No. 21-___

In the Supreme Court of the United States

THE STATES OF TEXAS, INDIANA, KANSAS, LOUISIANA, AND NEBRASKA, PETITIONERS,

v.

CHARLES P. RETTIG, IN HIS OFFICIAL CAPACITY AS COMMISSIONER OF INTERNAL REVENUE; UNITED STATES OF AMERICA; U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES; U.S. INTERNAL REVENUE SERVICE; XAVIER BECERRA, IN HIS OFFICIAL CAPACITY AS SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES.

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

PETITION FOR A WRIT OF CERTIORARI

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QUESTIONS PRESENTED

In 1981, Congress passed a statute requiring that reimbursement rates paid to managed-care organizations for managing state Medicaid plans be "actuarially sound." In 2002, unable to give that term a prescriptive meaning, the Centers for Medicare and Medicaid Services punted the question to a private group of actuaries. Because "actuarially sound" is not actually a term that actuaries use in their day-to-day practice, that group had no definition either. And that group did not adopt a binding definition to be applied to Medicaid capitation rates until 2015. That definition was then used to foist nearly $500 million of taxes under the Affordable Care Act onto Petitioner-States in only three years. The questions presented are:

(1) Whether an agency rule delegating rulemaking authority to a private entity violates the nondelegation doctrine.

(2) Whether the statute of limitations applicable to a challenge to an agency rule that delegates rulemaking authority to a private entity starts to run when the agency delegates the authority or when the private entity exercises the delegated authority.

PARTIES TO THE PROCEEDING

Petitioners the States of Texas, Indiana, Kansas, Louisiana, and Nebraska were plaintiffs-appellees/cross-appellants in the court of appeals.

Respondent the State of Wisconsin was a plaintiff in the trial court and appellee in the court of appeals but opted not to appeal the district court order.

Respondents Charles P. Rettig, in his official capacity as Commissioner of Internal Revenue; the United States of America; the U.S. Department of Health and Human Services; the U.S. Internal Revenue Service; and Xavier Becerra, in his official capacity as Secretary of the U.S. Department of Health and Human Services were defendants-appellants/cross-appellees in the court of appeals.

RELATED PROCEEDINGS

Texas v. United States, No. 7:15-cv-00151-O, U.S. District Court for the Northern District of Texas. Judgment entered July 30, 2019.

Texas v. United States, No. 4:18-cv-00779-O, U.S. District Court for the Northern District of Texas. Stayed pending resolution of this proceeding.

Texas v. Rettig, No. 18-10545, U.S. Court of Appeals for the Fifth Circuit. Judgment entered July 31, 2020, and revised February 12, 2021. Petition for rehearing en banc denied April 9, 2021.

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OPINIONS BELOW

The order of the court of appeals denying the petition for rehearing en banc (Pet. App. 168a-69a) is reported at 993 F.3d 408 (5th Cir. 2021) (per curiam), and the revised panel opinion (Pet. App. 1a-30a) is reported at 987 F.3d 518 (5th Cir. 2021). The opinion of the district court on the parties' cross-motions for summary judgment (Pet. App. 31a-109a) is reported at 300 F. Supp. 3d 810 (N.D. Tex. 2018), and the opinion of the district court regarding defendants' motion to dismiss (Pet. App. 110a-67a) is available at No. 7:15-cv-00151-O, 2016 WL 4138632 (N.D. Tex. Aug. 4, 2016).

JURISDICTION

The Plaintiff-States invoked federal jurisdiction under 28 U.S.C. §§ 1331, 1361. The Fifth Circuit entered its revised judgment on February 12, 2021, and denied the petition for rehearing en banc on April 9, 2021. The jurisdiction of this Court is invoked under 28 U.S.C. § 1254(1). The petition is timely under this Court's order of July 19, 2021.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

Pertinent constitutional provisions, statutory provisions (including relevant aspects of the Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, 124 Stat. 1029 (Reconciliation Act), the Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 124 Stat. 119 (2010) (ACA)), and regulations (including the Certification Rule, 42 C.F.R. § 438.6 (2002)), are set forth in the appendix to this petition. Pet. App. 189a-200a.

STATEMENT

I. Medicaid and Its Delivery Mechanisms

Since 1965, Medicaid has been the preeminent example of the growth of "cooperative federalism," under which programs are "financed largely by the Federal Government," but "administered by the States." *King v. Smith*, 392 U.S. 309, 316 (1968). Congress has made federal funds available to States to provide medical assistance to certain categories of needy individuals. So long as States meet certain criteria, they have considerable leeway to pursue their own healthcare policy objectives with those funds. 42 U.S.C. § 1396, *et seq*. Because meeting the healthcare needs of their underprivileged citizens is a significant priority for States, Medicaid represents a substantial portion of their overall budgets.[1] For example, since 2015, Texas has spent 25-30% of its budget on Medicaid, of which more than half was received from the federal government. TEX. HEALTH & HUMAN SERVS. COMM'N, TEXAS MEDICAID AND CHIP IN PERSPECTIVE 1-5 (11th ed. 2017), https://tinyurl.com/2c3t8rcp; *compare* Conference Comm. Report, Gen. Appropriations, Tex. S.B. 1, 87th Leg., R.S., art. II (2021), *with id.* at Recapitulation—art. II.

