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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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 Nebraska

Plaintiffs-Appellee:

State of Wisconsin

Defendants-Appellants-Cross-Appellees:

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SUMMARY OF ARGUMENT

A. The United States' Appeal

1. The root question in this case is whether private managed-care organizations must pay the Health Insurance Providers Fee when they provide Medicaid services on behalf of States. It is uncontroverted that all governmental entities are exempt from provider fees when they provide services themselves. The States are quite wrong, however, to maintain that the Affordable Care Act also exempts the private actors with whom States contract. Nothing in the text of the ACA permits that reading. Indeed, Congress separately addressed exemptions for Medicaid insurers, and exempted only certain nonprofit Medicaid insurers from the provider fee.

The States offer no textual basis for their assertion that the governmental-entity exemption can properly be applied to private entities. And at bottom, they fundamentally misunderstand the way that tax exemptions work. States are exempt from a broad range of federal taxes. But those exemptions do not extend to state contractors even though the cost imposed by those taxes may be passed on in whole or in part to the states. There is no basis to treat the provider fee any differently.

2. Because the Affordable Care Act does not excuse the States from their obligation to account for the provider fee, the States' case fails on two threshold grounds.

First, well before the passage of the Affordable Care Act, Congress required by statute that all rates paid by the States to managed-care organizations be actuarially

sound. 42 U.S.C. § 1396b(m)(2)(A)(iii). And there is no dispute that actuarial soundness for purposes of this statute has always required accounting for all reasonable costs, including taxes and fees. The rates here are subject to this statutory requirement, which mandates that the provider fees be taken into account.

Because the statutory actuarial-soundness requirement is established by statute—not by the 2002 Department of Health and Human Services (HHS) regulation defining actuarial soundness, and certainly not by any action of the Actuarial Standards Board—invalidating the regulation would not redress the States' asserted injuries. Indeed, the States have acknowledged in a subsequent complaint that the district court's judgment here has not afforded them relief because they must account for the provider fee regardless of how actuarial soundness is defined. Accordingly, as the United States explained in its opening brief, the States have no standing to challenge the regulation.

Second, the challenge to the 2002 actuarial-certification rule is barred by the applicable six-year statute of limitations. The States offer no proper basis for disregarding the statute other than to suggest that the provider fee in some undefined respect altered the nature of actuarial soundness. As noted, however, actuarial soundness has always required accounting for all taxes and fees, and the addition of an additional fee does not alter that analysis.

3. Even accepting the mistaken premises of their argument, the States' nondelegation argument is foreclosed by Supreme Court decisions holding that the

government may condition governmental action on private-party approval. The district court mistakenly believed that it could distinguish these precedents, which upheld statutes permitting the federal government to condition actions on the approval of private parties, on the ground that the regulation here requires an actuary to approve States' rates before the federal government reviews them. The States properly decline to defend the district court's reasoning. Instead, they contend that the Actuarial Standards Board violates the Constitution when it directs the behavior of actuaries. But, so long as the condition on governmental action is permissible, it does not matter under Supreme Court precedent whether the private party whose approval is necessary is an individual actuary or the Actuarial Standards Board.

4. Finally, assuming that the States asserted a timely and meritorious claim, they would not be entitled to $479 million in "equitable disgorgement." The States made no payments to the United States, and they would have been required to account for provider fees in the absence of the rule. Moreover, their claim does not fall within the narrow category identified in *Bowen v. Massachusetts*, 487 U.S. 879 (1988), that permits monetary recovery under the Administrative Procedure Act (APA). As the cases on which the States seek to rely demonstrate, the *Bowen* exception applies only when a statute requires the federal government to make monetary payments. There is no such statute here.

B. The States' Cross-Appeal

The district court correctly rejected the States' other challenges to the actuarial-certification rule.

1. The States claim that the actuarial-certification rule impermissibly construes Congress's command that rates be "actuarially sound." But Congress ratified that rule when it enacted a statute stating that rates paid by States should be "subject to the federal regulations requiring actuarially sound rates." 42 U.S.C. § 1396b(m)(2)(A)(xiii). The States' contentions that the rule is arbitrary and capricious and procedurally infirm are similarly without basis: the States do not dispute that HHS complied with all procedural requirements and rationally considered the issue when it promulgated the rule.

2. The States urge that 42 U.S.C. § 1396b(m)(2)(A)(iii), which established the actuarial soundness requirement, is an unconstitutional delegation of power to HHS because it fails to provide adequate guidance to the agency. The States never alleged in their complaint that the statutory actuarial-soundness requirement was unlawful, and that challenge thus cannot properly form part of this suit. In any event, Supreme Court precedent holds that Congress may use terms like "actuarially sound" and that doing so does not impermissibly delegate power to federal agencies.

3. The States' challenges to the provider-fee statute are also unavailing. Their argument that the provider fee exceeds Congress's Spending Clause powers is fundamentally misconceived. The provider fee does not impose any condition on

States; it merely assesses a fee on private insurers. The provider fee therefore is an exercise of Congress's taxing powers and does not implicate any Spending Clause doctrine. In any event, the imposition of a fee on health insurers neither coerces the States to adopt a federal policy nor transgresses any other limit on federal power. The States' claim that the provider fee violates the doctrine of intergovernmental tax immunity is similarly insubstantial. The States have not been taxed, and the Supreme Court has explicitly held that the nondiscriminatory imposition of costs on private entities that merely pass those costs on to States does not violate the Constitution. And, for similar reasons, the district court correctly rejected the States' alternative remedial claim for a tax refund on the ground that the States did not pay any tax.

REPLY BRIEF ARGUMENT

I. Private insurers are not exempt from the provider fee.

The States acknowledge that they contract with "private insurance companies," called managed-care organizations, to administer their Medicaid programs. States' Br. 5. The statutory question in this case is whether those private companies were correctly assessed the Health Insurance Providers Fee, which applies to "any entity which provides health insurance for any United States health risk," except (as relevant here) all "governmental entit[ies]." Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 9010(c)(1), (c)(2)(B), 124 Stat. 119, 865 (2010). As the United States' opening brief demonstrated (at 20-22), the answer to that question is

plainly yes. Private insurance companies are not governmental entities, and so are subject to the provider fee.[1]

Private insurance companies do not cease to be responsible for provider fees merely because they enter into an arms-length contract to provide Medicaid services. Nothing in the provider-fee statute supports that result, and the States' argument seriously misunderstands how tax exemptions work. For example, governmental entities are generally immune from the federal income tax. *See* 26 U.S.C. § 115. Private businesses, including health insurers, are not. *See id.* § 11. There is no doubt that, when a State purchases goods or services from a private business, the business does not acquire the State's immunity from the income tax. Nor is there any question that a business may charge a State prices that account for the costs of income taxation. The provider fee is no different than the income tax: it does not apply to States when they act as insurers, but it extends to private insurers with whom States do business. Those insurers may pass the cost of the provider fee onto the States, just as any private entity may charge a State (or anyone else) prices that account for the entity's tax burden generally.

The States make little attempt to address the fatal difficulties with their argument. They do not dispute that private managed-care organizations are not

[1] The States assert (at 11) that the United States "never previously raised" this issue "in this litigation." The United States has consistently opposed the States' atextual interpretation of the provider fee. *See, e.g.*, ROA.2859 (summary-judgment briefing).

government entities. They do not respond to the United States' showing that the structure of the ACA reveals that Congress knew how to exempt private insurance providers solely because they do business with States. *E.g.*, Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1406(a)(3), 124 Stat. 1029, 1066 (exempting nonprofit private insurers from the provider fee if over eighty percent of their gross revenue came from governmental insurance programs); *see also* 26 U.S.C. § 4377(b)(2) (exempting private insurers from a different fee if the insurers participate in an "exempt governmental program"). And they provide no reason why States' exemption from the provider fee should extend to the private entities with whom they contract.

Instead, the States assert (at 16-17) that states and localities will never be responsible for provider fees except to the extent that such fees are passed along by private organizations as part of the overall contract cost of a managed-care contract. Accordingly, they argue, their understanding of the statute must be correct because the governmental-entity exception otherwise would have no meaning.

