No. 21-379

In the Supreme Court of the United States

STATE OF TEXAS, ET AL., PETITIONERS

v.

COMMISSIONER OF INTERNAL REVENUE, ET AL.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

BRIEF FOR THE RESPONDENT IN OPPOSITION

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QUESTIONS PRESENTED

Since 1981, as a condition of a State's receiving payments from the federal government under the Medicaid program, 42 U.S.C. 1396 *et seq.*, Congress has required States that contract with third-party managed-care organizations to provide care for beneficiaries covered by the States' Medicaid plans to make "actuarially sound" per-patient payments to those managed-care organizations. 42 U.S.C. 1396b(m)(2)(A)(iii). In 2002, following notice and comment, the Centers for Medicare & Medicaid Services (CMS) promulgated a regulation identifying three criteria that "[a]ctuarially sound" payments must satisfy: the payment amounts must "[h]ave been developed in accordance with generally accepted actuarial principles and practices"; those amounts must be "appropriate for the populations to be covered, and the services to be furnished under the contract"; and, directly at issue here, the payment amounts must "[h]ave been certified, as meeting th[ose] requirements * * * , 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 [Board]." 42 C.F.R. 438.6(c)(1)(i) (2015) (emphasis omitted). The questions presented are as follows.

1. Whether the court of appeals correctly determined that the 2002 regulation requiring certification by an actuary who follows the Board's practice standards does not constitute an unlawful delegation of CMS's authority.

2. Whether petitioners' 2015 claims challenging the requirement in CMS's 2002 regulation of certification by an actuary who follows the Board's practice standards are barred by the six-year statute of limitations for civil claims against the United States, 28 U.S.C. 2401(a).

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OPINIONS BELOW

The revised opinion of the court of appeals (Pet. App. 1a-29a) is reported at 987 F.3d 518. The opinion of the district court granting in part and denying in part the parties' cross-motions for summary judgment (Pet. App. 30a-107a) is reported at 300 F. Supp. 3d 810. An earlier opinion of the district court (Pet. App. 108a-165a) is not published in the Federal Supplement but is available at 2016 WL 4138632.

JURISDICTION

The revised judgment of the court of appeals was entered on February 12, 2021. A petition for rehearing en banc was denied on April 9, 2021 (Pet. App. 166a-188a). On March 19, 2020, this Court extended the time within which to file a petition for a writ of certiorari to 150 days from the date of the lower-court judgment, order deny-

ing discretionary review, or order denying a timely petition for rehearing. The effect of that order was to extend the deadline for filing a petition for a writ of certiorari in this case to September 6, 2021. The petition for a writ of certiorari was filed on September 3, 2021. The jurisdiction of this Court is invoked under 28 U.S.C. 1254(1).

STATEMENT

1. a. The Medicaid program, enacted in 1965 as Title XIX of the Social Security Act (Medicaid Act), 42 U.S.C. 1396 *et seq.*, "is a cooperative endeavor in which the Federal Government provides financial assistance to participating States to aid them in furnishing health care to needy persons," *Bowen* v. *Massachusetts*, 487 U.S. 879, 883 (1988) (citation and internal quotation marks omitted). To participate in Medicaid and receive federal funding, a State must submit a plan for medical assistance that meets various statutory requirements, which must be approved by the Secretary of Health and Human Services. 42 U.S.C. 1396a(a) and (b). The State's plan, once approved, defines the categories of persons who are eligible for benefits under the plan and the nature and extent of medical assistance to be provided under the plan. 42 U.S.C. 1396a(a)(10) and (17). The Centers for Medicare & Medicaid Services (CMS) within the Department of Health & Human Services (HHS), which administers the Medicaid program, then "provid[es] matching funds to State agencies to pay for a portion of the costs of providing health care to Medicaid beneficiaries." CMS, HHS, *Medicaid Program; Medicaid Managed Care: New Provisions*, 67 Fed. Reg. 40,989, 40,989 (June 14, 2002) (2002 Regulation).

For many years, States typically paid healthcare providers directly for the specific services that the providers had rendered to patients who were enrolled in the States' Medicaid plans—known as the "fee-for-service" model. 2002 Regulation, 67 Fed. Reg. at 40,989. Although States continue to provide coverage for certain healthcare beneficiaries or services through the fee-for-service model, since 1982 States have increasingly utilized a different approach, known as the managed-care model. *Ibid.* Under that model, States enter "contracts with managed care organizations (MCOs), such as health maintenance organizations (HMOs)," through which a managed-care organization is "paid a fixed, prospective, monthly payment for each beneficiary enrolled with the entity for health coverage," an amount known as the "capitation payment." *Ibid.*

In a 1981 amendment to the Medicaid Act, Congress made it easier for States to offer services through the managed-care model by permitting States to require their beneficiaries to enroll in a managed-care organization to receive benefits. 2002 Regulation, 67 Fed. Reg. at 40,989; see Medicare and Medicaid Amendment of 1981 (1981 Act), Pub. L. No. 97-35, Tit. XXI, Subtit. C, Ch. 2, sec. 2178, § 1903(m), 95 Stat. 813-815 (42 U.S.C. 1396b). The 1981 Act also established certain requirements for contracts between States and managed-care organizations. See *ibid.* Among other things, the 1981 Act specified that the capitation payments that a State agreed to pay the managed-care organization under the contract—*i.e.*, the fixed per-beneficiary amounts—must be "actuarially sound." Sec. 2178(a)(2)(d), § 1903(m)(1)(A), 95 Stat. 814 (42 U.S.C. 1396b(m)(2)(A)(iii)). That actuarial-soundness requirement helps to ensure that States do not under-

finance 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). The requirement also helps to ensure that States do not overpay their managed-care organizations, thereby needlessly expending federal funds.

b. Prior to 2002, CMS—which Congress has authorized and entrusted to implement the Medicaid program, including through an express grant of rulemaking authority, see 42 U.S.C. 1302(a)—and its predecessor had taken the view that a State's payments to a managed-care organization could not "exceed the cost * * * of providing the same services on a fee-for-service basis." *E.g.*, 42 C.F.R. 447.361 (2001), repealed, 67 Fed. Reg. 41,116. States and other stakeholders, however, objected that the agency's approach unduly limited the States' flexibility. See 2002 Regulation, 67 Fed. Reg. at 40,996-40,997.