States provide care for Medicaid recipients either through a fee-for-service model or through a managed-care model. In the program's formative years, States relied almost exclusively on a fee-for-service model. ROA.1860.[2] A doctor who treated a Medicaid beneficiary

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[1] *See* U.S. Dep't of Health & Human Servs., *Profiles and Program Features*, https://tinyurl.com/x89yrpnp (last visited Sept. 2, 2021).

[2] Citations to "ROA.XX" refer to the Fifth Circuit Record on Appeal.

would submit a reimbursement request to the state Medicaid agency, and the State would pay the bill after confirming the individual's eligibility and need for the treatment. The State would then seek reimbursement from the federal government for a percentage of the cost, typically on a quarterly basis. MACPAC, *Fact Sheet: The Medicaid Fee-for-Service Provider Payment Process* (July 2018), tinyurl.com/ynmandd5; *cf. Bowen v. Massachusetts*, 487 U.S. 879, 884-85 (1988). This model functions much like the uninsured healthcare market because the State pays nothing for patients who are in good health and faces enormous costs for patients suffering from serious illness or injury who require significant care. It has been criticized for, among other things, leading to "low levels of medical screening, vaccination," and other preventative care. ROA.1860.

In an effort to improve delivery of Medicaid services and control costs, States started transitioning from the fee-for-service model to the managed-care model. ROA.1860. Under this model, States contract with private insurance companies, known as managed-care organizations (MCOs), to coordinate care provided to Medicaid beneficiaries. ROA.3083-84. As with employer-funded health insurance, beneficiaries may choose between preselected options. 42 C.F.R. § 438.52. The State then pays the MCO a monthly premium, known as a "capitation," for each beneficiary, regardless of whether the individual requires care. ROA.3081, 3083-84. Under this model, the MCO rather than the State bears the risk that any individual will require costly forms of care. MCOs are thus incentivized to encourage patients to have a primary-care physician and seek treatment early, rather than wait until they are very sick. ROA.1611-15.

As the United States acknowledged in the court of appeals, MCOs have become the typical method of providing Medicaid services. U.S. Principal C.A. Br. 1. Indeed, promoting this transition has been a goal of policymakers for years in order to (among other things) crack down on payment abuse. Aaron Mendelson, et al., *New Rules for Medicaid Managed Care—Do They Undermine Payment Reform?*, 4 HEALTHCARE 274, 274 (June 7, 2016), https://tinyurl.com/4yufxpts; ROA.1611. And that goal has largely been achieved: as of when this suit was filed, approximately 88% of Texas Medicaid patients were served by MCOs. ROA.284. As of late 2016, 92.5% of Louisiana's Medicaid beneficiaries received services through MCOs. ROA.1889. Other States have similarly high rates of MCO usage. Elizabeth Hinton, et al., *10 Things to Know About Medicaid Managed Care*, KFF: MEDICAID (Oct. 29, 2020), https://tinyurl.com/2hvpb2r2.

II. Adoption and Early Application of the Certification Rule

In 1981, as the managed-care model emerged but before industry norms regarding payment rates developed, Congress imposed several limitations on States' ability to contract with MCOs. Omnibus Reconciliation Act of 1981, Pub. L. No. 97-35, § 2178, 95 Stat. 357, 813-15 (codified at 42 U.S.C. § 1396b(m)(2)(A)(iii)). One such limitation was that payments made under an MCO contract must be "made on an actuarially sound basis." *Id.* Congress has never defined what "actuarially sound" means in this context, and for many years, that term remained undefined even by the actuarial profession. *See* ROA.3197 ("indicating that 'actuarial soundness' is not an actuarial concept, but is a concept imposed by outside

entities").[3] The concept of actuarial soundness, however, is generally designed to ensure that MCOs cover their costs without making excessive returns, thereby protecting both MCOs and taxpayers.

HHS, which oversees the Medicaid program through the Centers for Medicare and Medicaid Services, has struggled to define actuarial soundness with any greater specificity. Until 2002, HHS regulations defined actuarial soundness to mean that payments under an MCO contract could not "exceed the cost . . . of providing those same services on a fee-for-service basis." 42 C.F.R. § 447.361 (repealed 2002). By the late 1990s, however, this system had become unworkable because the managed-care model was so prevalent that existing fee-for-service data was insufficient to allow the comparisons required under the old rule. ROA.471. *Contra* U.S. Principal C.A. Br. 8 (suggesting the change was to allow States additional flexibility).

HHS responded by adopting a new rule that established a certification process for MCO contracts. Initially, the proposed process would have required States to certify that their rates were actuarially sound. ROA.465. Insurance companies objected that this proposed process did not protect their margins. *E.g.*, ROA.665, 672, 679, 681. Other parties objected that HHS should create "prescriptive standards for actuarial soundness." ROA.1411. HHS struggled with how to define "actuarial soundness" for so long that it had to extend the effective date of the regulations, and it drew

[3] *See also, e.g.*, ROA.3188 (acknowledging that "[t]he phrase 'actuarial soundness' has different meanings in different contexts and might be dictated or imposed by an outside entity"); ROA.473 ("[W]e have found that there is no universally accepted definition of the term actuarially sound.").

complaints from members of Congress that it had failed to comply with the APA. ROA.784-89. Needing to define an indeterminate term, HHS punted and decided to outsource its work to the Actuarial Standards Board, a private, standard-setting organization. ROA.1411. And so the Certification Rule was born.

