.S. 471, 475 (1994). The "States of the Union, like all other entities, are barred by federal sovereign immunity from suing the United States in the absence of an express waiver of this immunity by Congress." *Block v. North Dakota ex rel. Bd. of Univ. & Sch. Lands*, 461 U.S. 273, 280 (1983).

The district court mistakenly believed that its order was authorized by the Administrative Procedure Act's waiver of immunity.[9] By its terms, the APA waives the government's sovereign immunity only for "relief other than money damages." 5 U.S.C. § 702. Suits against the United States for money damages must generally be brought under the Tucker Act, 28 U.S.C. § 1491, unless they sound in tort, in which case they must be brought under the Federal Tort Claims Act, 28 U.S.C. § 2671 *et seq.* The States did not seek to sue the United States under either of those provisions.

[9] The district court correctly dismissed the States' claim that they were entitled to a tax refund under 26 U.S.C. § 7422, observing that the States had not paid the provider fee to the federal government and so were not eligible for any refund. *See* ROA.344.

The APA's waiver of immunity "must be strictly construed, in terms of its scope, in the sovereign's favor." *Department of the Army v. Blue Fox, Inc.*, 525 U.S. 255, 261 (1999). And the order here plainly does not entail "relief other than money damages." As the Supreme Court has explained, the "term 'money damages' . . . normally refers to a sum of money used as compensatory relief." *Bowen v. Massachusetts*, 487 U.S. 879, 895 (1988). The text of the APA therefore bars awarding any money relief "to *substitute* for a suffered loss." *Id.* That principle is dispositive here, where the States seek to force the federal government to pay them money to substitute for the States' payments to managed-care organizations.

Contrary to the States' assertions, this case is unlike the two circumstances, both discussed in *Bowen*, in which the Supreme Court has permitted suits to recover money under the APA.

First, as the district court correctly recognized, *see* ROA.4409, this is not a suit to recover "specific property *or monies*" seized by the government—for example, under a forfeiture statute. *See Bowen*, 487 U.S. at 893. The money that the States paid to insurers is not the "specific . . . monies" that they now seek to recover from HHS. *See Modoc Lassen Indian Hous. Auth. v. U.S. Dep't of Hous. & Urban Dev.*, 881 F.3d 1181, 1197 (10th Cir. 2017) (noting that the APA's text would bar a court from awarding "the 'cash equivalent' of the wrongfully withheld overpayments"). Instead, the monetary relief would impermissibly "*substitute* for a suffered loss." *Bowen*, 487 U.S. at 895.

Second, this is not a case in which plaintiffs are "seeking to enforce [a] statutory mandate" that "happens to be . . . for the payment of money." *Bowen*, 487 U.S. at 900. As discussed above, insurers are not exempt from the provider fee when they contract with States, and nothing in the ACA prohibits insurers from passing on provider-fee costs when they contract with the States. *See supra* Part I. But even were that incorrect, there still would be no statute requiring the federal government to pay any money to the States. In *Bowen*, the Supreme Court permitted monetary relief because the plaintiffs sought to enforce 42 U.S.C. § 1396b(a), a Medicaid provision that requires that "the Secretary 'shall pay'" certain money to the States. 487 U.S. at 900; *see id.* at 901 ("[The State] is seeking funds to which a statute allegedly entitles it, rather than money in compensation for the losses, whatever they may be, that [the State] will suffer or has suffered by virtue of the withholding of those funds."). Here, by contrast, there is no statute that requires the government to pay any money at all. At most, the States' suit seeks "compensation for the losses" that they "will suffer or [have] suffered" because managed-care organizations paid the provider fee and passed that cost to the States. *Id.* at 901. Sovereign immunity bars that sort of relief.