The States are incorrect, and the legislative history on which they seek to rely confirms the purpose and independent force of the governmental-entity exception. The Joint Committee on Taxation stated, for example, that "a county organized health system entity that is an independent public agency organized as a nonprofit under State law and that contracts with a State to administer State Medicaid benefits through local care providers or HMOs" would be exempted under the governmental-entity

exception. Joint Comm. on Taxation, *Technical Explanation of the Revenue Provisions of the "Reconciliation Act of 2010," As Amended, in Combination with the "Patient Protection and Affordable Care Act"* 90 (Mar. 21, 2010), https://go.usa.gov/xd55V. Put more plainly, in some States, like California, counties essentially act as managed-care organizations and are paid capitation rates by the States. In those arrangements, the governmental-entity exception immunizes the counties from paying a provider fee that they could otherwise bear.

The government-entity exemption also anticipated the possibility that some States would create new models to provide health insurance. At the time of the ACA's enactment, Vermont was seriously considering enacting a single-payer healthcare system that would have been entirely administered by the State's government. *See* Abby Goodnough, *A Doctor's Push for Single-Payer Health Care for All Finds Traction in Vermont*, N.Y. Times (May 21, 2011), https://perma.cc/JZW2-CLX9. Massachusetts likewise planned to hold a non-binding referendum asking voters whether they supported legislation that "creat[ed] a single payer health insurance system like Medicare." *See* Carey Goldberg, *Non-Binding Measure on Single-Payer System Passes in All 14 Districts*, WBUR (Nov. 4, 2010), https://perma.cc/DZ7P-UY9R. Had any State actually adopted such a system, the governmental-entity exemption might have applied to some or all services depending on the precise workings of the scheme.

In any event, the "canon against surplusage is not an absolute rule," *Marx v. General Revenue Corp.*, 568 U.S. 371, 385 (2013), and it cannot alter the meaning of the

statute's text. The Supreme Court has also noted that the "rigorous application of the canon does not seem a particularly useful guide to a fair construction" of the Affordable Care Act. *King v. Burwell*, 135 S. Ct. 2480, 2492 (2015); *see also* Antonin Scalia & Bryan A. Garner, *Reading Law: The Interpretation of Legal Texts* 176 (2012) ("[A] court may well prefer ordinary meaning to an unusual meaning that will avoid surplusage."). So even if the governmental-entity exception had limited force, that still would not be a reason to judicially create an exception that has no basis in the statutory text.

The States are on no firmer ground in their cursory assertion (at 18) that failure to impose an atextual exemption would defeat the purpose of the provider fee. The States make that argument on the basis of a single *Forbes* opinion column stating that the "political argument" in favor of the provider fee was that it was an appropriate measure to deal with the fact that insurance companies might make increased profits due to the Affordable Care Act. States' Br. 18 (citing ROA.1617). Given that "floor statements by individual legislators" receive minimal weight even from those who consider legislative history, *National Labor Relations Bd. v. SW General, Inc.*, 137 S. Ct. 929, 943 (2017), a purposive argument based solely on the punditry of a single opinion columnist is entitled to no weight whatsoever. And, of course, the asserted purpose of a provision cannot alter its text. *See Kucana v. Holder*, 558 U.S. 233, 252 (2010). The point, in any event, is that Congress, for whatever purpose or purposes, imposed a fee on private organizations and did not exempt them from payments to

the extent that they passed along costs to States in a managed-care program. Indeed, the opinion column cited by the States, which opposed the fees, noted that Congress was unconcerned with the risk that insurers might "pass most of this tax along," either to policyholders or otherwise. ROA.1617.

II. The States' private-nondelegation-doctrine challenge fails.

A. The States lack standing.

1. The States do not dispute that, if the ACA requires their managed-care organizations to pay the statutory provider fee, they lack standing to challenge the actuarial-certification rule, because the rule is not the cause of their asserted injury, and because invalidation of the rule would not redress the injury. *See* States' Br. 19. Congress required that the rates paid by States to private organizations be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii). It is not contested that actuarial soundness entails accounting for all reasonable and appropriate costs. U.S. Br. 9-10; *see* ROA.2848 & n.17 (tracing this requirement back as far as 1996). Those costs have long been understood to include all taxes and fees. ROA.2848 & n.17 (collecting sources). Regardless of how HHS defined "actuarial soundness" in its rule, therefore, there can be no dispute that Congress's actuarial-soundness provision requires accounting for the provider fee.

The States have admitted as much. After the district court in this case vacated the actuarial-certification rule, the States returned to the district court and, in their second complaint, explained that the court's order had not redressed their injury. *See*

U.S. Br. 16, 23-25. Specifically, they stated that "the general principles of actuarial soundness" require accounting for the provider fee, and that their own actuaries "conclude[d] that actuarial soundness" can only result from accounting for that fee. Complaint ¶¶ 26, 45, *Texas v. United States* (*Texas II*), No. 4:18-cv-779 (N.D. Tex. Sept. 20, 2018); *see also id.* ¶ 26 ("[T]he general principles of actuarial soundness[] nonetheless require that the 2018 [provider fee] *still be added* . . . .") (emphasis added). Plainly, therefore, the States lack standing to pursue any challenge to the actuarial-certification rule, because a litigant cannot challenge a statute or regulation unless the invalidation of the statute or regulation would "redress the alleged injury." *Steel Co. v. Citizens for a Better Env't*, 523 U.S. 83, 103 (1998). To conclude that the statute does not exempt the private insurers with whom States contract thus resolves the entire case, except for the States' challenges to the actuarial-soundness statute and to the provider fee itself, which fail for the reasons below. *See infra* Parts V-VI.

2. The States' counterarguments all miss the mark. The States assert that the actuarial-certification rule is the "sole basis by which the [provider fee] was imposed on the States during the tax years at issue in this lawsuit." States' Br. 20. But that is incorrect. As an initial matter, the provider fee is not imposed on the States, but on private entities, *supra* Part I, and all HHS has done is approve the contracts that the States proposed, *see, e.g.*, ROA.297-298 (approving Texas's contracts). But most decisively, HHS would have been required to reject hypothetical contracts that did not account for the provider fee. That decision would—as the States themselves admit—

have been compelled by Congress's actuarial-soundness requirement, not by any regulation. That is why the States have conceded that, whether the regulation is vacated or not, actuarial-soundness principles require accounting for the provider fee.

The States correctly note that the district court "did not award the States the full relief they sought, which would have fully redressed their harm." States' Br. 21 n.10. Invalidating the statutory provisions regarding actuarial soundness and the provider fee would redress the States' alleged injuries without any need to consider the actuarial-certification rule. But setting aside the actuarial certification rule has not redressed the States' claimed injuries because it is not the source of those injuries. If this Court vacates the statutory requirement of actuarial soundness, the way in which HHS has defined "actuarially sound" would be immaterial. And if this Court holds that the provider fee is unlawful as applied to private organizations with whom States contract, States would not have to account for the provider fee notwithstanding any actuarial-soundness requirement. Regardless of how the Court resolves the States' challenges to the two statutes, there is thus no need to consider their challenge to the actuarial-certification rule.

B. The States' challenge is untimely.

The United States' opening brief also demonstrated that the States' challenge to the actuarial-certification regulation is untimely, because the rule they challenge was promulgated in 2002, and because there has been no "direct, final agency action" involving the States in the last six years. U.S. Br. 25-28 (citing *Dunn-McCampbell*

Royalty Interest, Inc. v. National Park Serv., 112 F.3d 1283, 1287 (5th Cir. 1997). In response, the States largely agree (at 21) that the *Dunn-McCampbell* framework applies. The States, however, suggest that the States could not have understood the need to challenge the actuarial-certification rule in 2002. Three of the States' arguments are factually mistaken, and the fourth is incorrect for reasons discussed in the United States' opening brief.