Under the Certification Rule, States must develop rates "in accordance with generally accepted actuarial principles and practices," and the rates must be certified by an "actuar[y] who meet[s] 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) (2002).[4]

The Certification Rule drew immediate fire—including from members of Congress—because it "fails to define ambiguous terms, fails to require provision of necessary information, and generally fails to regulate." ROA.1064. And though the United States has asserted that the Actuarial Standards Board's standards "align[] with HHS Guidance," it has never disputed that the Certification Rule effectively allows the Actuarial Standards Board to set standards by which Medicaid MCO contracts are judged as a matter of federal law. U.S. Principal C.A. Br. 10. And because actuarial certification is required to obtain Medicaid reimbursement, this gives private parties the ability to determine whether States will receive billions of dollars in vital federal funding.

The Certification Rule's requirements, however, remained fundamentally unclear. Though it has informal

[4] Consistent with the parties' practice throughout this litigation, Petitioner-States cite the regulations in effect at the time the operative complaint was filed. The United States has never asserted that subsequent linguistic changes altered the way in which the Certification Rule has been applied.

ways of setting nonbinding guidance, the Actuarial Standards Board promulgates its binding rules through Actuarial Standards of Practice (ASOPs). Unlike informal guidance, an actuary must consider and may be disciplined for "[f]ailure to comply with an applicable ASOP." ROA.1810. But for over a decade after the promulgation of the Certification Rule, there was no ASOP "that applie[d] to actuarial work performed to comply with [HHS]'s regulations." ROA.3087 (2010 GAO Report 10-810). At most, there was a nonbinding 2005 "practice note" that "proposed [a] definition for 'actuarial soundness[]'" because "there was no other working definition of th[at] term." ROA.3087. Under that practice note, actuaries were permitted but not required to consider fourteen separate factors in assessing expected MCO revenues and expenses under contracts with state Medicaid agencies, including any "state-mandated assessments and taxes." ROA.1864-65. Actuaries were advised, however, that their analysis must comport with state and federal law. *E.g.*, ROA.1807. At the time, federal taxes were minor and not separately considered. ROA.2598, 2754.

III. The ACA and HIPF

In 2010, the ACA created the first federal tax on health-insurance premiums. The new tax was highly unusual in that it was not applied to an entity's revenues or net income. Instead, Congress set an annual assessment on the entire health-insurance industry. ACA, Pub. L. No. 111-148, § 9010(b)(1), 124 Stat. 119, 865 (2010); Reconciliation Act, Pub. L. No. 111-152, § 1406(a)(3), 124 Stat. 1029, 1065-66.[5] "Each covered entity engaged in the

[5] The ACA and the Reconciliation Act are functionally the same bill, which was passed in two pieces because the ACA's proponents lost their filibuster-proof majority in the Senate. *See* John Cannan, *A Legislative History of the Affordable Care Act: How Legislative*

business of providing health insurance" then paid the IRS a "fee in an amount determined" by multiplying that assessment by the entity's market share of "premiums written" in the health-insurance market. ACA § 9010(a)(1), (b). This fee (the HIPF) was treated as a nondeductible excise tax for certain tax purposes. *Id.* § 9010(f).

Covered entities included "any entity which provides health insurance" *except* "any government entity." *Id.* § 9010(c)(1), (2)(B); 26 C.F.R. § 57.2(b)(2)(ii)(B). It is undisputed that States are "government entities" for the purpose of this definition. Therefore, under the plain language of section 9010, Congress exempted States from paying the HIPF.

IV. ASOP 49

In March 2015, in response to criticism from the Government Accountability Office, the Actuarial Standards Board finally published a binding definition of "actuarial soundness" applicable specifically to Medicaid MCOs—ASOP 49. ROA.1649-81. ASOP 49 states that an MCO's capitation rate (the monthly premium it receives from a State) is "actuarially sound" only if "projected capitation rates . . . provide for all reasonable, appropriate, and attainable costs," including any "government-mandated assessments, fees, and taxes," ROA.1655, that are not tax deductible, 26 C.F.R. § 57.8. Unlike earlier guidance requiring actuaries to account for federal law, ASOP 49 makes no allowance for the fact that Congress exempted States from paying the HIPF. Instead, due to the well-established structure of the Medicaid MCO market, States had to pay 100% of the HIPF or else fail to comply

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Procedure Shapes Legislative History, 105 L. LIBR. J. 131, 163 (2013).

with the ASOP—and thus with the Certification Rule and the 1981 actuarial-soundness requirement. *E.g.*, ROA.1697-700.

While Petitioner-States' appeal was pending before the Fifth Circuit, Congress repealed the HIPF, effective December 31, 2020. Further Consolidated Appropriations Act, 2020, Pub. L. No. 116-94, § 502, 133 Stat. 2534, 3119. But the unconstitutional structure that allowed private entities to impose the HIPF (and other costs) on States—the Certification Rule—remains. 42 C.F.R. § 438.7 (2021) (requiring certification by an actuary); *id.* § 438.2 (defining actuary as "an individual who meets the qualification standards established by the American Academy of Actuaries for an actuary and follows the practice standards established by the Actuarial Standards Board").