The district court did not grapple with the Supreme Court's guidance. The district court concluded that "disgorgement in this case enforces Defendant's compliance with the ACA's mandate specifically exempting the states from paying the" provider fee. ROA.4410. As explained above, the ACA does not say that—and even if it did, it would not be a "mandate . . . for the payment of money" but rather an

exception to a statutory obligation. *Bowen*, 487 U.S. at 900. And the district court's view that it had "inherent and broad equitable jurisdiction to order" money payments, ROA.4411, is inconsistent with bedrock immunity principles.[10] Congress, not courts, must decide whether to waive the government's immunity. *Block*, 461 U.S. at 287. Here, Congress has not done so, and the district court plainly erred—and thus abused its discretion—in awarding monetary relief.

[10] The district court incorrectly relied on *Porter v. Warner Holding Co.*, 328 U.S. 395 (1946), a case in which the government sought disgorgement from a private party, and so where immunity was not at issue. *Id.* at 396-97.

CONCLUSION

The judgment of the district court should be reversed and summary judgment should be granted to the United States.

Respectfully submitted,

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November 2019

CERTIFICATE OF SERVICE

I hereby certify that on November 20, 2019, I electronically filed the foregoing brief with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. Participants in the case are registered CM/ECF users, and service will be accomplished by the appellate CM/ECF system.

s/ Joshua Revesz
Joshua Revesz

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 32(a)(7)(B) because it contains 11,144 words. This brief also complies with the typeface and type-style requirements of Federal Rule of Appellate Procedure 32(a)(5)-(6) because it was prepared using Microsoft Word 2016 in Garamond 14-point font, a proportionally spaced typeface.

s/ Joshua Revesz
Joshua Revesz

ADDENDUM

TABLE OF CONTENTS

Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 9010, 124 Stat. 119, 865 (2010), as amended by ACA, § 10905, as further amended by the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1406, 124 Stat. 1029, 1066

§ 9010. Imposition of Annual Fee on Health Insurance Providers

(a) **Imposition of fee.—**

(1) **In general.**—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2013 a fee in an amount determined under subsection (b).

(2) **Annual payment date.**—For purposes of this section [this note], the term 'annual payment date' means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) **Determination of fee amount.—**

(1) **In general.**—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to the applicable amount as—

(A) the covered entity's net premiums written with respect to health insurance for any United States health risk that are taken into account during the preceding calendar year, bears to

(B) the aggregate net premiums written with respect to such health insurance of all covered entities that are taken into account during such preceding calendar year.

* * *

(c) **Covered entity.—**

(1) **In general.**—For purposes of this section, the term 'covered entity' means any entity which provides health insurance for any United States health risk during the calendar year in which the fee under this section is due.

(2) **Exclusion.**—Such term does not include—

(A) any employer to the extent that such employer self-insures its employees' health risks,

(B) any governmental entity,

(C) any entity--

(i) which is incorporated as a nonprofit corporation under a State law,

(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as otherwise provided in section 501(h) of the Internal Revenue Code of 1986 [26 U.S.C.A. § 501(h)]), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and

(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII [42 U.S.C.A. § 1395 et seq.], XIX [42 U.S.C.A. § 1396 et seq.], and XXI [42 U.S.C.A. § 1397aa et seq.] of the Social Security Act, and

(D) any entity which is described in section 501(c)(9) of such Code [26 U.S.C.A. § 501(c)(9)] and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.

* * *

* * *

(f) **Tax treatment of fees.—**The fees imposed by this section—

(1) for purposes of subtitle F of the Internal Revenue Code of 1986 [26 U.S.C.A. § 6001 et seq.], shall be treated as excise taxes with respect to which only civil actions for refund under procedures of such subtitle shall apply, and

(2) for purposes of section 275 of such Code [26 U.S.C.A. § 275] shall be considered to be a tax described in section 275(a)(6).

* * *

(i) **Guidance**.—The Secretary shall publish guidance necessary to carry out the purposes of this section and shall prescribe such regulations as are necessary or appropriate to prevent avoidance of the purposes of this section, including inappropriate actions taken to qualify as an exempt entity under subsection (c)(2).