First, the States mistakenly assert that there was "no binding definition of 'actuarial soundness' applicable to Medicaid [managed-care organizations] until 2010," and so "any challenge to the Certification Rule would not have been ripe." States' Br. 22. That is flatly wrong. The actuarial-certification rule was issued in 2002, *see* 67 Fed. Reg. 40,989 (June 14, 2002), and has applied to all contracts between States and managed-care organizations since then.

Second, the States insist that "States still had the legal option to exclude the [provider fee] from capitation rates in their contracts with [managed-care organizations] as late as 2013." States' Br. 22. That is also mistaken. Since at least 1996, actuarial professional associations have defined actuarially sound rates as rates that are "adequate to provide for all expected costs." Actuarial Standards Board, *Compliance with Statutory and Regulatory Requirements for the Actuarial Certification of Small Employer Health Benefit Plans* 2 (Oct. 1996) (ASOP No. 26) (superseded), https://perma.cc/3CN2-VDWY. And the States misread the record citation that they provide to the contrary (at 22); the language they quote concerns actuaries'

flexibility to consider "the potential effect of the Health Insurance Providers Fee *on other taxes, fees and assessments*." ROA.2592 (emphasis added). Earlier in the guidance document that the States cite, HHS clearly stated that the provider fee "is like other taxes and fees that actuaries regularly reflect," and that it is a "reasonable business cost to health plans that is appropriate for consideration" in accounting for rates. ROA.2591.

Third, the States assert that the actuarial-certification rule was "change[d]" in 2015. States' Br. 22. But, as noted, the actuarial-certification rule has existed, unchanged, since 2002. In arguing to the contrary, the States do not cite an amendment to the rule, which is unsurprising since no relevant amendment exists. Instead, they cite a scholarly article stating that HHS "approved regulations [in 2015] that aim[ed] to eliminate previous ambiguities around actuarial soundness." States' Br. 22 (quoting Aaron Mendelson et al., *New Rules for Medicaid Managed Care—Do They Undermine Payment Reform?*, 4 Healthcare 274, 274 (2016) (States' alterations)). They fail to note, however, that the quoted section of the article was discussing amendments to HHS regulations that are not at issue in this case, and the language they quote has nothing to do with the actuarial-certification rule. *See* Mendelson et al., *supra*, at 274 (citing 81 Fed. Reg. 27,498 (May 6, 2016)).

Finally, the States contend (at 23) that their contracts with managed-care organizations were not required to account for the provider fee until 2015, reflecting the fact that the provider fee took effect beginning in 2014. *See* ROA.300. The States

provide no authority suggesting that Congress's enactment of a fee may restart the statute of limitations to challenge an unrelated regulation. Since the enactment of the actuarial-soundness statute and the actuarial-certification regulation, States have understood that they must account for all reasonable costs in their contracts with managed-care organizations; the addition of an extra cost through the provider fee in no way alters the substance of the actuarial-certification regulation. And in any event, as the United States' opening brief shows (at 26-27), HHS's decision to approve the contracts that the States submitted is not an adverse action involving the States for purposes of *Dunn-McCampbell*. *See* ROA.297 (stating that Texas's "amendment is approved" by HHS).

C. Under Supreme Court precedent, the actuarial-certification rule is not an impermissible delegation.

Even assuming that the States had standing to challenge the actuarial-certification rule and that their challenge was timely, their private nondelegation challenge would fail on the merits.

1. The Supreme Court has held that the Constitution permits the federal government to condition governmental action on private-party approval. *United States v. Rock Royal Co-Op.*, 307 U.S. 533, 577 (1939); *Currin v. Wallace*, 306 U.S. 1, 15 (1939); *see* U.S. Br. 30-31. Those precedents resolve the States' constitutional challenge to the actuarial-certification rule. Here, as in *Currin* and *Rock Royal*, HHS exercised its rulemaking authority, but chose to condition governmental action on the approval of

private parties (in this case, actuaries). That is not an "unconstitutional delegation of legislative power." *Currin*, 306 U.S. at 15.

The district court distinguished *Currin* and *Rock Royal* on the grounds that those cases permitted private actors to veto governmental actions, whereas in this case actuaries certified rates before HHS could approve the contract. The United States' opening brief explained (at 34-36) why that distinction was illogical and inconsistent with precedent. *See Cook v. Ochsner Found. Hosp.*, 559 F.2d 968, 975 (5th Cir. 1977) (noting that *Currin* permits any "condition *precedent* to the operative effect of the Secretary's regulations") (emphasis added); *see also Confederated Tribes of Siletz Indians of Or. v. United States*, 110 F.3d 688, 696 & n.5 (9th Cir. 1997) (rejecting the district court's timing theory).

2. The States make no effort to respond to this analysis, and concede that the district court's timing ruling cannot be defended. *See* States' Br. 34 (arguing that the "certification decisions of individual actuaries are separately problematic *but not because of the order in which the decisions occur*") (emphasis added). Instead, the States make a variety of arguments, all of which are foreclosed by precedent. Notably, the States do not cite a single post-*Currin* case, from any court, that invalidated a federal policy under their theory of the private nondelegation doctrine.

First, the States argue that it violates the private nondelegation doctrine for actuaries to certify contracts unless "HHS [has] the right to approve a contract where an actuary refuses certification." States' Br. 34. That argument is foreclosed by *Currin*

and *Rock Royal*. In *Currin*, the federal government's tobacco policy could not go into effect "unless two-thirds of the growers" voted in favor of it. 306 U.S. at 15. In *Rock Royal*, likewise, the Court upheld a statute that permitted milk producers to block pricing orders. 307 U.S. at 577. In neither case did the statute provide the federal government the ability to override private decisions. Since those cases, this Court has also upheld schemes that give private entities an absolute veto. *See Cook*, 559 F.2d at 975 (upholding scheme that required the Federal Hospital Council to approve certain regulations).

Second, changing tack, the States argue (at 33-34) that the real constitutional problem is not the decisions of individual actuaries, but rather the fact that those actuaries must "follow the practice standards established by the Actuarial Standards Board." 42 C.F.R. § 438.6(c)(1)(i)(C) (2011). This challenge is misplaced factually and legally.

As a factual matter, the States are wrong that any of the Actuarial Standards Board's pronouncements are "binding" on individual actuaries. States' Br. 33. Indeed, the very document of which they complain, ASOP 49, indicates that an actuary may "deviate[] materially from the guidance of this ASOP" if doing so is in the "actuary's professional judgment." Actuarial Standards Board, *Medicaid Managed Care Capitation Rate Development and Certification* 12 (Mar. 2015) (ASOP No. 49), https://perma.cc/G83P-L86E.

As a legal matter, private actuaries may be guided by the standards set by their professional association without running afoul of the Supreme Court's private-nondelegation. Nothing suggests that *Currin* and *Rock Royal* would have come out differently had the tobacco growers and milk producers been obligated to consider the wishes of their trade associations. And even before *Currin* and *Rock Royal*, the Court observed that the government may "avail[] itself of" private "assistance . . . in matters of a more or less technical nature, as in designating the standard height of drawbars," at least as to conditions for governmental action. *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935); *accord Cospito v. Heckler*, 742 F.2d 72, 87 nn.24-25 (3d Cir. 1984).

Finally, the States suggest (at 32) that *Currin* and *Rock Royal* are distinguishable because, on their theory of the private nondelegation doctrine, the doctrine arises from the separation of powers and not from due-process principles. This Court has held otherwise. *See Boerschig v. Trans-Pecos Pipeline, L.L.C.*, 872 F.3d 701, 707 (5th Cir. 2017) ("Boerschig's nondelegation claim arises from a constitutional provision that does apply to states: the Due Process Clause."). But, regardless of the nature of the private nondelegation doctrine, there is no dispute that *Currin* and *Rock Royal* are nondelegation cases. *Rock Royal*, 307 U.S. at 578 (rejecting argument that the challenged statute was "an invalid delegation"); *Currin*, 306 U.S. at 9 (rejecting argument "that the Act provides for an unconstitutional delegation of legislative power"). The States cannot evade those holdings regardless of whether the private

nondelegation doctrine stems from the Due Process Clauses, separation-of-powers guarantees, or both.