In 2002, HHS promulgated the 2002 Regulation at issue here, in which it revised its approach to actuarial soundness in order to "give[] States and actuaries maximum flexibility while still ensuring that rates be certified as actuarially sound." 67 Fed. Reg. at 40,998; see *id.* at 41,097 (42 C.F.R. 438.6(c)(1)(i) (2015)).* Under the 2002 Regulation, to qualify as actuarially sound, the

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* Effective in 2016, HHS modified and recodified the regulatory provisions relating to the actuarial-soundness requirement, which now appear in 42 C.F.R. 438.2 and 438.4. Because petitioners challenge the 2002 version of the actuarial-soundness rule, which was in effect in 2015, and because the definitions relevant to their claims are unchanged, this brief follows the court of appeals in referring to the pre-2016 codified version. See Pet. App. 4a n.3. Unless otherwise indicated, all subsequent citations of the codified regulations in this brief refer to the pre-2016 codified version.

amounts of a State's capitation payments (known as its capitation rates) must satisfy three conditions. First, those rates must have been "developed in accordance with generally accepted actuarial principles and practices." 42 C.F.R. 438.6(c)(1)(i)(A). Second, they must be "appropriate for the populations to be covered, and the services to be furnished." 42 C.F.R. 438.6(c)(1)(i)(B). The 2002 Regulation set forth in detail various parameters for how those determinations are to be made—such as data sources and adjustments to data—and what documentation a State must furnish. 42 C.F.R. 438.6(c)(2)-(4). Third, an actuary must "certif[y]" that the rates satisfy the regulation's substantive requirements. 42 C.F.R. 438.6(c)(1)(i)(C). It is that third requirement—the actuarial-certification rule—that is the subject of this litigation.

The 2002 Regulation specified that, to be able to certify capitation rates, actuaries must "meet the qualification standards established by the American Academy of Actuaries [Academy] and follow the practice standards established by the Actuarial Standards Board [Board]." 42 C.F.R. 438.6(c)(1)(i)(C). The Academy is a private, membership-based professional organization that sets qualification, practice, and professionalism standards for actuaries. Am. Compl. ¶¶ 27-29 (C.A. ROA 159-160). The Board is an independent organization that sets standards for actuarial practice in the United States, including by adopting guidance in the form of Actuarial Standards of Practice. *Id.* ¶¶ 29-31 (C.A. ROA 160); see Pet. App. 3a. The actuarial-certification rule thus requires States to have their capitation rates verified as compliant with the substantive actuarial-soundness standards set forth in the 2002 Regulation by actuaries who possess the qualifications and follow the practice

standards established by the relevant professional organizations in the actuarial field. In adopting that approach—as opposed to prescribing its own, context-specific set of actuarial-practice standards, as some commenters had proposed—CMS explained that it preferred to "bas[e] the definition" of actuarial soundness 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." 67 Fed. Reg. at 40,998.

c. In 2015, the Board issued Actuarial Standard of Practice 49 (Standard 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." Pet. App. 207a; see *id.* at 201a-289a. As relevant here, Standard 49 explained that a managed-care capitation rate is "'actuarially sound'" only if it "provide[s] for all reasonable, appropriate, and attainable costs." *Id.* at 208a (emphasis omitted). 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.* at 208a-209a.

With respect to government fees in particular, the Board's Standard 49 aligned with existing CMS guidance documents, which explained that government fees should "be considered a business cost to health plans" and thus should be considered in capitation rates. CMS, HHS, *Medicaid and CHIP FAQs: Health Insurance Providers Fee for Medicaid Managed Care Plans* 1 (Oct. 2014), https://go.usa.gov/xVMgu; see *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 uncontroversial proposition that actuarial soundness requires taking into account all of an insurer's costs, including taxes and fees.

2. a. In 2010, in the Patient Protection and Affordable Care Act (ACA), Pub. L. No. 111-148, 124 Stat. 119, Congress imposed an annual tax on health-insurance providers, § 9010, 124 Stat. 865-868, which is known as the Health Insurance Providers Fee (Providers Fee) or the Section 9010 tax. Congress set the aggregate annual amount of the Providers Fee for the entire health-insurance industry and then apportioned it across insurers according to a statutory formula. § 9010(b), 124 Stat. 865-866; Health Care and Education Reconciliation Act of 2010 (2010 Reconciliation Act), Pub. L. No. 111-152, Tit. I, Subtit. E, § 1406(a)(4), 124 Stat. 1066. Congress exempted from the Providers Fee government entities that provide health insurance and certain nonprofit insurers. ACA § 9010(c)(2)(B), 124 Stat. 866; 2010 Reconciliation Act § 1406(a)(3), 124 Stat. 1065-1066; see 26 C.F.R. 57.2(b)(2)(ii-iii). In accordance with the actuarial-soundness requirement, States incorporated the cost of the Providers Fee into their contracts with managed-care organizations.

b. In October 2015, petitioners—Texas and several other States—commenced this action against the United States and various federal officials (respondents in this Court) challenging the Providers Fee and respondents' "actions implementing" it. Compl. 1-2 (C.A. ROA 21-22); see Compl. ¶¶ 6-70 (C.A. ROA 23-37); Am. Compl. 1-2, ¶¶ 6-80 (C.A. ROA 147-172). Petitioners sought declaratory and injunctive relief, and "monetary relief against the United States in the form of a return

of the * * * Providers Fees previously made," *i.e.*, "a refund of the amounts [petitioners] have paid (or may pay during the course of this litigation) under the * * * Providers Fee." Am. Compl. 2, 29 (C.A. ROA 148, 175); see *id.* ¶¶ 38-39 (C.A. ROA 163); see also *id.* ¶¶ 69-71 (C.A. ROA 170-171).

Petitioners contended that the Providers Fee itself, as applied to the managed-care organizations with which petitioners contracted, violated the Constitution's Spending Clause, Art. I, § 8, Cl. 1, the Tenth Amendment, and principles of federalism. Am. Compl. ¶¶ 46-49, 58-59, 66-68, 72-77 (C.A. ROA 165-166, 168-170, 172-173). Petitioners, however, do not challenge the Providers Fee itself in this Court, and they acknowledge (Pet. 9 n.6) that their claims challenging it are "likely moot" in light of Congress's repeal of the Providers Fee in 2019, see p. 10, *infra*.