(j) **Effective date.—**This section [this note] shall apply to calendar years—

(1) beginning after December 31, 2013, and ending before January 1, 2017,

(2) beginning after December 31, 2017, and ending before January 1, 2019, and

(3) beginning after December 31, 2019.

42 U.S.C. § 1396b

§1396b. Payment to States

* * *

(m) "Medicaid managed care organization" defined; duties and functions of Secretary; payments to States; reporting requirements; remedies

* * *

(2)

(A) Except as provided in subparagraphs (B), (C), and (G), no payment shall be made under this subchapter to a State with respect to expenditures incurred by it for payment (determined under a prepaid capitation basis or under any other risk basis) for services provided by any entity (including a health insuring organization) which is responsible for the provision (directly or through arrangements with providers of services) of inpatient hospital services and any other service described in paragraph (2), (3), (4), (5), or (7) of section 1396d(a) of this title or for the provision of any three or more of the services described in such paragraphs unless—

* * *

(iii) such services are provided for the benefit of individuals eligible for benefits under this subchapter in accordance with a contract between the State and the entity under which prepaid payments to the entity are made on an actuarially sound basis and under which the Secretary must provide prior approval for contracts providing for expenditures in excess of $1,000,000 for 1998 and, for a subsequent year, the amount established under this clause for the previous year increased by the percentage increase in the consumer price index for all urban consumers over the previous year;

* * *

(xiii) such contract provides that * * * (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, * * * .

* * *

* * *

* * *

42 C.F.R. § 438.6 (2015)

§ 438.6. Contract requirements

* * *

(c) Payments under risk contracts—

(1) Terminology. As used in this paragraph, the following terms have the indicated meanings:

(i) Actuarially sound capitation rates means capitation rates that—

(A) Have been developed in accordance with generally accepted actuarial principles and practices;

(B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and

(C) Have 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.

* * *

(2) Basic requirements.

(i) All payments under risk contracts and all risk-sharing mechanisms in contracts must be actuarially sound.

(ii) The contract must specify the payment rates and any risk-sharing mechanisms, and the actuarial basis for computation of those rates and mechanisms.

* * *

(4) Documentation. The State must provide the following documentation:

(i) The actuarial certification of the capitation rates.

(ii) An assurance (in accordance with paragraph (c)(3) of this section) that all payment rates are—

(A) Based only upon services covered under the State plan (or costs directly related to providing these services, for example, MCO, PIHP, or PAHP administration).

(B) Provided under the contract to Medicaid-eligible individuals.

* * *

* * *

* * *

42 C.F.R. § 438.2

§ 438.2. Definitions

As used in this part—

* * *

Actuary means an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board. In this part, Actuary refers to an individual who is acting on behalf of the State when used in reference to the development and certification of capitation rates.

* * *

42 C.F.R. § 438.4

§ 438.4. Actuarial soundness

(a) Actuarially sound capitation rates defined. Actuarially sound capitation rates are projected to provide for all reasonable, appropriate, and attainable costs that are required under the terms of the contract and for the operation of the MCO, PIHP, or PAHP for the time period and the population covered under the terms of the contract, and such capitation rates are developed in accordance with the requirements in paragraph (b) of this section.

(b) CMS review and approval of actuarially sound capitation rates. Capitation rates for MCOs, PIHPs, and PAHPs must be reviewed and approved by CMS as actuarially sound. To be approved by CMS, capitation rates must:

> (1) Have been developed in accordance with standards specified in § 438.5 and generally accepted actuarial principles and practices. Any proposed differences among capitation rates according to covered populations must be based on valid rate development standards and not based on the rate of Federal financial participation associated with the covered populations.
>
> * * *
>
> (6) Be certified by an actuary as meeting the applicable requirements of this part, including that the rates have been developed in accordance with the requirements specified in § 438.3(c)(1)(ii) and (e).
>
> * * *