V. Procedural History

In October 2015, Plaintiff-States brought this suit challenging HHS's role in imposing the HIPF via the Certification Rule as unlawful under the APA, ROA.166-69, and the nondelegation doctrine derived from the Constitution's separation of powers, ROA.159-63, 168. They also challenged the imposition of the HIPF as it had been applied to the States, arguing that section 9010 exceeds Congress's spending and taxing powers. ROA.165-66, 168-72. And they sought return of funds unlawfully collected by the IRS between 2014 and 2016. ROA.170-75. Because the HIPF is not currently in effect, this petition focuses on Petitioner-States' challenge to the structure of the Certification Rule.[6]

[6] Petitioner-States disagree with the Fifth Circuit's analysis regarding their remaining claims, but they acknowledge that in light of the subsequent repeal of the HIPF, those claims are likely moot.

In March 2018, the district court held that HHS violated the nondelegation doctrine by allowing a private entity to (1) formulate the standards that determine whether a State may receive Medicaid funding and (2) certify a State's compliance with those standards. Pet. App. 79a-89a. The district court concluded, however, that the Certification Rule as adopted in 2002 was lawful under the APA. Pet. App. 94a-95a. Moreover, the district court said, Congress did not exceed its taxing authority because it was the Actuarial Standards Board's "imposition of the HIPF on Plaintiffs, not the HIPF itself," that caused the alleged injury. Pet. App. 106a. The district court concluded that because the ACA "prohibits [the United States] from collecting the HIPF from the states in the first place," equity requires the IRS to disgorge the nearly $500 million that the Plaintiff-States had been required to pay up to that point. ROA.4411.

On July 31, 2020, a panel of the U.S. Court of Appeals for the Fifth Circuit reversed; the court issued a revised opinion on February 12, 2021, but that opinion did not change the court's holdings. Pet. App. 1a-30a. The Fifth Circuit did not disagree with the district court's holding that a private party may not define "actuarial soundness" for purposes of federal law. But the Fifth Circuit concluded that subsection (C) of the Certification Rule was acceptable because HHS retained significant control over the process—a theory the United States did not press on appeal. Pet. App. 20a-24a. Moreover, the Fifth Circuit held that Plaintiff-States' APA challenges to the Certification Rule were untimely because the Certification Rule was promulgated in 2002, and "HHS took no

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They respectfully request those rulings be vacated under *United States v. Munsingwear, Inc.*, 340 U.S. 36 (1950).

direct, final agency action in 2015 to create a new obligation." Pet. App. 17a.[7]

Petitioner-States timely filed a petition for panel rehearing and rehearing en banc, but the Fifth Circuit denied that petition over the objection of five judges. Pet. App. 168a-90a. In his dissent, Judge Ho explained that the Certification Rule violates the nondelegation doctrine in three different ways:

> (1) It subdelegates substantive lawmaking power, rather than some minor factual determination or ministerial task; (2) the subdelegation is authorized by an administrative agency, rather than by Congress; and (3) the agency is subdelegating power to a private entity, rather than to another governmental entity that is at least minimally accountable to the public in some way.

Pet. App. 173-74a (Ho, J., dissenting). This combination is "uniquely offensive to the Constitution." Pet. App. 173a.

ARGUMENT

Administrative agencies may not punt their obligation—or their power—to create federal law to private entities, regardless of whether defining a particular statutory requirement proves difficult. The Fifth Circuit

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[7] The panel also suggested that the district court and Plaintiff-States were somehow both "confused" about whether the operative complaint had challenged the Actuarial Standards Board's role in setting the rules by which state Medicaid contracts are judged. Pet. App. 5a-6a n.4. Tellingly, however, the United States has *never* asserted any form of waiver argument—either in its principal briefing or in its opposition to rehearing en banc.

incorrectly held that federal administrative agencies can skirt the nondelegation doctrine whenever the delegatee waits out the APA's six-year limitations period before wielding unconstitutionally delegated power. These weighty matters present important federal questions that merit this Court's review. *See* SUP. CT. R. 10(c).

I. The Legality of the Certification Rule Presents an Important Federal Question.

A. This case presents a perfect vehicle for the Court to clarify the scope of the nondelegation doctrine.

This case presents an opportunity to address a vital question of constitutional law: whether a federal agency may delegate to a private party the power to set standards governing the relationship between States and the federal government. This Court has previously granted a petition for a writ of certiorari to determine whether a provision of federal law "effect[ed] an unconstitutional delegation of legislative power to a private entity." Petition for a Writ of Certiorari at I, *Dep't of Transp. v. Ass'n of Am. R.Rs.*, 575 U.S. 43 (*Amtrak*) (2015) (No. 13-1080); *see Dep't of Transp. v. Ass'n of Am. R.Rs.*, 573 U.S. 930 (2014) (granting cert.). But the Court could not reach that issue because the Court determined that the delegatee in question—Amtrak—was actually a public entity. *See Amtrak*, 575 U.S. at 51, 55-56.