Petitioners additionally asserted claims under the Administrative Procedure Act (APA), 5 U.S.C. 551 *et seq.*, 701 *et seq.*, challenging the actuarial-certification rule adopted by CMS in the 2002 Regulation. Pet. App. 7a. Petitioners alleged that the actuarial-certification rule "constitutes an unconstitutional delegation of Congress's legislative power to a private entity," that it exceeded CMS's statutory authority, that it was arbitrary and capricious in violation of the APA, 5 U.S.C. 706(2)(A), and that CMS had "failed to properly engage in notice-and-comment rulemaking" in accordance with the APA. Am. Compl. ¶¶ 57, 62 (C.A. ROA 167-168); see *id.* ¶¶ 50-57, 60-65 (C.A. ROA 166-169).

The district court granted partial summary judgment to petitioners in relevant part and vacated the actuarial-certification rule. Pet. App. 30a-107a. The court concluded (as relevant) that petitioners had standing to challenge the actuarial-certification rule and that

their claim was not barred by the six-year limitations period generally applicable to claims against the United States, 28 U.S.C. 2401(a), or the Anti-Injunction Act, 26 U.S.C. 7421. Pet. App. 43a-72a. On the merits, the court rejected petitioners' contentions that the actuarial-certification rule was arbitrary and capricious and adopted in contravention of notice-and-comment requirements. See *id.* at 94a-95a. But the court concluded that the actuarial-certification rule is an impermissible delegation of legislative power and exceeds CMS's statutory authority. See *id.* at 72a-94a.

The district court vacated the actuarial-certification rule, Pet. App. 89a, and it additionally ordered the United States to pay $479 million in what the court described as "equitable disgorgement" to compensate the States for what they had paid to their managed-care organizations to account for the Providers Fee. C.A. ROA 4411-4412; see Pet. App. 8a. The court acknowledged that the APA does not waive federal sovereign immunity for monetary awards—whether legal or equitable—that substitute for a loss suffered by the plaintiffs. C.A. ROA 4406-4407, 4409. But the court stated that it had "inherent and broad equitable jurisdiction to order [the United States] to disgorge" the money. *Id.* at 4411. The court subsequently entered final judgment, but it has stayed that judgment pending the exhaustion of appellate review. See D. Ct. Doc. 171 (Apr. 16, 2021).

c. In September 2018, following the district court's summary-judgment ruling in this case, petitioners commenced a separate action in the same court "contest[ing] the calculation, assessment, and distribution of liability for the 2018 [Providers Fee]." Compl. 1, *Texas* v. *United States* (*Texas II*), No. 18-cv-779 (N.D. Tex.

Sept. 20, 2018). The complaint in that case acknowledged that the district court's ruling in this case did not prevent States from being required to account for the Providers Fee, stating that "Congress's admonition of 'actuarial soundness,' and the general principles of actuarial soundness, nonetheless require[d] that the 2018 [Providers Fee] still be added to the negotiated capitation rates of Plaintiffs' Medicaid * * * contracts." *Id.* ¶ 26 (citing 42 U.S.C. 1396b(m)(2)(A)(iii)) (brackets omitted); see *id.* ¶ 45. Proceedings in that case have been stayed. 18-cv-779 D. Ct. Doc. 42 (Apr. 16, 2021).

3. The government appealed. In December 2019, while this litigation was pending in the court of appeals, Congress repealed Section 9010 of the ACA and thus eliminated the Providers Fee prospectively for "calendar years beginning after December 31, 2020." Further Consolidated Appropriations Act, 2020 (2020 Appropriations Act), Pub. L. No. 116-94, Div. N, Tit. I, Subtit. E, § 502(b), 133 Stat. 3119.

The court of appeals affirmed in part and reversed in part. Pet. App. 1a-29a (amended panel opinion issued in conjunction with denial of petition for rehearing). As relevant here, the court first held that petitioners had standing to challenge CMS's actuarial-certification rule. *Id.* at 10a-14a. The court stated that petitioners "alleged a particular injury in fact"—namely, "having to pay millions of dollars in Provider[s] Fees despite the ACA's explicit exemption for governmental entities"—that the court deemed "arguably traceable" to the actuarial-certification rule. *Id.* at 11a.

The court of appeals rejected the government's contention that petitioners' asserted injury would not be redressed by relief regarding the actuarial-certification rule itself. The court noted that, as petitioners had

acknowledged in *Texas II*, see p. 10, *supra*, they "may still have to pay the Provider[s] Fee under" the provision of the 1981 Act that independently required capitation rates to be "actuarially sound." Pet. App. 12a-13a & n.8; see 42 U.S.C. 1396b(m)(2)(A)(ii). But the court reasoned that Standard 49's "explicit requirement to pay the Provider[s] Fee would be removed" if the actuarial-certification rule were set aside, such that a ruling for petitioners in this case would "remove one of two legal barriers to defeating this obligation." Pet. App. 12a-13a.

The court of appeals next concluded that what it described as petitioners' "APA claims" were "time-barred." Pet. App. 14a; see *id.* at 14a-16a. The court observed that challenges to agency action under the APA "are governed by 28 U.S.C. § 2401(a)," which permits such an action to be brought (and waives sovereign immunity) only "'within six years after the right of action first accrues.'" *Id.* at 14a (quoting 28 U.S.C. 2401(a)). The court explained that CMS had "published the [actuarial-certification rule] in 2002, thirteen years before [petitioners] filed their complaint." *Ibid.*

The court of appeals acknowledged that, under Fifth Circuit precedent, "a plaintiff may 'challenge . . . a regulation after the limitations period has expired' if the claim is that the 'agency exceeded its constitutional or statutory authority,'" but only if the plaintiff "'show[s] some direct, final agency action involving the particular plaintiff within six years of filing suit.'" Pet. App. 14a (citation omitted). Here, the court found that petitioners had not identified any such "direct and final" actions by CMS in the six years preceding their commencement of this suit in 2015. *Id.* at 15a. The court rejected petitioners' contentions that CMS had

taken such actions in 2015 when it sent a letter to Texas's Medicaid Director approving that State's amended contract with its managed-care organization; when the government collected the Providers Fee from the managed-care organizations with which petitioners contracted; or when CMS issued a guidance document that "restated" the requirement under the 2002 Regulation that, to be actuarially sound, a State's capitation rates must be certified by an actuary who follows the Board's practice standards. *Id.* at 16a; see *id.* at 15a-16a.