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

TEXAS, KANSAS, LOUISIANA, INDIANA, WISCONSIN, and NEBRASKA, *Plaintiffs,* v. UNITED STATES OF AMERICA, UNITED STATES INTERNAL REVENUE SERVICE, and DAVID J. KAUTTER, in his official capacity as ACTING COMMISSIONER OF THE INTERNAL REVENUE SERVICE *Defendants.*	§ § § § § § § § § § § § § § § § §	Civil Action No. _____

ORIGINAL COMPLAINT FOR
DECLARATORY AND INJUNCTIVE RELIEF

TO THE HONORABLE JUDGE OF SAID COURT:

This time-sensitive suit and request for injunctive relief contests the calculation, assessment, and distribution of liability for the 2018 Health Insurance Providers Fee ("HIPF") by the United States of America, United States Internal Revenue Service, and David J. Kautter, in his official capacity as Acting Commissioner of the Internal Revenue Service ("Defendants" or "IRS"). In order for Plaintiffs to avoid liability for the 2018 HIPF, injunctive relief is requested as soon as possible, and no later than September 24, 2018, before 2018 HIPF payments are due.[1]

I. PARTIES

1. Plaintiffs are all sovereigns within the United States.

[1] HIPF payments are due October 1, 2018. But Plaintiff Wisconsin is contractually obligated to pay its Medicaid and CHIP managed care organizations 2018 HIPF liability up front, by September 25, 2018.

2. Defendants are the United States of America, the United States Internal Revenue Service ("IRS" or "Service"), and David J. Kautter, in his official capacity as Acting Commissioner of the Internal Revenue Service.

3. The Service is a bureau of the Department of the Treasury, under the direction of the Acting Commissioner of Internal Revenue, David J. Kautter, and is responsible for collecting taxes, administering the Internal Revenue Code, and overseeing various aspects of the Affordable Care Act, including the laws challenged here. *See generally* 26 U.S.C. § 7803 *et. seq.*; 26 C.F.R. § 57.1 *et. seq.*; *see* IRS, Affordable Care Act Tax Provisions, https://www.irs.gov/affordable-care-act/affordable-care-act-tax-provisions.

4. Any injunctive relief requested herein must be imposed upon both the IRS and the Commissioner for Plaintiffs to obtain full relief.

II. JURISDICTION AND VENUE

5. The Court has jurisdiction pursuant to 28 U.S.C. § 1331 because this suit concerns the legality of the regulations that function to apply the HIPF in the Patient Protection and Affordable Care Act on Plaintiffs. The Court also has jurisdiction to compel the Commissioner of Internal Revenue to perform their duties pursuant to 28 U.S.C. § 1361.

6. Plaintiffs' claims for declaratory and injunctive relief are authorized by 5 U.S.C. § 706, 28 U.S.C. §§ 2201 and 2202, by Rules 57 and 65 of the Federal Rules of Civil Procedure, and by the general legal and equitable powers of the Court. Though Plaintiffs seek to restrain the collection of a portion of the 2018 HIPF, which is treated as an excise tax by the IRS, *South Carolina v. Regan*, 465 U.S. 367 (1984), ensures that the Anti-Injunction Act ("AIA"), 26 U.S.C. § 7421, does not preclude the Court from exercising jurisdiction over this matter because Plaintiffs have no adequate, alternative judicial remedy through which to contest the imposition of 2018 HIPF liability. As the Supreme Court recognized, "Congress intended the [AIA] to

bar a suit only in situations in which Congress had provided the aggrieved party with an alternative legal avenue by which to contest the legality of a particular tax." *Regan*, 465 U.S. at 373. Moreover, "Congress did not intend the [AIA] to apply where an aggrieved party would be required to depend on the mere possibility of persuading a third party to assert [its] claims." *Id.* at 381.