This case presents the perfect vehicle to address this issue. There is no dispute that the delegatees here—the Actuarial Standards Board and private actuaries—are private parties. Unlike in *Amtrak*, the party being regulated is a State carrying out its sovereign role of providing healthcare to vulnerable citizens. The delegation at issue affects up to a third of any given State's budget.

And it was not Congress that delegated legislative power to the Actuarial Standards Board and private actuaries: it was HHS. Taken together, the delegation contained in the Certification Rule implicates the nondelegation doctrine rooted in the separation of powers created by the Vesting Clauses of Articles I and II of the Constitution. The Fifth Circuit's approval of this delegation creates a circuit split and warrants this Court's review. *See* SUP. CT. R. 10(a), (c).

B. The nondelegation doctrine prohibits any entity other than Congress from exercising the legislative power of the United States.

Since the Founding, the power to "prescrib[e] the rules by which the duties and rights of every citizen are to be regulated" has belonged to Congress. THE FEDERALIST No. 78, at 465 (Hamilton) (C. Rossiter ed., 1961); *see Fletcher v. Peck*, 10 U.S. (6 Cranch) 87, 136 (1810). "Accompanying that assignment of power to Congress is a bar on its further delegation. Congress, this Court explained early on, may not transfer to another branch 'powers which are strictly and exclusively legislative.'" *Gundy v. United States*, 139 S. Ct. 2116, 2123 (2019) (plurality op.) (quoting *Wayman v. Southard*, 23 U.S. (10 Wheat.) 1, 42-43 (1825)).

1. Because "tak[ing] Care that the Laws be faithfully executed," U.S. CONST. art. II, § 3, can—indeed must—require the exercise of some judgment about what the law means, this Court has permitted Congress to empower the Executive to do three things: (a) perform nonlegislative tasks, (b) "fill up the details" of how a statute functions on a day-to-day basis, *Wayman*, 23 U.S. (10 Wheat.) at 43, and (c) find that the law has been triggered by "certain fact[s] being established," *Miller v. Mayor of N.Y.*, 109 U.S. 385, 393 (1883).

The scope of these authorities, however, is delimited by the fact that the Framers' understanding "that it would frustrate 'the system of government ordained by the Constitution' if Congress could merely announce vague aspirations and then assign others the responsibility of adopting legislation to realize its goals." *Gundy*, 139 S. Ct. at 2133 (Gorsuch, J., dissenting) (quoting *Marshall Field & Co. v. Clark*, 143 U.S. 649, 692 (1892)).

This "nondelegation principle can be traced to John Locke's *Second Treatise*, which was deeply influential on the Founding generation." Ilan Wurman, *Nondelegation at the Founding*, 130 YALE L.J. 1490, 1518 (2021); *see also Gundy*, 139 S. Ct. at 2133 (Gorsuch, J., dissenting). As Locke explained:

> The legislative cannot transfer the power of making laws to any other hands; for it being but a delegated power from the people, they who have it cannot pass it over to others. . . . [W]hen the people have said we will submit to rules, and be governed by laws made by such men, and in such forms, nobody else can say other men shall make laws for them; nor can the people be bound by any laws but such as are enacted by those whom they have chosen and authorised to make laws for them.

Gundy, 139 S. Ct. at 2133-34 (Gorsuch, J., dissenting) (quoting JOHN LOCKE, SECOND TREATISE § 141, at 71). Moreover, the Framers understood that these boundaries must be maintained because "[t]he accumulation of all powers, legislative, executive, and judiciary, in the same hands . . . may justly be pronounced the very definition of tyranny." THE FEDERALIST No. 47, at 301 (Madison).

2. Properly applying these limitations, Congress likely could not delegate the authority to define "actuarially sound" to HHS in the first instance. Unlike other vague standards that have been upheld, the "boundaries of [the Executive's] authority" are not defined elsewhere in the statute, *Gundy*, 139 S. Ct. at 2129 (plurality op.), customary practice, *Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 472-73 (2001), or common law, *cf. A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 531-32 (1935). Indeed, the Actuarial Standards Board officially stated in 2013 that actuarial soundness "has different meanings in different contexts," ROA.3667, because "'actuarial soundness' is not an actuarial concept," ROA.3676. A term that is not used in the relevant field hardly provides a discernible standard to the Executive.

In the Fifth Circuit, the United States insisted that such delegation was necessary because "actuarial soundness" is simply a technical term. U.S. Principal C.A. Br. 32-33. This justification is, however, precisely what Justice Scalia warned about when he said that allowing Congress to delegate its lawmaking powers will make such delegations "much more attractive" to Congress "in the future." *Mistretta v. United States*, 488 U.S. 361, 422 (1989) (Scalia, J., dissenting):

> If rulemaking can be entirely unrelated to the exercise of judicial or executive powers, I foresee all manner of "expert" bodies, insulated from the political process, to which Congress will delegate various portions of its lawmaking responsibility. How tempting to create an expert Medical Commission (mostly M.D.'s, with perhaps a few Ph.D.'s in moral philosophy) to dispose of such thorny, "no-win" political issues as the

> withholding of life-support systems in federally funded hospitals, or the use of fetal tissue for research.