The court of appeals, however, viewed petitioners' nondelegation challenge to the actuarial-certification rule to be distinct from what the court had termed their "APA claims," Pet. App. 17a, and it proceeded to address that constitutional claim on the merits, *id.* at 17a-23a. The court rejected petitioners' nondelegation challenge on two grounds. See *ibid.*

First, the court of appeals held that the actuarial-certification rule, and with it the incorporation of the Board's practice standards, did not constitute an improper delegation of authority. Pet. App. 17a-20a. The court explained that "an agency does not improperly subdelegate its authority when it 'reasonably conditions' federal approval on an outside party's determination of some issue." *Id.* at 17a (quoting *United States Telecom Ass'n* v. *FCC*, 359 F.3d 554, 566-567 (D.C. Cir.), cert. denied, 543 U.S. 925 (2004)) (brackets omitted). In this case, the court observed, CMS had conditioned its approval of an insurance contract on an actuary's certification that the agency's own standards had been met. See 42 C.F.R. 438.6(c)(1)(i)(C) (requiring capitation rates to "[h]ave been certified" by an actuary "as meeting the requirements of this paragraph"). The court

found that the actuarial-certification requirement here was a "reasonable" condition. Pet. App. 19a.

The court of appeals observed that "Congress requires capitation rates to be actuarially sound, as defined by HHS." Pet. App. 19a. And it found "[c]ertification by a qualified actuary who applies the Board's standards" to be "reasonably connected to ensuring actuarially sound rates," given that both "the Board and a qualified actuary have institutional expertise in actuarial principles and practices." *Ibid.* That approach, the court explained, did not represent a "subdelegation[] of authority"; instead, CMS had "simply incorporated the Board's actuarial standards into its [actuarial-certification rule], a common and accepted practice by federal agencies." *Id.* at 19a-20a (citing *American Soc'y for Testing & Materials* v. *Public.Resource.Org, Inc.*, 896 F.3d 437, 442 (D.C. Cir. 2018), and *Amerada Hess Pipeline Corp.* v. *FERC*, 117 F.3d 596, 601 (D.C. Cir. 1997)). The court agreed with the government's contention that CMS "could achieve exactly the same result by promulgating regulations that adopted the substance of the . . . Board's standards." *Id.* at 20a.

Second, the court of appeals determined in the alternative that, "even assuming arguendo that [CMS] subdelegated authority" to the Board, "such subdelegations were not unlawful" because CMS retained "final reviewing authority." Pet. App. 20a; see *id.* at 20a-23a. The court noted that CMS "'reviewed and accepted' the Board's standards." *Id.* at 22a (citation omitted). And it observed that CMS "closely 'superintended'" the contract-approval process "'in every respect,'" which it exercised through an extensive, independent review process for each contract approval, of which actuarial certification was but one "small part." *Ibid.* (citation omitted).

Having rejected all of petitioners' claims challenging the actuarial-certification rule (and other claims involving the Providers Fee itself, not at issue here, see Pet. App. 23a-29a), the court of appeals found it unnecessary to address the propriety of the district court's equitable-disgorgement monetary remedy. *Id.* at 29a & n.20.

4. The court of appeals denied rehearing en banc. Pet. App. 166a-167a. Judge Ho, joined by four other judges, dissented from the denial of rehearing en banc, disagreeing with the panel's rejection of petitioners' nondelegation challenge to the actuarial-certification rule. *Id.* at 168a-188a.

ARGUMENT

Petitioners contend (Pet. 18-22) that CMS's actuarial-certification rule represents an unconstitutional delegation of legislative authority to private entities. They further contend (Pet. 26-31) that the court of appeals erred in rejecting their remaining claims challenging the actuarial-certification rule on other grounds as time-barred because they filed suit 13 years after that rule was promulgated. The court of appeals correctly rejected petitioners' arguments, and its decision does not conflict with any decision of this Court or of another court of appeals. The questions petitioners raise also lack any ongoing practical significance because the Providers Fee previously imposed on petitioners' managed-care organizations, which was the genesis of petitioners' grievance and the source of their asserted injury, was repealed by Congress in 2019. In any event, this case would be an unsuitable vehicle for this Court's review for multiple reasons. Further review is not warranted.

1. The court of appeals correctly rejected the States' nondelegation challenge to the actuarial-certification rule.

a. The Medicaid Act and CMS regulations both require that the fixed, per capita payments made by a State to a managed-care organization that provides care to the State's Medicaid enrollees must be "actuarially sound." 42 U.S.C. 1396b(m)(2)(A)(iii); 42 C.F.R. 438.6(c)(2). As relevant here, the actuarial-certification rule adopted by CMS in the 2002 Regulation requires a State to submit a certification that its payment rates comply with that requirement, which must be made by an actuary who "meet[s] the qualification standards established by the [Academy] and follow[s] the practice standards established by the [Board]," 42 C.F.R. 438.6(c)(1)(i)(C)—two independent professional organizations that set standards for practice in the actuarial field, Am. Compl. ¶¶ 27-31 (C.A. ROA 159-160). Petitioners contend (Pet. 18-22) that the actuarial-certification rule amounts to an impermissible delegation of legislative authority because the Board is a private entity. The court of appeals correctly rejected that contention. Pet. App. 17a-23a.

i. The court of appeals recognized, consistent with its own longstanding precedent, that "[a] federal agency may not 'abdicate its statutory duties' by delegating them to a private entity." Pet. App. 17a (quoting *Sierra Club* v. *Lynn*, 502 F.2d 43, 59 (5th Cir. 1974), cert. denied, 421 U.S. 994, and 422 U.S. 1049 (1975)). As the court explained, however, the actuarial-certification rule does not constitute such a "subdelegation[] of [CMS's] authority." *Id.* at 20a; see *id.* at 17a-20a. The requirement that a state Medicaid plan's capitation rates for paying a managed-care organization be "actuarially sound" was set forth by Congress 40 years ago in the Medicaid Act itself. 42 U.S.C. 1396b(m)(2)(A)(iii). The actuarial-certification rule implements that statu-

tory directive by requiring that a State's rates be "developed in accordance with generally accepted actuarial principles and practices" and "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) and (B). Petitioners do not appear to take issue with either of those unremarkable substantive criteria.

Instead, petitioners challenge here only the actuarial-certification rule's further requirement that a State submit a certification by an actuary that its capitation rates comply with those two substantive criteria and other parameters that CMS prescribed in its regulations. See 42 C.F.R. 438.6(c)(1)(i)(C). The rule requires that the actuary making that certification possess the relevant professional qualifications (identified by the Academy) and follow the applicable professional standards (promulgated by the Board) in the actuarial field.