7. Venue is proper under 28 U.S.C. § 1391 because the United States, an agency, and an officer in his official capacity are Defendants; and a substantial part of the events giving rise to the Plaintiffs' claims occurred in this District. Further, a plaintiff "resides" in this district, a "substantial part of the events [] giving rise to the claim occurred" in this district, and "no real property is involved." *Id.* § 1391(e)(1).

III. BACKGROUND FACTS

A. The Affordable Care Act and Health Insurance Provider Fee.

8. In 2010, Congress enacted a sweeping new regulatory framework for the nation's healthcare system by passing the Patient Protection and Affordable Care Act, Pub. L. No. 111–48, 124 Stat. 119, and the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111–52, 124 Stat. 1029, collectively and commonly referred to as the "Affordable Care Act." *See Patient Protection and Affordable Care Act*, Pub. L. No. 111–48, 124 Stat. 119–1025 (Mar. 23, 2010) (hereinafter, collectively, "the Affordable Care Act" or "the ACA"). President Obama signed the Patient Protection and Affordable Care Act (H.R. 3590, 111th Cong.), and the Health Care and Education Reconciliation Act (H.R. 4872, 111th Cong.) into law in March 2010.

9. Among other things, the ACA requires health insurance providers who are "covered entities" to pay a Health Insurance Providers Fee (HIPF) to the IRS. *See* ACA § 9010. Covered entities must pay a portion of the HIPF proportionate to each entity's share of net premiums for the previous calendar year. *See id.*

10. The ACA specifically excludes "any governmental entity" (and thus Plaintiffs) from paying the HIPF. ACA § 9010(c)(2)(B) (2010); *see* 26 C.F.R. § 57.2(b)(2)(ii)(B).

B. Calculating and Assessing the Health Insurance Provider Fee.

11. Per the ACA, the IRS began collecting the HIPF in 2014. Each year, the IRS collects a predetermined amount. 26 C.F.R. § 57.4(a)(3).

12. For 2014, the IRS collected $8,000,000,000 for the HIPF. In 2015, the IRS collected $11,300,000,000 for the HIPF. In 2016, the IRS collected $11,300,000,000 for the HIPF.

13. For 2017, Congress enacted, and the President signed into law a one-year moratorium on the HIPF. *See* Consolidated Appropriations Act, 2016, Pub. L. No. 114–113, Div. P, Title II, § 201, 129 Stat. 2242, 3037–38 (2015).

14. Another moratorium was enacted by Congress, and signed into law by the President, on the HIPF for 2019. *See* H.R. 195, Division D – Suspension of Certain Health-Related Taxes, § 4003 (Jan. 22, 2018).

15. However, there is no moratorium on the HIPF for 2018. For 2018, the IRS is charged with collecting $14,300,000,000 for the HIPF. 26 C.F.R. § 57.4(a)(3).

16. The timelines associated with the 2018 HIPF are as follows:

a. "Covered entities" filed Form 8963 with the IRS by Tax Day, April 17, 2018. *See* IRS, *Affordable Care Act Provision 9010 – Health Insurance Providers Fee*, https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

b. The IRS mailed notices of its preliminary HIPF calculations on or before June 15, 2018. *See Health Ins. Providers Fee; Procedural & Admin. Guidance*, Notice 2013-76 (IRS ANN), 2013-51 I.R.B. 769, 2013 WL 6182798.

c. Challenges to the preliminary fee calculations were remitted in writing to the IRS on or before July 16, 2018. *Id*.

d. The IRS mailed notices of its final HIPF calculations on or before August 31, 2018. *Id*.

e. HIPF payments are due on or before September 30, 2018. *Id*.; IRS, *Affordable Care Act Provision 9010 – Health Insurance Providers Fee*, https://www.irs.gov/businesses/corporations/affordable-care-act-provision-9010.

C. Medicaid, CHIP, and Managed Care.

17. Congress created Medicaid in 1965. *See* Social Security Amendments Act of 1965, Pub. L. 89–97, 79 Stat. 286 (1965). The Medicaid program provides healthcare to individuals with insufficient income and resources. *See generally* 42 U.S.C. §§ 1396–1396w. All Plaintiffs participate in Medicaid.