Id. Setting the rules by which Medicaid is governed is just such a thorny political question. Allowing Congress to punt it to an executive agency "is an undemocratic precedent." *Id.*

Instead, our system makes passing legislation difficult *by design* in order to force legislators to "promote fair notice and the rule of law, ensuring the people would be subject to a relatively stable and predictable set of rules." *Gundy*, 139 S. Ct. at 2134 (Gorsuch, J., dissenting) (citing THE FEDERALIST No. 62, at 378-80 (Madison)). If Congress could do no better than to "le[ave] the matter to the President ... to be dealt with as he pleased," *Pan. Ref. Co. v. Ryan*, 293 U.S. 388, 418 (1935), then Congress could not condition States' receipt of Medicaid funds on MCOs having actuarially sound capitation rates.

But this case presents an easier question because regardless of whether Congress could allow the Executive to define "actuarial soundness," the Executive could not re-delegate that authority to the private Actuarial Standards Board.

C. The nondelegation doctrine prohibits private parties from making federal law.

Even if Congress did not violate the Constitution by relying on HHS to define "actuarial soundness," HHS's decision to give the reins to a private party to determine the scope of that term—and thereby dictate what States must do to receive Medicaid funding—violated the nondelegation doctrine.

1. This Court has permitted delegation to some extent to "other branches of Government [that] have vested

powers of their own that can be used in ways that resemble lawmaking." *Amtrak*, 575 U.S. at 61 (Alito, J., concurring). "When it comes to private entities, however, there is not even a fig leaf of constitutional justification." *Id.* at 62. Indeed, the United States has previously "accept[ed] that Congress 'cannot delegate regulatory authority to a private entity.'" *Id.* at 61. And for good reason: the Constitution does not vest private entities with "legislative Powers," U.S. CONST. art. I, § 1, *or* the "executive Power," *id.* art. II, § 1, cl. 1. As Justices Alito and Kennedy have noted, even the creation of citizen suits "raises '[d]ifficult and fundamental questions'" because it allows private parties to exercise some aspect of the Executive's power to enforce the law. *Amtrak*, 575 U.S. at 62 (Alito, J., concurring) (quoting *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs. (TOC), Inc.*, 528 U.S. 167, 197 (2000) (Kennedy, J., concurring)). And "[a] citizen suit to enforce existing law ... is nothing compared to delegated power to create new law." *Id.*

Such a "[d]elegation of legislative power to private entities is 'unknown to our law' and 'utterly inconsistent with the constitutional prerogatives and duties of Congress.'" Pet. App. 173a (Ho, J., dissenting) (quoting *Schechter Poultry*, 295 U.S. at 537). "It is a fundamental principle that no branch of government can delegate its constitutional functions to an actor who lacks authority to exercise those functions." *Wellness Int'l Network, Ltd. v. Sharif*, 575 U.S. 665, 700-01 (2015) (Roberts, C.J., dissenting) (citing *Whitman*, 531 U.S. at 472; *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936)). "Such delegations threaten liberty and thwart accountability by empowering entities that lack the structural protections the Framers carefully devised." *Id.* (citing *Amtrak*, 575 U.S. at 60-62 (Alito, J., concurring); *id.* at 66-68 (Thomas, J.,

concurring in judgment); *Mistretta*, 488 U.S. at 417-22 (Scalia, J., dissenting)).

2. The delegation in this case is particularly problematic because it directly impinges upon state sovereignty. This Court long ago called "power conferred" on one private entity to regulate another "delegation in its most obnoxious form." *Carter*, 298 U.S. at 311 ("[O]ne person may not be [e]ntrusted with the power to regulate the business of another, and especially of a competitor."). If a private party regulating a private party is constitutionally "most obnoxious," *id.*, authorizing a private entity to regulate a sovereign State is constitutionally repugnant.

This Court has held that not even Congress may interfere directly with state sovereignty because to do so would blur lines of accountability. *Printz v. United States*, 521 U.S. 898, 920 (1997) (citing *inter alia New York v. United States*, 505 U.S 144, 168-69 (1992)). Allowing legislative power to be placed "in purely private hands, wholly unaccountable to the people," is even more contrary to our constitutional system. Pet. App. 170a (Ho, J., dissenting). It "devalues the right to vote and desecrates the entire premise of our constitutional democracy—that our laws are supposed to be written by members of Congress elected by the American people, not by private interests pursuing unknown private agendas." Pet. App. 170a.

D. The Certification Rule impermissibly delegates authority to make federal law to a private party.

Because the Certification Rule purports both to make the Actuarial Standards Board's standards binding federal law and to give private actuaries the authority to approve—or reject—a proposed capitation rate, the rule is

an unconstitutional delegation of power to a private entity.

Petitioner-States do not dispute that under the nondelegation doctrine, Congress may condition the effect of its legislation on the acquiescence of disinterested groups of affected private parties, as the Court recognized in *Currin v. Wallace*, 306 U.S. 1 (1939), and *United States v. Rock Royal Co-op., Inc.*, 307 U.S. 533 (1939). The lower courts also agree that this Court's caselaw permit agencies to "employ private entities for *ministerial* or *advisory* roles, but [agencies] may not give these entities governmental power over others," even if the entities are disinterested. *Pittston Co. v. United States*, 368 F.3d 385, 395 (4th Cir. 2004) (citing *United States v. Frame*, 885 F.2d 1119, 1129 (3d Cir. 1989)). But private entities' roles in giving content to and applying the Certification Rule is far from ministerial or advisory.