As the court of appeals recognized, CMS "could achieve exactly the same result" that it did through the actuarial-certification rule "by promulgating regulations that adopted the substance of the . . . Board's standards." Pet. App. 20a (emphasis omitted). Or it could have chosen to prescribe its own distinct, parochial set of professional qualifications and standards of practice for actuaries applicable only to the context of managed-care-organization contracts for Medicaid plans. Instead, CMS elected to require actuaries making certifications to the federal government to follow the widely accepted professional standards established by an expert body that apply to the actuarial profession, in order to "give[] States and actuaries maximum flexibility while still ensuring that rates be certified as actuarially sound." 67 Fed. Reg. at 40,998. The court of appeals correctly determined that CMS's approach does

not improperly delegate its authority and instead fully comports with the constitutional structure.

ii. That determination accords with this Court's precedent. The Court has long recognized Congress's "broad power to set the terms on which it disburses federal money to the States," *Arlington Cent. Sch. Dist. Bd. of Educ.* v. *Murphy*, 548 U.S. 291, 296 (2006). The Court also has long recognized that the government may "avail[] itself of" private assistance in resolving "matters of a more or less technical nature." *A. L. A. Schechter Poultry Corp.* v. *United States*, 295 U.S. 495, 537 (1935). As the court of appeals observed, federal agencies frequently incorporate by reference standards established by private entities. Pet. App. 19a (citing *American Soc'y for Testing & Materials* v. *Public.Resource.Org, Inc.*, 896 F.3d 437, 442 (D.C. Cir. 2018)), for the proposition that agencies have incorporated "over 1,200 standards established by private organizations"). Here, petitioners do not challenge Congress's ability to condition Medicaid payments to a State on the State's employment of actuarially sound rates. And they do not appear to dispute that implementing any actuarial-soundness requirement presupposes the existence of standards of appropriate actuarial practice, or that those standards are necessarily of a relatively "technical nature." *Schechter Poultry*, 295 U.S. at 537.

An agency's reliance on outside input is especially appropriate where, as here, that input comes from a disinterested, independent body with relevant expertise in the industry. The chief concern that this Court's cases addressing impermissible delegations of authority to private entities have recognized sounds in due process: the possibility that regulatory power would be wielded

by private persons whose own "interests may be and often are adverse to the interests of others in the same business." *Carter* v. *Carter Coal Co.*, 298 U.S. 238, 311 (1936) (holding invalid a federal statute allowing the producers of two-thirds of the coal in a given district to set wages and hours for all producers in that district); see, *e.g.*, *Eubank* v. *City of Richmond*, 226 U.S. 137, 143-144 (1912) (addressing ordinances that allowed homeowners to set zoning requirements for their own neighborhoods and noting the concern that private parties may act "solely for their own interest or even capriciously"). Nothing like that concern of entrusting self-interested private entities to adopt regulations to govern others in their own industry is implicated by requiring actuaries certifying the compliance of States' Medicaid capitation rates to follow actuarial guidance adopted by the independent organization (the Board) that prescribes standards for their profession. Cf. *Association of Am. R.Rs.* v. *United States 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."). There is no suggestion here that the Board is a self-interested actor regulating its own competitors.

Moreover, the Court has repeatedly upheld laws that prescribe a requirement but make its application to regulated entities contingent on the approval of some or all of the regulated entities themselves, which "merely placed a restriction upon [Congress's] own regulation." *Currin* v. *Wallace*, 306 U.S. 1, 15 (1939); see *United States* v. *Rock Royal Co-Operative*, 307 U.S. 533, 545 (1939). Such laws do not constitute an "unlawful delegation" because "Congress had the power to put" those

requirements "into effect without the approval of anyone" and merely chose to make the requirements' operation contingent. *Rock Royal*, 307 U.S. at 577. Here, similarly, Congress established the actuarial-soundness requirement that CMS's regulations reiterate, and CMS "exercise[d] its [rulemaking] authority in making the regulation and in prescribing the conditions of its application." *Currin*, 306 U.S. at 16. No improper delegation occurred because CMS "ha[s] the power to" determine actuarial soundness "without the approval of anyone." *Rock Royal*, 307 U.S. at 577. States' actuaries must follow the Board's practice standards only because CMS has imposed that requirement as one of the "conditions" of receiving federal funding. *Currin*, 306 U.S. at 16. If CMS disagreed with the Board's standards, it could amend its regulations to override them at any time.

Notably, the due-process principles that underlie the private nondelegation doctrine petitioners invoke apply to state law as well as federal law, and many state statutes entrust private entities to impose or implement technical conditions as part of a regulatory scheme. See, *e.g.*, Tex. Tax Code Ann. § 11.1826(b)(1)(A) (West 2015) (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"); see also Gov't C.A. Br. 39 n.6 (collecting additional examples). For example, each petitioner here, like the federal government, requires private actors to comply with private safety standards set by disinterested organizations. See, *e.g.*, Tex. Health & Safety Code Ann. § 247.0273(a) (West Supp. 2017) ("The executive commissioner by rule shall specify an 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."); see also Gov't C.A. Br. 40 n.7 (collecting additional examples). And, of particular relevance, each petitioner has laws requiring compliance with the Board's technical standards for actuaries. See, *e.g.*, Tex. Ins. Code Ann. § 425.0545(a) and (c)(4) (West Supp. 2016) (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"); 28 Tex. Admin. Code § 21.2211(b) (2018) ("The illustration actuary shall certify that the disciplined current scale used in illustrations is in conformity with the Actuarial Standard of Practice * * * promulgated by the Actuarial Standards Board."); see also Gov't C.A. Br. 40 n.8 (collecting additional examples). Petitioners do not contend that those state laws constitute improper delegations to private entities

Finally, the court of appeals correctly recognized that, even if the actuarial-certification rule could be thought to have subdelegated some authority to private entities, it would not be unlawful because CMS retained "final reviewing authority." Pet. App. 22a. CMS "reviewed and accepted" the Board's standards, *ibid.* (citation omitted), which it is always free to supersede for Medicaid managed-care contracts. And CMS also "'superintend[s]'" the managed-care contract-approval process—of which actuarial "certification is a small part"—"'in every respect.'" *Ibid.* (citation omitted). The court correctly determined that the actuarial-certification rule did not impermissibly subdelegate CMS's authority.

b. Petitioners' contention (Pet. 22-26) that the decision below conflicts with decisions of other courts of appeals addressing analogous nondelegation issues lacks merit.