3. The States also misstate the practical consequences of the district court's holding. They claim (at 35) that generally accepted accounting principles are never binding on the government, even though this Court has explained that a defendant commits securities fraud so long as the defendant "knew the numbers violated GAAP or was severely reckless in disregarding the concerns." *Owens v. Jastrow*, 789 F.3d 529, 543 (5th Cir. 2015).[2] In response to the fact that their position would apply equally to statutes giving States vetoes over federal government action, *e.g.*, 15 U.S.C. § 2645(b)-(c); *see* U.S. Br. 38-39, the States try (at 34) to distinguish such statutes based on principles of federalism. But if the States are correct that the private nondelegation doctrine stems from the separation of powers, then any delegation outside the federal government would pose equal concern.

Finally, the States are mistaken to urge (at 36) that their laws requiring private actors to comply with private safety standards set by disinterested organizations are different from the laws that they challenge. *See* U.S. Br. 39-40. Their argument on that score relies on an incomplete citation to this Court's *Boerschig* opinion. The language that they cite, that "federal separation-of-powers concerns . . . cannot dictate

[2] The case that the States cite (at 36), *Indiana Electrical Workers' Pension Trust Fund IBEW v. Shaw Group, Inc.*, 537 F.3d 527, 534 & n.3 (5th Cir. 2008), holds only that a GAAP violation does not establish the scienter necessary to commit securities fraud.

how state governments allocate their powers" comes in a paragraph about the doctrine that "prevents Congress from delegating too much authority to executive branch agencies." 872 F.3d at 707. In the very next paragraph, this Court held that the "doctrine preventing governments from delegating too much power to private persons and entities" "does apply to states." *Id.* And, regardless of doctrinal intricacies, it is remarkable that the States cannot explain why they maintain arrangements with actuarial organizations identical to the one about which they complain.

III. The States are not entitled to equitable disgorgement.

Finally, the district court erred in its decision to award the States $479 million in equitable disgorgement. This Court need not reach this remedial question unless it determines that the States have standing, that their challenge to the actuarial-certification rule is timely, and that their challenge is meritorious.

A. As a threshold matter, the States are not entitled to any equitable disgorgement because they would have incurred precisely the same costs with or without the actuarial-certification rule. U.S. Br. 41-42. As the States' *Texas II* complaint admits, the principles of actuarial soundness require accounting for the provider fee regardless of the actuarial-certification rule, and, therefore, the States would have entered into exactly the same contracts regardless. *Supra* p. 11. The States' only response (at 27), that an actuary might have thought otherwise, is belied by their admission that their own actuaries, "employing their best judgment and

discretion, [have] conclude[d] that actuarial soundness . . . can only result from a full, dollar-for-dollar imposition upon Plaintiffs of any . . . [provider fee] liability." Complaint ¶ 45, *Texas II*. Because the States suffered no harm, no disgorgement would be equitable.

B. Even if the States had suffered monetary harm from the actuarial-certification rule, sovereign immunity prohibits the award of monetary relief here. In *Bowen v. Massachusetts*, 487 U.S. 879 (1988), the Supreme Court distinguished between suits for "specific relief," which may be brought under the Administrative Procedure Act, and suits that seek money to "substitute[] for that which ought to have been done," which may not. *Id.* at 910. As the United States' opening brief demonstrates (at 43-45), this is not a suit for specific relief and so is barred by sovereign immunity.

The States do not dispute (at 23-24) that *Bowen*'s framework controls. And they do not argue that this is a suit to recover "specific property *or monies* seized by the government." *Bowen*, 487 U.S. at 893; *see* U.S. Br. 43. Under *Bowen*, therefore, the States may succeed only if this is a "suit seeking to enforce [a] statutory mandate itself, which happens to be one for the payment of money." *Bowen*, 487 U.S. at 900. As the United States' opening brief noted (at 44-45), there is no statute here (unlike in *Bowen*) that requires the federal government to pay any money and, therefore, this is not a suit for specific relief.

In response, the States do not point to any statutory mandate "for the payment of money." Instead, they claim that they seek specific relief because "States were not

supposed to bear th[e] financial burden" of the provider fee. States' Br. 25. But that is a paradigmatic claim for *compensatory* relief, not for *specific* relief. "[T]he basic principle of compensatory damages [is] that the injured party should be made whole" by being compensated fully for any losses he has sustained. *Wilkerson v. Ingalls Shipbuilding, Inc.*, 125 F.3d 904, 907 (5th Cir. 1997). This contrasts with a statute that mandates the payment of money, where the award is properly thought of as a form of "specific performance." *Bowen*, 487 U.S. at 895; *see also Hubbard v. Administrator, EPA*, 982 F.2d 531, 538 (D.C. Cir. 1992) (en banc) ("Whether we or someone else call a remedy restitutionary, equitable or anything else, it fits within § 702's waiver only if it gives the plaintiff the specific thing to which he was originally entitled.").

The States underscore their error by removing significant language when quoting *Bowen*. In *Bowen*, the Supreme Court observed that plaintiffs seek specific relief when they sue to force a government "to belatedly pay expenses that it should have paid all along and would have borne in the first instance" had it followed the law. 487 U.S. at 894 (quotation marks omitted). In their brief, the States remove the crucial word "paid," and change the subject of this sentence from the governmental defendant to the plaintiff. States' Br. 25 ("Instead, the only question was whether the requested relief would have placed the monetary burden where it "'should have [been] all along and would have [been] in the first instance'" had the agency complied with federal law." (quoting *Bowen*, 487 U.S. at 894) (States' alterations)). The States' attempt to rewrite the Supreme Court's language cannot alter the fact that this is not a

suit "seeking funds to which a statute allegedly entitles" the States, and that it is therefore not a suit for specific relief. *Id.* at 895.

The appellate decisions on which the States rely (at 25-26) further confirm the unprecedented nature of their theory. In those cases, the courts of appeals permitted a litigant to sue for specific relief because of an "explicit statutory directive" entitling the plaintiffs "to payment." *Linea Area Nacional de Chile S.A. v. Meissner*, 65 F.3d 1034, 1042-43 (2d Cir. 1995) (considering 8 U.S.C. § 1356(h)(2)(A) (1994), which directed that the "Secretary of the Treasury *shall refund*" certain funds) (emphasis added); *see also Zellous v. Broadhead Assocs.*, 906 F.2d 94, 98 (3d Cir. 1990) (considering, *inter alia*, 24 C.F.R. § 886.109(a), which directs that "the Utility Reimbursement *will be paid* to the Family") (emphasis added); *Maryland Dep't of Human Res. v. HHS*, 763 F.2d 1441, 1444, 1446 (D.C. Cir. 1985) (noting that "Maryland is seeking funds to which a statute allegedly entitles it," and discussing 42 U.S.C. § 1397a(b)(2) (1976), which provided that "[t]he Secretary *shall then pay* to the State" various funds) (emphasis added). There is no similar mandate in this case, which is why monetary relief is barred by the APA.

RESPONSE BRIEF ARGUMENT

Because the States cannot present their nondelegation challenge, because that challenge fails on the merits, and because sovereign immunity bars any monetary award, the district court's contrary judgment should be reversed, and summary judgment should be granted to the United States. On all other counts, the district

court's judgment should be affirmed, and the arguments raised by the States in their cross-appeal should be rejected.[3]

IV. The actuarial-certification rule is lawful.

In their cross-appeal, the States contend that the actuarial-certification rule violates the Administrative Procedure Act because it is contrary to law, arbitrary and capricious, and procedurally infirm. *See* 5 U.S.C. § 706(2)(A), (C)-(D). All of those arguments suffer from the same threshold defects as the States' nondelegation claim, and so the Court need not reach these issues if it agrees that States lack standing or that their challenge is time-barred. *See supra* Sections II.A-B. Were the Court to reach the merits, it should conclude that the district court correctly rejected the States' arguments.