18. Congress created the Children's Health Insurance Program ("CHIP") in 1997. *See* Balanced Budget Act of 1997, Pub. L. 105–33, Title IV, Subtitle J, 111 Stat. 251 (Aug. 5, 1997). CHIP covers children in families who have too much income to qualify for Medicaid, but cannot afford to buy private insurance, and provides basic primary health care services to children, as well as other medically necessary services, including dental care. *See generally* 42 U.S.C. § 1397aa *et. seq*. All Plaintiffs participate in CHIP.

19. Plaintiffs provide a substantial portion of their Medicaid and CHIP services through managed care organizations ("MCO"). By so doing, Plaintiffs save hundreds of millions of dollars. *Texas v. United States*, 300 F. Supp. 3d 810, 823 (N.D. Tex. 2018).

20. In 1981, Congress determined that MCO capitation rates (insurance premiums) regarding Medicaid and CHIP must be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii) (1981).

21. HHS interpreted the meaning of "actuarially sound" through the Certification Rule. *See* 42 C.F.R. § 438.6(c)(i)(A)–(C) (2002). The Certification Rule is now codified at 42 C.F.R. §§ 438.2–438.4.

D. Significance of Related Litigation.

22. The Parties to this matter are also involved in a related lawsuit. *See generally*, *Texas v. United States*, No. 7:15-cv-00151-O, 300 F. Supp. 3d 810 (N.D. Tex. 2018). The focus of that litigation regarded the Certification Rule, which the court declared unlawful. *Id*. at 850.

23. The Court's prior ruling declared the Certification Rule unlawful because the Certification Rule delegated legislative power to a private entity—the Actuarial Standards Board ("ASB")—to discern what did and did not qualify as actuarially sound. *See id.* at 844.

24. In response to this delegation of power, the ASB enacted Actuarial Standard of Practice Number 49 ("ASOP 49"). ACTUARIAL STANDARDS BOARD, *Actuarial Standard of Practice No. 49: Medicaid Managed Care Capitation Rate Development and Certification* (Mar. 2015), http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf. ASOP 49 forbids actuaries from certifying any Medicaid contract with an MCO *unless* the contract *requires* the sovereign to pay the HIPF to the MCO. ASOP 49 § 3.2.12(d). In other words, ASOP 49 removed from actuaries any discretion as to how to treat the HIPF.

25. The Court's ruling that the Certification Rule is unlawful removes ASOP 49 as a legal requirement and its mandate that the HIPF be added to a capitation rate for the rate to be actuarially sound under 42 U.S.C. § 1396b(m)(2)(A)(iii). Thus, in the wake of the Court's ruling, actuaries once again have discretion to discern actuarial soundness using general principles of actuarial analysis and do not have their hands unnecessarily forced by ASOP 49.

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

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

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

29. In order to prevent the unlawful payment of hundreds of millions of dollars in taxpayer money, and to ensure that Plaintiffs are not left without a remedy, Plaintiffs file this lawsuit seeking declaratory and injunctive relief.

30. Because Congress is clear that Plaintiffs are exempt from HIPF liability, federal agencies and regulations may not operate or function in a manner that works to impose HIPF liability upon Plaintiffs.

E. Facts Regarding the 2018 HIPF and this Matter.

31. For the 2018 HIPF, the IRS is to assess and collect a total of $14,300,000,000 from "covered entities." 26 C.F.R. § 57.4(a)(3). Plaintiffs do not quarrel with the amount that the IRS is to collect. Thus, this action seeks to neither change nor lower the HIPF amount that the IRS is to collect for fee year 2018 (based

on premiums from Jan. 1, 2017 through Dec. 31, 2017). As per Congress, the IRS should collect $14,300,000,000 in 2018 for the HIPF.