Petitioners principally assert (Pet. 22-25) that the decision below conflicts with the D.C. Circuit's decision in *United States Telecom Ass'n* v. *FCC*, 359 F.3d 554, cert. denied, 543 U.S. 925 (2004) (*U.S. Telecom*), which held that the Federal Communications Commission could not "subdelegate" its regulatory authority over certain telecommunications carriers to state regulatory commissions to make certain regulatory determinations on a localized basis, "absent affirmative evidence of authority to do so." *Id.* at 566; see *id.* at 565-568. That decision does not conflict with the decision below because, as the court of appeals found, CMS's actuarial-certification rule is not a "subdelegation[] of authority" to the Board. Pet. App. 20a. The rule merely places "reasonable conditions" that make "federal approval" of capitation rates contingent on "an outside party's determination of [an] issue." *Id.* at 17a, 20a.

The court of appeals' conclusion that such reasonable conditions are permissible accords with the D.C. Circuit's decision, which expressly recognized such conditions as permissible. See *U.S. Telecom*, 359 F.3d at 567 ("[A] federal agency entrusted with broad discretion to permit or forbid certain activities may condition its grant of permission on the decision of another entity, * * * , so long as there is a reasonable connection between the outside entity's decision and the federal agency's determination."). Indeed, the court of appeals here relied on *U.S. Telecom* for the proposition that an agency may reasonably condition its approval on "an outside party's determination of some issue," as "such

conditions only amount to legitimate requests for input." Pet. App. 17a. Petitioners' assertion that *U.S. Telecom* limited that principle to delegations to government entities contradicts the D.C. Circuit's recognition that "[t]he fact that the subdelegation in th[at] case [wa]s to state commissions rather than private organizations d[id] not alter the analysis." 359 F.3d at 566.

Petitioners likewise err in contending (Pet. 25) that the court of appeals' alternative holding that CMS's "final reviewing authority" renders any putative delegation to the Board lawful conflicts with the Second Circuit's decision in *The Fund for Animals* v. *Kempthorne*, 538 F.3d 124 (2008). Petitioners point to that court's statement that an agency "abdicates its 'final reviewing authority'" if "all it reserves for itself is 'the extreme remedy of totally terminating the delegation agreement.'" Pet. 25 (quoting *Fund for Animals*, 538 F.3d at 133). But the court of appeals here did not suggest that an agency's reserving to itself only that limited kind of review authority is sufficient. Instead, it recognized that CMS retains authority to review and accept or reject the Board's standards and that "[t]he contract approval process is closely 'superintended by HHS in every respect.'" Pet. App. 22a (brackets and citation omitted).

2. Petitioners' contention (Pet. 26-31) that the court of appeals erred in applying Section 2401(a)'s six-year limitations period to their statutory challenges to the actuarial-certification rule lacks merit and does not warrant further review.

a. As petitioners acknowledge, their statutory claims challenging the actuarial-certification rule "are subject to a six-year statute of limitations." Pet. 28 (citing 28 U.S.C. 2401(a)). Section 2401(a) provides that,

"[e]xcept as provided by chapter 71 of title 41" of the United States Code—which pertains to government contracts—"every civil action commenced against the United States shall be barred unless the complaint is filed within six years after the right of action first accrues." 24 U.S.C. 2401(a). Section 2401(a) makes an exception for "[t]he action of any person under legal disability or beyond the seas at the time the claim accrues," whose action "may be commenced within three years after the disability ceases." *Ibid.* And Section 2401(b) prescribes a distinct framework of deadlines for seeking administrative and judicial review of "[a] tort claim against the United States." 28 U.S.C. 2401(b).

As the court of appeals explained, the actuarial-certification rule that petitioners challenged was "published * * * in 2002, thirteen years before [petitioners] filed their complaint." Pet. App. 14a. And none of the exceptions to Section 2401(a)'s six-year deadline applies. Petitioners thus correctly recognize (Pet. 28) that "[a]ny challenge to the procedures by which the [actuarial-certification] rule was adopted thus became untimely in 2008."

Petitioners nevertheless argue that they "may still challenge the legality of the [actuarial-certification] [r]ule * * * if it has been applied to them within the last six years." Pet. 28 (citing *Dunn-McCampbell Royalty Interest, Inc.* v. *National Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997)). As petitioners recognize (Pet. 29), however, the court of appeals applied that very principle, stating that a "plaintiff may 'challenge . . . a regulation after the limitations period has expired' if the claim is that the 'agency exceeded its constitutional or statutory authority,'" but only if the plaintiff "'show[s] some direct, final agency action involving the particular

plaintiff within six years of filing suit.'" Pet. App. 14a (quoting *Dunn-McCampbell*, 112 F.3d at 1287). The court of appeals found, however, that petitioners had failed to "show some direct, final agency action involving the particular plaintiff[s] within six years of filing suit." *Ibid.* (quoting *Dunn-McCampbell*, 112 F.3d at 1287).

Petitioners contend (Pet. 28) that the court of appeals' application of that principle here is "inconsistent with the record" in this case. But the court considered and properly rejected each of the three events that the district court had found to constitute direct and final agency action applying CMS's actuarial-certification rule to them. Pet. App. 15a-16a.

First, the district court had cited "a 2015 letter sent by [CMS] to the Texas Medicaid Director approving Texas's amended [managed-care-organization] contract, which included Provider[s] Fees in the capitation rates for additional groups of Medicaid beneficiaries." Pet. App. 15a. But, as the court of appeals explained, that letter "d[id] not show that [CMS] was issuing a new ruling requiring Texas to include Provider[s] Fees in its capitation rates." *Ibid.* Moreover, "Texas paid costs associated with Provider[s] Fees for the 2013 calendar year," which was not covered by the 2015 letter. *Ibid.* "Thus, even before the letter, Texas accounted for the Provider[s] Fee in its capitation rates," and "[t]he letter did not mark a change to Texas's obligation under the [actuarial-certification] [r]ule." *Ibid.*

Second, the district court had cited "the government's collection of the Provider[s] Fee through [petitioners'] 2015 capitation rates." Pet. App. 15a. As the court of appeals observed, however, the federal government "does not collect the Provider[s] Fee directly from

states" such as petitioners, and thus its "decision to collect" the Fee "from [managed-care organizations] is not a 'direct . . . action involving the States.'" *Id.* at 15a-16a (quoting *Dunn-McCampbell*, 112 F.3d at 1287) (brackets omitted).