A. The regulation permissibly interprets the phrase "actuarially sound."

The States contend that HHS's definition of "actuarially sound," contained at 42 C.F.R. § 438.6(c)(1)(i) (2011), impermissibly interprets that phrase as used by Congress. The core inquiry here is one of congressional design: so long as "the intent of Congress is clear," the "court, as well as the agency, must give effect to the

[3] In a footnote, the States contend (at 26 n.12) that they should have been awarded interest. "Arguments subordinated in a footnote are 'insufficiently addressed in the body of the brief,' and thus are waived." *Arbuckle Mountain Ranch of Tex., Inc. v. Chesapeake Energy Corp.*, 810 F.3d 335, 339 n.4 (5th Cir. 2016) (citation omitted). In any event, the district court correctly declined to award interest for the reasons stated in its opinion. ROA.4659-4663.

unambiguously expressed intent of Congress." *Chevron, U.S.A., Inc. v. National Res. Def. Council, Inc.*, 467 U.S. 837, 842-43 (1984). And if the intent of Congress is unclear, the reviewing court will typically inquire whether the agency's interpretation "is based on a permissible construction of the statute." *Id.* at 843.

1. Here, there is no need to determine whether HHS's interpretation is permissible because Congress has explicitly approved of HHS's actuarial-soundness definition. In section 2501 of the ACA, Congress amended 42 U.S.C. § 1396b to provide that "capitation rates paid to [managed-care organizations] shall be based on actual cost experience related to rebates and *subject to the Federal regulations requiring actuarially sound rates*"—that is, to the very regulations that the States contend are contrary to congressional intent. Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, § 2501, 124 Stat. 119, 308 (2010) (creating 42 U.S.C. § 1396b(m)(2)(A)(xiii)) (emphasis added). In doing so, Congress ratified the actuarial-soundness regulation that HHS promulgated, incorporating it into the United States Code.

That ratification resolves this issue. It is settled that an agency's "interpretation of a statute may be confirmed or ratified by subsequent congressional failure to change that interpretation." *Motor Vehicle Mfrs. Ass'n of U.S., Inc. v. State Farm Mut. Auto. Ins. Co.*, 463 U.S. 29, 45 (1983); *see J.H. Rutter Rex Mfg. Co. v. United States*, 706 F.2d 702, 711 (5th Cir. 1983) ("[A] consistent administrative interpretation of a statute, shown clearly to have been brought to the attention of Congress and not

changed by it, is almost conclusive evidence that the interpretation has congressional approval." (quoting *Kay v. FCC*, 443 F.2d 638, 646-47 (D.C. Cir. 1970)). Here, the clarity of Congress's intent is even stronger, because the ACA makes apparent that HHS's actuarial-soundness regulation "has congressional approval." *J.H. Rutter Rex*, 706 F.2d at 711. And the fact that Congress did so in the same law that created the provider fee refutes the States' argument (at 41-42) that the actuarial-soundness regulation became infirm as a result of the provider fee's enactment.

2. Even if Congress had not clearly ratified HHS's interpretation, the agency's regulation is a permissible interpretation of the phrase "actuarially sound." As the district court correctly recognized, "the words 'actuarially sound' indicate that Congress intended capitation rates to be economically sustainable according to principles of actuarial science."[4] ROA.4012. HHS accomplished that goal by requiring that all capitation rates be "developed in accordance with generally accepted actuarial principles and practices," be "appropriate for the populations to be covered, and the services to be furnished under the contract," and be "certified . . . by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board." 42 C.F.R. § 438.6(c)(1)(i). In so doing, HHS ensured that rates "accord with

[4] The district court ultimately held that HHS acted in excess of statutory authority because its regulation violated the private nondelegation doctrine. ROA.4013. That ruling entirely stands or falls on whether the court's constitutional holding was correct. *See supra* Part II.

actuarial principles that rise to the level of a professional consensus in the field of actuarial science." ROA.4013.

The States advance no argument that HHS's definition somehow misunderstood the nature of actuarial science. And indeed, their doing so would be remarkable, because they have admitted in their *Texas II* complaint that their own actuaries believe that the "general principles of actuarial soundness" point in the same direction as HHS's regulations, and require that States account for the provider fee. Complaint ¶ 26, *Texas II*. Given that the States' contrary-to-law arguments focus solely on the imposition of the provider fee, *see* States' Br. 40, it is difficult to square their arguments here with that admission.

For these reasons, this Court can conclude that the actuarial-soundness regulation is within HHS's statutory authority without any resort to principles of deference. But, to the extent that deference is required, HHS's regulation easily qualifies for deference under *Chevron*. The States' contention otherwise (at 40-41) is that *Chevron* deference is inappropriate because the Affordable Care Act is a significant piece of legislation. *See King v. Burwell*, 135 S. Ct. 2480, 2488-89 (2015). But that is a red herring, because the phrase "actuarially sound" was enacted in 1981, decades before the ACA. Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, tit. XXI, § 2178, 95 Stat. 357, 813-15. This Court has regularly applied *Chevron* deference to HHS's interpretations of the Medicaid statutes, *see, e.g.*, *Texas v. HHS*, 61 F.3d 438, 442 (5th Cir. 1995), and the States' arguments provide no reason to proceed

differently. And, even if this Court believes that the provider fee bears on the question of actuarial soundness, the imposition of that fee, which represents a mere fraction of one percent of a State's budget, ROA.240 & n.9, does not present the sort of "extraordinary" circumstance that would warrant an exception to *Chevron* deference, *see King v. Burwell*, 135 S. Ct. at 2488.

B. The regulation is not arbitrary or capricious.

The States also appear to assert (at 42) that the actuarial-soundness regulation is arbitrary and capricious. Whether a regulation is arbitrary and capricious turns on whether the agency articulated "a rational connection between the facts found and the choice made." *State Farm*, 463 U.S. at 43. As the district court understood, ROA.4015, that question must be assessed "solely on the basis of the agency's stated rationale at the time of its decision," based on the "record before the agency." *Luminant Generation Co. v. EPA*, 675 F.3d 917, 925 (5th Cir. 2012).

Here, the agency enacted the current actuarial-soundness regulations after multiple notice-and-comment periods, *see* 67 Fed. Reg. at 40,991, and explained that it "considered various approaches in defining actuarial soundness," *id.* at 40,998. The definition it chose was the one urged by States, and HHS explained that it adopted this definition in order to "give[] States and actuaries maximum flexibility." *Id.*

The States point to no flaw in that decisionmaking process. *See* ROA.4015 (noting the States' concession that the actuarial-certification rule was reasonable in 2002). Instead, they contend (at 42-43) that the adoption of the provider fee

somehow rendered the regulation arbitrary and capricious. That assertion is flawed, procedurally and substantively.

Procedurally, as the district court recognized, whether an agency action is arbitrary and capricious depends on the information available to the agency "at the time of its decision." *Luminant Generation*, 675 F.3d at 925. Bedrock principles of administrative law prohibit agencies from altering legislative rules based on post hoc information not available in the administrative record. *Id.* (citing, *e.g.*, *SEC v. Chenery Corp.*, 332 U.S. 194, 196 (1947)). Accordingly, the "focal point for judicial review" of the agency's decision is "the administrative record already in existence, not some new record made initially in the reviewing court." *Id.* (quoting *Camp v. Pitts*, 411 U.S. 138, 142 (1973)).

The States cite no authority to the contrary. Instead, they cite (at 38) decisions holding that subsequent congressional enactments affect whether agency interpretations are foreclosed by statute. *See, e.g.*, *Mississippi Poultry Ass'n v. Madigan*, 31 F.3d 293, 310 (5th Cir. 1994) (en banc). Here, of course, subsequent congressional enactments confirm that Congress approved of HHS's regulation. *See supra* pp. 25-26. And, once that issue is resolved, there is no basis to consider subsequent developments to determine whether the agency's regulation was rational.

Substantively, it is hard to understand why Congress's creation of the provider fee should alter what is and is not actuarially sound. No one in this litigation disputes the basic principle that actuarial soundness requires accounting for all expenses

incurred. And indeed, any contrary argument would be belied by the States' own admission that actuarial soundness, however defined, requires accounting for the provider fee. *Supra* p. 11. The creation of a new expense, therefore, should not alter whether HHS rationally defined the phrase "actuarially sound."