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

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

F. Operative Law.

34. In the wake of the Court's ruling declaring the Certification Rule unlawful, *Texas*, 300 F. Supp. 3d 810, what remains is the plain text of Congress. According to Congress, federal monies for Medicaid and CHIP services administered by an MCO shall not flow to Plaintiffs unless payments made by Plaintiffs to MCOs under Medicaid and CHIP contracts "are made on an actuarially sound basis." *See* 42 U.S.C. § 1396b(m)(2)(A)(iii). In other words, notwithstanding the unlawfulness of the Certification Rule, and its delegation of legislative power to a private entity, the general Congressional requirement of "actuarial soundness" remains. *Id.*

35. But Congress subsequently admonished in the ACA that Plaintiffs are exempt from HIPF liability. *Texas*, 300 F. Supp. 3d at 821 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)).

36. Because Plaintiffs are exempt from HIPF liability, *Texas*, 300 F. Supp. 3d at 821 (citing ACA § 9010(c)(2)(B) (2010); 26 C.F.R. § 57.2(b)(2)(ii)(B)),

and their Medicaid and CHIP contracts with MCOs must be "actuarially sound," 42 U.S.C. § 1396b(m)(2)(A)(iii), then the way to honor both of these Congressional requirements is for the IRS to *not* include Plaintiffs' Medicaid and CHIP capitation rates in distributing the $14,300,000,000 HIPF liability for 2018. In other words, if Plaintiffs' Medicaid and CHIP MCO capitation rates are not included in the IRS's calculations, then Plaintiffs maintain their exemption from HIPF liability and can establish "actuarially sound" contracts with their Medicaid and CHIP MCOs.

G. IRS Action and Inaction.

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

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

39. Following the notice of the IRS's preliminary calculations of the 2018 HIPF liability, Plaintiffs wrote to the IRS to contest its calculations of the 2018 HIPF liability. Plaintiffs explained their exemption from HIPF liability in the ACA, provided a copy of the Court's March 5, 2018 Order in the related litigation, and identified with specificity the premiums that should be removed from the IRS's calculations because "Congress expressly exempted the states from paying the HIPF." *Texas*, 300 F. Supp. 3d at 821. Regarding Texas, for example, the IRS erroneously included in its calculations and distribution of HIPF liability $11,794,848,747.00 in Medicaid and CHIP premiums.

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

41. Upon information and belief, some of Plaintiffs' MCOs also wrote to the IRS to contest its calculations of the 2018 HIPF liability. The IRS contested these corrections coming from the MCOs and demanded that they reinstate and refile their original Form 8963.

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

43. Each Letter 5067C sent to Plaintiffs' Medicaid and CHIP MCOs demanded payment of the assessed HIPF liability no later than September 30, 2018.

H. IRS Action and Inaction Irreparably Injures Plaintiffs.

44. As long as Part 57, as currently constituted, remains in place, and without exempting Plaintiffs' MCOs' Medicaid and CHIP contracts, liability for the HIPF will be unlawfully imposed upon Plaintiffs through Medicaid and CHIP contracts that are subject to the actuarial soundness requirement of 42 U.S.C. § 1396b(m)(2)(A)(iii). For the HIPF liability for 2018, this is evidenced by the IRS's calculations, actions, and inactions as chronicled in the prior paragraphs.

45. Notwithstanding the unlawfulness of the Certification Rule, *see Texas*, 300 F. Supp. 3d 810 (Certification Rule is now codified at 42 C.F.R. §§ 438.2–438.4), the actuarial soundness requirement of 42 U.S.C. § 1396b(m)(2)(A)(iii) has caused Plaintiffs' actuaries, employing their best judgment and discretion, to conclude that

actuarial soundness in 2018 can only result from a full, dollar-for-dollar imposition upon Plaintiffs of any 2018 HIPF liability upon their Medicaid or CHIP MCOs.