Third, the district court had relied on a 2015 CMS "guidance document 'for use in setting capitation rates.'" Pet. App. 16a (brackets and citation omitted). But as the court of appeals noted, "the guidance document did not create any new obligations or consequences." *Ibid.* Instead, the document merely "restated that for capitation rates to be actuarially sound, they had to be consistent with" the Board's Actuarial Standards of Practice, a requirement that "ha[d] existed since [CMS] promulgated the [actuarial-certification] [r]ule" in 2002. *Ibid.*

The court of appeals' determination that none of those events constituted a further direct, final agency action applying the actuarial-certification rule to petitioners themselves is sound. At a minimum, petitioners' disagreement with the court of appeals' assessment of "the record" of this particular case (Pet. 29) does not warrant this Court's review. See *United States* v. *Johnston*, 268 U.S. 220, 227 (1925) ("We do not grant a certiorari to review evidence and discuss specific facts.").

Petitioners contend (Pet. 26) that application of the general six-year limitations period to their challenges "allows agencies and private parties to shield * * * unconstitutional delegations from judicial" review. That is incorrect. Under the court of appeals' approach, a plaintiff aggrieved by final agency action predicated on an allegedly unconstitutional delegation may bring suit within six years of that agency action. See Pet. App. 14a. The court of appeals simply concluded that peti-

tioners had not identified any final agency action applicable to them. *Id.* at 15a-16a. In any event, petitioners' concern about insulating impermissible delegations from judicial review is not implicated here because the court of appeals nevertheless did reach the merits of their nondelegation challenge and properly rejected it.

b. Petitioners do not contend that the decision below squarely conflicts with any decision of this Court "that directly addressed this question." Pet. 28 n.11. They cursorily assert that the decision below is inconsistent with decisions of the Ninth and D.C. Circuits. Pet. 28, 31 (citing *California Sea Urchin Comm'n* v. *Bean*, 828 F.3d 1046, 1049-1050 (9th Cir. 2016); *National Envtl. Dev. Ass'n's Clean Air Project* v. *EPA*, 752 F.3d 999, 1003 (D.C. Cir. 2014); and *United States* v. *Picciotto*, 875 F.2d 345, 347-348 (D.C. Cir. 1989)). That assertion of a lower-court conflict lacks merit. Neither D.C. Circuit decision that petitioners cite involved the application of a statute of limitations to claims challenging agency action. See *National Envtl. Dev. Ass'n's Clean Air Project*, 752 F.3d at 1003, 1005-1008 (rejecting arguments that plaintiffs lacked standing and that their claims challenged non-final agency action and were not ripe); *Picciotto*, 875 F.2d at 347-348 (addressing distinction between substantive and interpretive rules). And the Ninth Circuit in *California Sea Urchin Commission* concluded that the plaintiffs' claim there was timely because "the operative agency action challenged"—the termination of a particular program, pursuant to authority set forth in an earlier agency regulation—occurred within the limitations period. 828 F.3d at 1049. The court of appeals here found no analogous "operative agency action," *ibid.*, within the limitations period. See Pet. App. 14a-16a. Finally, petitioners' contention (Pet.

30) that the decision below "creates intra-Circuit disagreement" with other decisions of the Fifth Circuit does not warrant this Court's review. See *Wisniewski* v. *United States*, 353 U.S. 901, 902 (1957) (per curiam).

3. Even if either question presented in the petition might otherwise warrant review, this case would be an unsuitable vehicle to address them.

a. Although the court of appeals held that petitioners had standing to challenge the actuarial-certification rule in this case, the government respectfully disagrees with that conclusion, and at a minimum, substantial doubt exists whether that conclusion is correct. As the government argued below, it is far from clear how petitioners' asserted injury—*i.e.*, having to include in their capitation rates, and thus to pay to their managed-care organizations, "millions of dollars in Provider[s] Fees" that the ACA imposed on those organizations, Pet. App. 11a—could be redressed by a favorable decision on their claims challenging CMS's actuarial-certification rule. See Gov't C.A. Br. 23-25. As petitioners recognized in a separate suit that they brought after they prevailed in the district court here, even if CMS's rule incorporating the Board's practice standards (including Standard 49) did not exist, petitioners still would be required to account for the Providers Fee in setting capitation rates. The Medicaid Act has required capitation rates to be "actuarially sound" since 1981. 42 U.S.C. 1396b(m)(2)(A)(iii). And as petitioners correctly acknowledged in their complaint in *Texas II*, "Congress's admonition of 'actuarial soundness'" in Section 1396b(m)(2)(A)(iii), "and general principles of actuarial soundness, nonetheless require that the 2018 [fee] still be added to the negotiated capitation rates of Plaintiffs' Medicaid * * * contracts." Compl. ¶ 26,

Texas II, *supra* (No. 18-cv-779) (brackets omitted); accord *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 [Providers Fee] liability upon their Medicaid" managed-care organizations.). That concession was correct. See Medicaid Health Plans of Am. C.A. Amicus Br. 15-17. Even if petitioners succeeded in having the actuarial-certification rule set aside, it would have had no effect on their obligation to account for the Providers Fee in setting their capitation rates before the Providers Fee was repealed.

The court of appeals did not question that petitioners' statutory obligation to account for the Providers Fee would persist irrespective of a decision on their challenge to the actuarial-certification rule. See Pet. App. 13a. Instead, it reasoned that, "[h]owever true the United States's argument may be," vacatur of the actuarial-certification rule "would remove one explicit requirement to pay the Provider[s] Fee." *Ibid.* And it deemed petitioners' "statutory injury" from the Medicaid Act's independent actuarial-soundness requirement irrelevant because it "[wa]s not complained of here." *Ibid.*

That reasoning has matters backwards. If petitioners had challenged both the actuarial-certification rule *and* Section 1396b(m)(2)(A)(iii) in this case and had prevailed with respect to both, it might at least be possible for the district court in this case to fashion relief that would redress their injury. But precisely because that separate, statutory obligation is unchallenged in this case, and thus must be taken as a given as the case

comes to this Court, petitioners fail to identify how relief directed to CMS's actuarial-certification rule could redress their injury.