The Certification Rule requires capitation rates to be approved by an actuary who "follow[s] the practice standards established" by the Actuarial Standards Board. 42 C.F.R. § 438.6(c) (2002). In other words, the rule delegates the authority to set the standards for approving capitation rates to the Actuarial Standards Board, and it also delegates the task of approving a given capitation rate to a private actuary who is required to apply those standards. Moreover, "there is no agency review of capitation rates unless and until they are approved by the private actuaries." Pet. App. 179a (Ho, J., dissenting).

As a result of this highly unusual regulatory structure, HHS has final review of a State's MCO rates, but "before [HHS] even *begins* to exercise its own judgment," private parties must "apply the Board's private standards and determine that a capitation rate is *not*

actuarially sound." Pet. App. 179a. If the private actuary determines that the State's rates do *not* comply with the Board's standards, "the agency's review process ends before it ever begins." Pet. App. 179a. As a result, "HHS neither sets the regulatory standard nor exercises final authority over the application of that standard." Pet. App. 179a. Private actuaries "act as veto-gates that categorically preclude agency review—whether it's review of the 'actuarially sound' standard itself, the determination that a capitation rate complies with that standard, or both." Pet. App. 180a.

The Fifth Circuit insisted that this process was permitted by *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381 (1940). *See* Pet. App. 21a-24a (panel op.). But in *Adkins*, "it was Congress itself, not the agency, that enlisted the assistance of private parties in rulemaking. As [the D.C. Circuit] has noted, '*Adkins* . . . affirmed a modest principle: *Congress* may formalize the role of private parties in proposing regulations.'" Pet. App. 183a (Ho, J., dissenting) (quoting *Ass'n of Am. R.Rs. v. U.S. Dep't of Transp.*, 721 F.3d 666, 671 (D.C. Cir. 2013) (emphasis added), *rev'd on other grounds by Amtrak*, 575 U.S. 43). *Adkins* thus provides no support for "allow[ing] an agency—already acting pursuant to delegated power—to *re*-delegate that power out to a private entity." Pet. App. 184a.

More fundamentally, HHS does not retain final reviewing authority over the standards promulgated by the Actuarial Standards Board, nor has HHS retained the power to approve an MCO contract that has not been certified by a private actuary under the Certification Rule. *But see* Pet. App. 19a-21a (panel op.). Instead, "HHS has delegated to the Board the power to *define* actuarial soundness. And that power is reviewable only

in the sense that the agency can amend or repeal the Certification Rule altogether." Pet. App. 184a-85a (Ho, J., dissenting). HHS does not retain any other authority to depart from the standards set by the Board. And refusal by an actuary to provide the necessary certification "can prevent a state's capitation rate and associated MCO contract from ever reaching CMS for review." Pet. App. 185a. In essence, as Judge Ho explained, HHS has not "continue[d] to exercise oversight" over the Board's actions; "[i]t just made a one-time decision to hand the private parties a blank check." Pet. App. 186a.

This Court has never permitted a private party such control over whether States receive billions of dollars in federal funds. *Supra* p. 17-18. This is also far beyond the scope of power that other courts of appeals have read this Court's precedents to permit agencies to delegate to private parties. *Cf. Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1488 (9th Cir. 1992) (approving delegation because an agency actor "retains ultimate authority to issue the regulation"); *Cospito v. Heckler*, 742 F.2d 72, 89 (3d Cir. 1984) (application of accreditation standards).

It does not, as the Fifth Circuit reasoned, satisfy the nondelegation doctrine that "HHS could achieve *exactly the same result* by promulgating regulations that adopted the substance of the . . . Board's Standards," Pet. App. 21a. Indeed, that argument misses the point: the nondelegation doctrine is not about whether any given substantive policy was correct—only whether it was adopted by the correct policymaker. In other words, that HHS did not "promulgat[e] regulations that adopted the substance of the Board's Standards," *id.*, *is the constitutional problem*, *see Whitman*, 531 U.S. at 472-73 (discussing the need for Congress to make

significant decisions); *Schechter Poultry*, 295 U.S. at 531-32 (same).

And this procedural point is important: "when it comes to the Constitution and the separation of powers, the ends do not justify the means." Pet. App. 188a n.5 (Ho, J., dissenting). "[E]nforcing the separation of powers"—or federalism for that matter—"isn't about protecting institutional prerogatives or governmental turf." *Gundy*, 139 S. Ct. at 2135 (Gorsuch, J., dissenting). It is about "secur[ing] to citizens the liberties that derive from the diffusion of sovereign power," *New York*, 505 U.S. at 181, and "respecting the people's sovereign choice to vest the legislative power in Congress alone," *Gundy*, 139 S. Ct. at 2135 (Gorsuch, J., dissenting).