C. The regulation complied with the APA's procedural requirements.

The States further assert that HHS violated the APA's procedural requirements. As relevant to this case, and with exceptions not at issue here, those requirements demand that every "agency" provide the public with notice of a proposed rulemaking and the opportunity to comment on that proposal. 5 U.S.C. § 553(c). An "agency" means an "authority of the Government of the United States," again with various exceptions. *Id.* § 551(1).

In this case, all parties agrees that the actuarial-certification regulation underwent notice and comment in 2002, and that HHS's process complied with the APA. *See* ROA.4014 ("It is undisputed that HHS promulgated the Certification Rule through notice and comment."). HHS's actuarial-certification rule requires all actuaries to "follow the practice standards established by the Actuarial Standards Board," 42 C.F.R. § 438.6(c)(1)(i)(C), and it was fully understood that future practice standards, such as ASOP 49, would bear on the question of actuarial soundness. The States are quite wrong to contend (at 43-44) that ASOP 49 is itself a legislative rule that required notice and comment. As the actuarial-certification regulation

contemplated, ASOP 49 was issued by the Actuarial Standards Board, a private organization that is not an "agency" within the meaning of the APA. *See* 5 U.S.C. § 553(c). Indeed, that fact is central to the States' nondelegation challenge. *See supra* pp. 16-17.

If the States in fact believe that ASOP 49 requires a revision to the definition of actuarial soundness, the Administrative Procedure Act permits them to "petition for the issuance, amendment, or repeal of a rule," including the actuarial-certification rule. 5 U.S.C. § 553(e). If HHS declined to revise the regulations, it would be required to provide a statement of its grounds for doing so. *See id.* § 555(e). And the States could then challenge that decision under the APA. *See id.* §§ 702, 706. But the States have not done so—likely because they have admitted that their preferred policy outcome (not having to account for the provider fee) is irreconcilable with actuarial soundness, however defined. *See supra* p. 11.

V. The actuarial-soundness statute is constitutional.

The States also contend that 42 U.S.C. § 1396b(m)(2)(A)(iii), which requires that States' payments to managed-care organizations be "actuarially sound," is constitutionally "problematic." States' Br. 28-30. Although the States never actually state that the actuarial-soundness statute is unconstitutional, any such argument would fail because it is both forfeited and foreclosed by precedent.

A. The States' constitutional challenge to the actuarial-soundness statute is forfeited because the States never presented this challenge in their complaint or in

subsequent district court briefing. *See Bower v. Quarterman*, 497 F.3d 459, 475 (5th Cir. 2007) ("We will not consider issues raised for the first time on appeal . . . ."). The States' operative complaint has ten counts. ROA.165-173. Seven of them attack the constitutionality of the provider-fee statute (Counts I, IV, VI, VII, VIII, IX, and X), and three of them attack the legality of the actuarial-certification rule (Counts II, III, and V). ROA.165-173. None of them states, or even suggests, that the actuarial-certification statute suffers from any constitutional defect. That is why the district court correctly observed that "[p]laintiffs do not claim that the 'actuarially sound' language is a delegation," and so declined to reach this argument. ROA.4012 n.49.

The States' only response is difficult to comprehend. They contend (at 39) that their failure to challenge the constitutionality of a federal statute in their complaint should be excused because, in their summary-judgment briefing, they urged that *Chevron* deference is unavailable to the United States' interpretation given the economic and political significance of the Affordable Care Act. *See* ROA.1583.[5] That argument is incorrect for the reasons discussed above. *See supra* pp. 27-28. But, regardless, the States cite no authority for the remarkable proposition that an argument about the scope of an agency's interpretive deference should preserve an independent constitutional challenge to a statute. And at the very least, no summary-judgment argument may excuse the States' core obligation to include in their

[5] The States cite ROA.1563 but appear to do so in error.

complaint "a short and plain statement of the claim" that they bring. Fed. R. Civ. P. 8(a)(2). Because none of the counts in their complaint state a constitutional challenge to the actuarial-soundness statute, their challenge to that statute is not before this Court. *See Reid v. Hughes*, 578 F.2d 634, 639 (5th Cir. 1978) ("The scope of our inquiry is limited to the allegations on the face of the plaintiff's complaint, and the complaint does not allege such a theory . . . .").

B. In any event, the States' forfeited constitutional challenge to the actuarial-soundness statute is foreclosed by precedent. Although "Congress generally cannot delegate its legislative power to another Branch," *Mistretta v. United States*, 488 U.S. 361, 372 (1989), Supreme Court precedent permits Congress to delegate "at least some authority that it could exercise itself," *Loving v. United States*, 517 U.S. 748, 758 (1996). The Supreme Court has held that, "[s]o long as Congress shall lay down by legislative act an intelligible principle to which the person or body authorized to [exercise the delegated authority] is directed to conform, such legislative action is not a forbidden delegation of legislative power." *Mistretta*, 488 U.S. at 372 (quotation marks omitted; alterations in original). Since 1935, the Supreme Court has rejected every challenge to a congressional delegation of power that has been presented to it. *Whitman v. American Trucking Ass'ns*, 531 U.S. 457, 474 (2001); *see Gundy v. United States*, 139 S. Ct. 2116, 2129 (2019) (plurality op.).

Congress's use of the phrase "actuarially sound" easily falls within the intelligible-principle test announced by the Supreme Court. As Justice Scalia

explained for the Court, the "degree of agency discretion that is acceptable varies according to the scope of the power congressionally conferred." *Whitman*, 531 U.S. at 475. Under that sliding-scale test, "Congress need not provide any direction" to an agency "regarding the manner in which it is to define" a technical term. *Id.*; *see also id.* (noting that, in a prior case, "we did not require the statute to decree how 'imminent' was too imminent, or how 'necessary' was necessary enough, or even . . . how 'hazardous' was too hazardous"). Statutes regularly leave agencies technical definitions to further define, and none of those statutes has ever been invalidated on nondelegation grounds. Here, therefore, there is no question that Congress provided ample direction, and that the agency was constrained by the ordinary meaning of the term "actuarially sound." The fact that the States' actuaries and the United States agree that actuarial soundness requires accounting for the provider fee only underscores that the term has an intelligible meaning.

Congress's use of the phrase "actuarially sound" would also pass constitutional muster under the approach set forth in Justice Gorsuch's dissenting opinion in *Gundy v. United States*, 139 S. Ct. 2116. Although his opinion called for the Court to reconsider its approach to congressional delegations, the opinion emphasized that "as long as Congress makes the policy decisions when regulating private conduct, it may authorize another branch to 'fill up the details.'" *Id.* at 2136 (Gorsuch, J., dissenting). For example, Justice Gorsuch's opinion noted that the Court has correctly sustained statutes like one "authorizing the Secretary of Agriculture to adopt rules regulating the

'use and occupancy' of public forests to protect them from 'destruction' and 'depredations.'" *Id.* (citing *United States v. Grimaud*, 220 U.S. 506, 522 (1911)). The States provide no reason why Congress's use of "actuarially sound" is any different from its use of "use and occupancy," "destruction," and "depredations."

VI. The provider-fee statute is constitutional.

The States also challenge the Affordable Care Act's creation of the provider fee.[6] They contend that the fee is unconstitutional "as applied" to States, States' Br. 45, on the grounds that it exceeds Congress's power under the Spending Clause, U.S. Const. art. I, § 8, cl. 1, and that it violates the doctrine of intergovernmental tax immunity. Neither argument has merit.

A. The provider fee does not violate the Spending Clause.

1. The States' Spending Clause claims fail at the outset because the provider fee was not enacted under the Spending Clause, but rather under the Taxing Clause. U.S. Const. art. I, § 8, cl. 1 ("The Congress shall have Power To lay and collect Taxes, Duties, Imposts, and Excises . . . ."). Thus, none of the Spending Clause-specific limits on Congress's power that the States identify bear on this case at all.