At the very least, significant doubt exists whether petitioners had standing to commence this suit challenging the actuarial-certification rule. Before addressing the merits of either of petitioners' claims, this Court would have to confront that threshold question. See, *e.g.*, *Frank* v. *Gaos*, 139 S. Ct. 1041, 1046 (2019) (per curiam) ("We have an obligation to assure ourselves of litigants' standing under Article III." (quoting *DaimlerChrysler Corp.* v. *Cuno*, 547 U.S. 332, 340 (2006))). That alone makes the case a poor candidate for review.

b. In any event, Congress's repeal of the Providers Fee in 2019 eliminates any prospective injury to petitioners, casts further doubt on the existence of any redressable injury, and renders the case devoid of ongoing practical significance. See p. 10, *supra*; 2020 Appropriations Act § 502, 133 Stat. 3119. That repeal removes any possibility that invalidating the actuarial-certification rule would shield petitioners' managed-care organizations from financial obligations going forward because those obligations no longer exist.

Petitioners themselves maintain (Pet. 27) that their untimeliness in filing suit should be excused on the basis that they lacked a cognizable injury, and could not have sued to challenge the actuarial-certification rule, before the Providers Fee was imposed and Standard 49 made clear that capitation rates in State managed-care contracts must account for it. See *ibid.* ("Any lawsuit before such time would likely have been dismissed for lack of Article III jurisdiction."). But, as petitioners acknowledge, the Providers Fee now no longer exists and injures no one. See Pet. 9 & n.6. Petitioners assert (Pet.

9) that they continue to have a viable claim against the "structure of the [actuarial-]certification [r]ule" itself, on the theory that the rule renders them vulnerable to future fees that Congress may choose to enact and assess against their managed-care organizations. But such speculation about hypothetical future legislation does not preserve a live controversy, much less a practically important one warranting this Court's review.

The only relief that petitioners requested that has not been overtaken by subsequent events is their claim for monetary relief from the federal government for sums that it collected not from petitioners, but from their managed-care organizations. See Pet. App. 8a. But as the government explained in the court of appeals, although the district court granted such relief—in the form of an order of equitable disgorgement of more than $479 million, see *ibid.*—that novel remedy was manifestly improper as a matter of law. The APA's limited waiver of sovereign immunity, 5 U.S.C. 702, expressly excludes "money damages." *Ibid.* That waiver must "be strictly construed, in terms of its scope, in favor of the sovereign." *Department of the Army* v. *Blue Fox, Inc.*, 525 U.S. 255, 261 (1999). It does not plausibly permit the monetary relief petitioners sought here as compensation for increased capitation rates that they paid to third-party managed-care organizations. See Gov't C.A. Br. 42-45.

Accordingly, because petitioners cannot obtain retrospective monetary relief from the federal government to compensate for alleged damages caused by the application of the Providers Fee to their managed-care organizations, it is far from clear what "effectual relief" a federal court could order that would redress their asserted injuries. *Chafin* v. *Chafin*, 568 U.S. 165, 172

(2013) (citation omitted). The court of appeals expressly reserved that question. Pet. App. 29a & n.20. But before this Court could address the merits, it would likely need to confront at the threshold whether the retrospective monetary award that petitioners sought, or any other form of relief, is available that could redress petitioners' putative injuries.

c. Finally, this case would be an unsuitable vehicle for addressing petitioners' nondelegation challenge to the actuarial-certification rule because that claim, like petitioners' statutory challenges to the rule, is time barred by the same six-year limitations period applicable to their other claims. 28 U.S.C. 2401(a).

As discussed above, the court of appeals correctly determined that petitioners' statutory claims challenging the actuarial-certification rule—to which the court referred as petitioners' "APA claims"—were time-barred because petitioners filed their suit 13 years after the rule was adopted in the 2002 Regulation. Pet. App. 14a-16a; see pp. 22-26, *supra*. Although the court of appeals thus correctly rejected petitioners' other claims as untimely, it apparently viewed Section 2401(a)'s limitations period as inapplicable to petitioners' nondelegation challenge to that rule. But Section 2401(a) is equally applicable by its terms to that claim as well. Section 2401(a) encompasses "every civil action commenced against the United States" except those for which the statute expressly provides a different deadline. 28 U.S.C. 2401(a). It is not limited to claims asserting noncompliance with the APA, and it does not exclude claims challenging an agency action on nondelegation or other constitutional grounds. Indeed, the caveat that the court of appeals articulated—which would

allow untimely claims that an "agency exceeded its constitutional or statutory authority" if an additional showing is made, namely, "some direct, final agency action involving the particular plaintiff within six years of filing suit," Pet. App. 14a (citation omitted)—presupposes that the general six-year limitations period applies to constitutional claims, and that an untimely constitutional challenge to a regulation is barred unless a plaintiff identifies a new, direct, and final agency action involving that plaintiff within the six-year limitations period.

In any event, the court of appeals' distinction between petitioners' APA claims and their nondelegation claim overlooks that petitioners' nondelegation claim was also brought expressly under the APA. In asserting that claim, their complaint observed that the APA provides for review of agency action that a court finds to be (*inter alia*) "contrary to constitutional right, power, privilege, or immunity." 5 U.S.C. 706(2)(B); see Am. Compl. ¶ 61 (C.A. ROA 168) (alleging that "[t]he [APA] requires this Court to hold unlawful and set aside any agency action that is 'contrary to constitutional right' or 'in excess of statutory jurisdiction, authority, or limitations'" (quoting 5 U.S.C. 706(2)(B) and (C))). It then proceeded to allege that "[t]he determination that [petitioners] must pay the * * * Providers Fee * * * constitutes an unconstitutional delegation of Congress's legislative power to a private entity." *Id.* ¶ 62 (C.A. ROA 168).

Although the court of appeals assumed without analysis that the limitations period did not bar petitioners' nondelegation challenge, and accordingly reached (and rejected) that claim on the merits, the court's judgment rejecting their nondelegation claim may be affirmed on

the alternative basis that that claim, like petitioners' other claims, was untimely. See, *e.g.*, *Dahda* v. *United States*, 138 S. Ct. 1491, 1498 (2018). Affirmance on that ground would be especially appropriate because, as the court of appeals recognized, the limitations period in actions against the United States conditions the APA's waiver of sovereign immunity and thus is properly addressed at the threshold. Pet. App. 14a. For the reasons explained above, the court of appeals' case-specific, fact-dependent application of the limitations period to the circumstances of this case does not warrant this Court's review. See pp. 22-27, *supra*. At a minimum, the fact that petitioners' nondelegation challenge to the actuarial-certification rule can and should be rejected on that separate ground makes this case an unsuitable vehicle to address their nondelegation challenge.

CONCLUSION

The petition for a writ of certiorari should be denied.

Respectfully submitted.

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