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

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

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

IV. CLAIMS FOR RELIEF

COUNT I

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

49. Plaintiffs incorporate the allegations contained in paragraphs 1 through 48 as if fully set forth herein.

50. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "(A) arbitrary, capricious, an abuse of

discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A)–(C).

51. The IRS promulgated regulations regarding the HIPF. *See* 26 C.F.R. Part 57. The regulations do not comply with the ACA by failing to properly account for and address Plaintiffs' exemption from HIPF liability.

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

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

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

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

COUNT II

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

56. Plaintiffs incorporate the allegations contained in paragraphs 1 through 55 as if fully set forth herein.

57. The Administrative Procedure Act requires this Court to hold unlawful and set aside any agency action that is "(A) arbitrary, capricious, an abuse of

discretion, or otherwise not in accordance with law; (B) contrary to constitutional right, power, privilege, or immunity; (C) in excess of statutory jurisdiction, authority, or limitations, or short of statutory right." 5 U.S.C. § 706(2)(A)–(C).

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

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

COUNT III

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

60. Plaintiffs incorporate the allegations contained in paragraphs 1 through 59 as if fully set forth herein.

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

62. As demonstrated herein, Defendants have not sought to remedy the deficiencies in its regulations regarding the HIPF. *See* 26 C.F.R. Part 57. This agency action, both unlawfully withheld and unreasonably delayed, is compelled by the text of the ACA and the clear inconsistencies of Part 57 with the ACA. This agency action is unreasonably delayed, especially in light of the related litigation and the Court's ruling thereon on March 5, 2018. *See Texas*, 300 F. Supp. 3d 810.

63. Defendants have failed to make any effort to appropriately harmonize and implement Congress's actuarial soundness requirement, 42 U.S.C. § 1396b(m)(2)(A)(iii), with Plaintiffs' exemption from HIPF liability, ACA § 9010(c)(2)(B) (2010). "The justification for the *in pari materia* canon is that Congress should be assumed to have legislated with reference to the other provision." *Little v. Shell Expl. & Prod. Co.*, 690 F.3d 282, 289 (5th Cir. 2012). Reading the two provisions *in pari materia* demands that MCO premiums for Plaintiffs' Medicaid and CHIP services be exempted from Defendants' calculations and distribution of the HIPF liability such that Plaintiffs can maintain their exemption from HIPF liability while simultaneously engaging in Medicaid and CHIP contracts with MCOs that are actuarially sound.

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

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

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

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

V. PRAYER FOR RELIEF

WHEREFORE, Plaintiffs respectfully request that the Court:

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

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

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

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

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

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

G. Direct Defendants, for agency action unlawfully withheld and unreasonably delayed, to respond to Plaintiffs' timely protests regarding 2018 HIPF liability and confirm Plaintiffs' exemption from 2018 HIPF liability.

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

I. Enjoin Defendants from receiving or collecting, from Plaintiffs' Medicaid and CHIP MCOs, any and all payments, or portions of payments, for the 2018 HIPF that are based, in part or in whole, upon Defendants' calculations for 2018 HIPF liability involving premiums (capitation rates) for Plaintiffs' Medicaid and CHIP services until such time as new, amended final fee calculations (Letters 5067C) for 2018 HIPF liability to Plaintiffs' Medicaid and CHIP MCOs, which properly exempt from the calculations premiums (capitation rates) for Medicaid and CHIP programs for Plaintiffs, are remitted and received by Plaintiffs' Medicaid and CHIP MCOs.

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

K. Enjoin Defendants from including Plaintiffs' Medicaid and CHIP MCO premiums in the calculation of HIPF liability during the pendency of the case.

L. Enjoin Defendants from including Plaintiffs' Medicaid and CHIP MCO premiums in the calculation of HIPF liability.

M. Disgorge Plaintiffs' 2018 HIPF payments, and any payments in future years during the pendency of this lawsuit, collected by Defendants.

N. Grant such other and further relief as the Court may deem just, proper, and equitable.

Respectfully submitted this 20th day of September, 2018.

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