[6] Congress repealed the provider fee in December 2019, after the United States filed its opening brief. *See* Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, div. N., § 502(a), 133 Stat. 2534, 3119 ("Subtitle A of title IX of the Patient Protection and Affordable Care Act is amended by striking section 9010."). This repeal takes effect beginning in 2021. *Id.* § 502(b). Because the Department of the Treasury intends to collect the provider fee for the 2020 data year, however, the United States does not argue that the repeal of the provider fee moots this case.

The "essential feature" of any tax is that it "produces at least some revenue for the Government." *National Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 564 (2012); *see Texas v. United States*, 945 F.3d 355, 389 (5th Cir. 2019) (same). It is also relevant whether the payment is "collected solely by the IRS through the normal means of taxation," and whether the tax is "paid into the Treasury." *NFIB*, 567 U.S. at 563, 566. So long as a congressional action meets these criteria, the label Congress uses is irrelevant: whether described as a tax, as an exaction, as a penalty, as a fee, or as a license, the money-raising law may be sustained under the taxing power. *Id.* at 564; *see License Tax Cases*, 72 U.S. 462, 471 (1866).

These precedents confirm that the provider fee easily falls within Congress's Taxing Clause power. The *NFIB* dissenting opinion coauthored by Justice Scalia, Justice Kennedy, Justice Thomas, and Justice Alito confirms as much, describing the provider fee as an "excise tax." 567 U.S. at 694, 698 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting); *see* ACA § 9010(f)(1) ("The fees imposed by this section . . . shall be treated as excise taxes . . . ."); *see also id.* § 9010(f)(2) ("The fees imposed by this section . . . shall be considered to be a tax . . . ."). And the provider fee meets all the criteria identified in *NFIB*: it produces revenue for the government, it is assessed by the Internal Revenue Service, *see* 26 C.F.R. § 57.8, and it is paid into the Treasury by managed-care organizations. Indeed, the States have admitted that the provider fee "is a tax." ROA.1557.

The States contend on appeal that the United States has abandoned this tax argument and that the United States has "directly contradict[ed]" the tax arguments that it made to the district court. States' Br. 2; *see id.* at 37, 45. That is flatly incorrect. As the United States' opening brief indicates on the pages that the States cite, the "*actuarial-soundness statute*" was "enacted . . . as a condition for state participation in the Medicaid program." U.S. Br. 33 (emphasis added). The United States' (undisputed) position that the actuarial-soundness requirement is a condition on Medicaid participation does not undermine its consistent view that the provider fee—enacted twenty-eight years later as part of a different statute—is a tax. And the fact that the actuarial-soundness requirement is enacted pursuant to the Spending Clause does not bear on the States' challenge to the provider fee.[7]

2. To hold that the provider fee is a tax fully resolves the States' Spending Clause challenge. All of the doctrines that they identify (at 45-50) apply only when Congress has legislated under its Spending Clause powers. *See NFIB*, 567 U.S. at 576 (plurality op.) ("[O]ur cases have recognized limits on Congress's power under the Spending Clause . . . ."); *id.* at 676 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) ("[O]ur cases have long held that the power to attach conditions to grants to the States has limits."); *see also South Dakota v. Dole*, 483 U.S. 203, 207 (1987) ("The spending power is of course not unlimited, but is instead subject to several general

[7] The States have not contended that the actuarial-soundness requirement itself violates the Spending Clause.

restrictions articulated in our cases.") (citation omitted). When Congress does not legislate pursuant to the Spending Clause, but rather pursuant to a different enumerated power, no Spending Clause limitation applies.

Although the district court agreed that the provider fee was a tax, ROA.4016, the court nevertheless asserted that a tax could still "violate the Spending Clause," ROA.4018. The district court cited no precedent for that view, and the United States is aware of no such precedent. And, solely as a matter of the Constitution's text, it makes no sense that anything in the Spending Clause—a *grant* of authority to Congress—could *limit* Congress's authority under other constitutional provisions, such as the Taxing or Commerce Clauses.

To hold otherwise would have far-reaching consequences. Whenever Congress raises the corporate income tax, for example, it increases the tax burdens on managed-care organizations—potentially by significantly more than the provider fee does. *See supra* p. 6. Principles of actuarial soundness, which require States to account for all relevant costs, ensure that States (and the federal government) would partially bear the costs of that tax increase. *See supra* pp. 10, 13. It cannot be that Congress implicates a bevy of Spending Clause doctrines every time it raises a tax. Accordingly, if this Court holds (in line with the States' concession) that the provider fee is a tax, it need not proceed to the States' Spending Clause arguments.

3. Even if the provider fee did implicate the Spending Clause, it would be constitutional in all respects. The Spending Clause grants Congress the power "to pay

the Debts and provide for the . . . general Welfare of the United States." U.S. Const. art. I, § 8, cl. 1. Often, Congress exercises its Spending Clause power by giving money to the States and, "in return for federal funds, the States agree to comply with federally imposed conditions." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981). When it does so, though, its Spending Clause authority is subject to several conditions, including that the federal government may not use its spending to "coerce[]" States to follow a federal policy and may not impose "'retroactive' conditions" on State programs. *NFIB*, 567 U.S. at 578, 584 (plurality op.) (quoting *Pennhurst*, 451 U.S. at 25). Additionally, conditions on federal grants must not be "unrelated 'to the federal interest'" in the particular program. *Dole*, 483 U.S. at 207. The provider fee would pass muster under all of these tests.

a. First, the provider fee in no way coerces States in the management of their Medicaid programs. As the Supreme Court recently reemphasized, the courts "have upheld Congress's authority to condition the receipt of funds on the States' complying with restrictions on the use of those funds, because that is the means by which Congress ensures that the funds are spent according to its view of the 'general Welfare.'" *NFIB*, 567 U.S. at 580 (plurality op.). In contradistinction, "[c]onditions that do not . . . govern the use of the funds" are potentially problematic, particularly when they "take the form of threats to terminate other significant independent grants," and so "are properly viewed as a means of pressuring the States to accept policy changes." *Id.* at 580.

If the provider fee implicated the Spending Clause at all (and it does not), it would be a valid condition under these precedents. The provider fee simply requires managed-care organizations to pay a percentage of their premiums to the federal government. *See* ACA § 9010(b). It is not even directed at the States, and so cannot "pressur[e]" them at all.

It is true that the interaction between the provider fee and Congress's insistence that rates be actuarially sound means that, in practice, States bear some of the cost of managed-care organizations' paying the provider fee. (The federal government, which subsidizes the States' Medicaid programs, bears the majority of that cost.) But that is nothing new. As the States concede, it merely reflects longstanding principles of actuarial soundness, which dictate that all costs must be accounted for. *Supra* p. 11.

There is thus nothing coercive about the provider fee. The coercion doctrine applies only where Congress compels "States to act in accordance with federal policies." *NFIB*, 567 U.S. at 577 (plurality op.); *accord id.* at 681 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) ("[C]ourts should not conclude that legislation is unconstitutional on this ground unless the coercive nature of an offer is unmistakably clear."). Much like the statute considered in *Harris v. McRae*, 448 U.S. 297 (1980), the actuarial-soundness requirement is part of "a cooperative program of shared . . . responsibilit[ies], not . . . a device for the Federal Government to compel a State to provide services that Congress itself is unwilling to fund." *Id.* at 309. Indeed, the

actuarial-soundness requirement aims to protect the public fisc and the public health by ensuring that States are neither profligate nor stingy when entering into contracts to provide Medicaid services. There is no effort to compel the States to act in accordance with any federal objective, much less the sort of "gun to the head" that raises constitutional concerns. *NFIB*, 567 U.S. at 581 (plurality op.).

The States' contrary argument (at 50) relies on their belief that, if they do not account for the provider fee, HHS will not approve their managed-care contracts and potentially withhold Medicaid reimbursement. Of course, if that alone were enough to render a condition unconstitutional, there could be no condition on Medicaid funding. *But see NFIB*, 567 U.S. at 580 (plurality op.) (emphasizing that the federal government may "condition the receipt of funds on the States' complying with restrictions on the use of those funds"). Even the most benign Medicaid conditions—such as the requirement that each State designate "a single State agency to administer" the State's Medicaid plan, 42 U.S.C. § 1396a(a)(5)—would be unconstitutional under the States' view, because a State that fails to comply with such requirements would lose its Medicaid reimbursement funds.

Nothing in the Supreme Court's holding in *NFIB* is to the contrary. There, the Court observed that a condition that took "the form of [a] threat[] to terminate other significant independent grants" could raise constitutional concerns, at least where Congress created an entirely "new health care program" and threatened to strip States of Medicaid funding unless they joined that program. 567 U.S. at 580, 584 (plurality

op.). Here, by contrast, there is no disconnect between any alleged condition and the program for which the condition is imposed. Rather, the provider fee is simply an additional tax imposed on managed-care organizations that (like all other costs) States must account for in developing actuarially sound rates. At most, the fee is a permissible shift in "degree," not an impermissible shift in "kind." *Id.* at 583; *accord id.* (noting that Congress "was entitled to make adjustments to the Medicaid program as it developed").

b. Second, even if an exercise of Spending Clause power, the provider fee would not be an impermissible retroactive condition. The requirement that States account for the provider fee merely reflects long-standing Medicaid requirements of actuarial soundness. 42 U.S.C. § 1396b(m)(2)(A)(iii). The States have long understood that any increased costs borne by managed-care organizations (whether imposed by a government or the consequence of market forces) would result in higher costs to them and to the federal government. Therefore, the provider fee did not add any further conditions to the receipt of federal Medicaid funds, and certainly did not add any conditions that are different in "kind" rather than in "degree." *NFIB*, 567 U.S. at 583 (plurality op.).

The States' argument to the contrary (at 46-47) relies on their assertions that the phrase "actuarial soundness" is somehow unclear and that the States are exempt from accounting for the provider fee. Their first argument is belied by their own

actuaries' understanding of actuarial soundness, *see supra* p. 11, and their second argument is wrong for the reasons stated above, *supra* Part I.

c. Finally, there is no merit to the States' suggestion that the provider fee is unrelated to the purpose of the Medicaid program. *Dole*, 483 U.S. at 207; *see New York v. United States*, 505 U.S. 144, 172 (1992). The provider fee aims solely to raise revenue that can be used by the government to fund all governmental programs. At the very least, the raising of revenue is not unrelated to a government program that costs the United States billions of dollars every year—and indeed, the fact that the sole purpose of the provider fee is to raise revenue only underscores why any Spending Clause analysis is inappropriate here.

The States suggest, without any citation, that the provider fee is used to "cover the costs of providing coverage" to persons who are not Medicaid-eligible. States' Br. 47. But nothing in the Affordable Care Act or its implementing regulations directs how the provider fee should be used. On the contrary, money raised through the provider fee is deposited in the U.S. Treasury, and may not be "drawn" from the Treasury except in accordance with "Appropriations made by Law" by the Congress. U.S. Const. art. I, § 9, cl. 7. However Congress chooses to spend the revenue raised by the provider fee, a decision to generate additional funds for the Treasury cannot be "unrelated" to the purpose of a federal expenditure.

B. The provider fee does not violate the doctrine of intergovernmental tax immunity.

The States also argue that the provider fee "violates principles of intergovernmental tax immunity embodied in the Tenth Amendment." States' Br. 50. This argument is inconsistent with both the facts of this case and the Supreme Court's precedents. The district court was correct to reject it. ROA.4021-4024.

As discussed above, the States do not pay any portion of the provider fee to the federal government. *See supra* pp. 5-6. Only managed-care organizations do. The district court held, and the States do not dispute, that private managed-care organizations are not entitled to any intergovernmental tax immunity. ROA.4023 (citing *United States v. New Mexico*, 455 U.S. 720, 736 (1982)).

The sole question, therefore, is whether it violates the Tenth Amendment for the federal government to impose a tax on private entities if those private entities then pass that cost onto the States when the States choose to contract with them. The Supreme Court has answered that question directly. It has "completely foreclosed any claim that the nondiscriminatory imposition of costs on private entities that pass them on to States or the Federal Government unconstitutionally burdens state or federal functions." *South Carolina v. Baker*, 485 U.S. 505, 521 (1988). As early as *Alabama v. King & Boozer*, 314 U.S. 1 (1941), the Court upheld a state sales tax imposed on a government contractor even though the economic burden of the tax was passed on by contract to the federal government. *Id.* at 8-9. "Subsequent cases have

consistently reaffirmed the principle that a nondiscriminatory tax collected from private parties contracting with another government is constitutional even though part or all of the financial burden falls on the other government." *Baker*, 485 U.S. at 521 (citations omitted); *see also id.* (noting that "the rationale for conferring a tax immunity on parties dealing with another government" has been "rejected"). Therefore, the *Baker* Court summarized, "the States can never tax the United States directly but can tax any private parties with whom it does business, even though the financial burden falls on the United States, as long as the tax does not discriminate against the United States or those with whom it deals." *Id.* at 523; *see id.* ("The rule with respect to state tax immunity is essentially the same, except that at least some nondiscriminatory federal taxes can be collected directly from the States . . . .") (citation omitted).

These precedents resolve the States' intergovernmental immunity claim. Tellingly, the States never address these clear holdings, even though the States cite both *Baker* and *King & Boozer* in their brief (at 51-52). Because the provider fee is assessed on private parties with whom the States do business, the tax is constitutional even though the financial burden partially falls on the States. There is thus no reason to reach the States' arguments (at 54-55) that the provider fee is not a traditional source of revenue and that it unduly interferes with States' sovereignty.

Also without merit is the States' contention (at 53-54) that the provider fee is discriminatory. As *Baker* explained, and as the States acknowledge, a tax is not discriminatory if it applies to all healthcare contracts, "whether issued by state or local

governments, the Federal Government, or private corporations." *Baker*, 485 U.S. at 526-27. Here, it is undisputed that the provider fee applies to all entities that "provide[] health insurance," ACA § 9010(c)(1), *except* for government entities and certain nonprofit insurers that do business with governmental entities, *id.* § 9010(c)(2)(A)-(B). Under these circumstances, it is not plausible to argue that the provider fee discriminates against States.

VII. The States cannot pursue a tax refund.

Finally, the States argue that they should be allowed to pursue a tax refund. If the Court were to reach that remedial question, it should hold that the district court correctly rejected this argument at the motion-to-dismiss stage. ROA.341-345. The States did not pay the provider fee to the federal government. They may not seek a refund for a tax that they did not pay.

Congress has offered a limited waiver of sovereign immunity for "any civil action against the United States for the recovery of any internal-revenue tax alleged to have been erroneously or illegally assessed or collected." 28 U.S.C. § 1346(a)(1). The Supreme Court has held that only "one from whom taxes are erroneously or illegally collected" may "sue for a refund of those taxes." *United States v. Williams*, 514 U.S. 527, 536 (1995); *see also id.* at 538 ("Section 1346(a)(1) is a postdeprivation remedy, available only if the taxpayer has paid the Government in full."). Parties "generally may not challenge the tax liabilities of others." *Id.* at 539; *cf.* 26 U.S.C. § 7426 (permitting a limited class of refund requests by third parties).

That principle, as the district court recognized, is fatal to the States' refund claim. The States "were neither directly subject" to the provider fee, nor "actually paid the relevant tax on behalf of the taxpayer assessed." ROA.344. Rather, the States "allege that they paid the full amount *to* the taxpayer against whom the tax was assessed." ROA.344. The States do not dispute those decisive facts, and provide no authority suggesting that entities in that situation may sue to seek a tax refund. The logic of their position—that anyone who pays a higher price based on the passing on of a tax may sue for a refund of that tax—is plainly unworkable. Accordingly, the district court correctly held that the States may not seek a "refund" of money that they did not pay to the federal government.

CONCLUSION

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

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CERTIFICATE OF SERVICE

I hereby certify that on February 28, 2020, 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.

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CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limit of Federal Rule of Appellate Procedure 28.1(e)(2)(A) because it contains 11,960 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.

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