"[M]ajor national policy decisions must be made by Congress and the President in the legislative process, not delegated by Congress to the Executive Branch." *Paul v. United States*, 140 S. Ct. 342, 342 (2019) (Kavanaugh, J., statement respecting the denial of certiorari). And they certainly should not be made by a group of actuaries who are accountable to no one. *See Carter*, 298 U.S. at 311. This Court should grant the Petitioner-States' petition for a writ of certiorari to address the Certification Rule's unconstitutional delegation of federal lawmaking power to private parties.

E. The Fifth Circuit's decision creates a split among the circuits on when and how agencies may delegate authority to private parties.

In upholding the Certification Rule, the Fifth Circuit split from the D.C. and Second Circuits. This creates an

important constitutional issue that warrants this Court's attention. *See* SUP. CT. R. 10(c).[8]

1. The Fifth Circuit split from the D.C. Circuit's decision in *U.S. Telecom Ass'n v. FCC*, 359 F.3d 554 (D.C. Cir. 2004), about the role that private parties can play in a federal agency's approval process. "*Telecom* makes clear that any 'subdelegation[] to outside parties [is] assumed to be improper absent an affirmative showing of congressional authorization.'" Pet. App. 178a (Ho, J., dissenting) (alterations in original) (quoting *Telecom*, 359 F.3d at 565). Neither the Fifth Circuit nor the United States claimed any such congressional authorization for the Certification Rule.

Instead, the Fifth Circuit cited *Telecom* for the proposition that an agency may "reasonabl[y] condition" federal approval on an outside party's determination of some issue if there is a "reasonable connection between the outside entity's decision and the federal agency's determination." Pet. App. 181a (Ho, J., dissenting) (alteration in original) (first quoting Pet. App. 19a (panel op.), then quoting *Telecom*, 359 F.3d at 567). "But *Telecom* limited this principle to *governmental* conditions—determinations by 'state, local, or tribal government[s].'" Pet. App. 179a (Ho, J., dissenting) (quoting *Telecom*, 359 F.3d at 567). This principle applies very narrowly

[8] This is particularly true as the United States has insisted that the Certification Rule is no different from any number of other regulations that supposedly allow private parties to set federal law. U.S. C.A. Resp. Br. 37-38. Assuming this is correct, the need for clarification is that much more urgent. "Past practice does not, by itself, create power." *Medellin v. Texas*, 552 U.S. 491, 532 (2008) (cleaned up). But past exercise of power that does not exist shows a need for this Court's intervention.

because it serves only to avoid "wast[ing] agency resources on futile approvals." Pet. App. 182a.

In other words, *Telecom* allows a federal agency to condition federal approval on the approval of a state, local, or tribal government when the approval of such a government is independently required for the regulated party to engage in the contemplated activity. *See Telecom*, 359 F.3d at 567 (citing *United States v. Matherson*, 367 F. Supp. 779, 782-83 (E.D.N.Y. 1973), *aff'd* 493 F.2d 1339 (2d Cir. 1974); *S. Pac. Transp. Co. v. Watt*, 700 F.2d 550, 556 (9th Cir. 1983)).

"The situation here could not be more different. The private Board and private actuaries would have no say at all in the approval of capitation rates or MCO contracts but for HHS's decision to hand them its rulemaking and review powers in the first place." Pet. App. 182a (Ho, J., dissenting); *see also* Pet. App. 182a-83a ("HHS has not only 'delegated to another [private] actor almost the entire determination of whether a specific statutory requirement . . . has been satisfied,'—it has even granted a private party the power to *define* the statutory requirement in the first place." (alterations in original) (quoting *Telecom*, 359 F.3d at 567)).

The Certification Rule thus does not involve the type of "reasonable condition" on federal approval that the D.C. Circuit contemplated in *Telecom*, 359 F.3d at 567, or that the Ninth Circuit encountered in *Southern Pacific Transportation Co. v. Watt*, 700 F.2d 550 (9th Cir. 1983). To the contrary, the Certification Rule impermissibly delegates rulemaking and permitting authority to private parties. By upholding the Certification Rule, the Fifth Circuit discarded a key limitation on the narrow principal the D.C. Circuit invoked in *Telecom*: that an administrative agency may not condition federal approval

on the approval of an outside entity unless that entity's approval is independently required. Moreover, that outside entity must be a government entity. In doing so, the Fifth Circuit split with the D.C. Circuit. This Court should resolve that split. *See* SUP. CT. R. 10(a).

2. The Fifth Circuit also split with the Second Circuit about the extent to which an agency can delegate its rulemaking and approval authority by ruling that the Certification Rule was somehow a permissible delegation because a State can petition HHS to amend or repeal the rule. *See* Pet. App. 22a n.13 (panel op.). That ruling stands in stark contrast with the Second Circuit's decision in *Fund for Animals v. Kempthorne*, 538 F.3d 124 (2d Cir. 2008). There, the Second Circuit recognized that "[i]f all it reserves for itself is 'the extreme remedy of totally terminating the [delegation agreement],' an agency abdicates its 'final reviewing authority.'" *Id.* at 133 (citation omitted).

The Fifth Circuit's divergence from the Second Circuit on this issue warrants this Court's review. "After all, any agency can always claw back its delegated power by issuing a new rule." Pet. App. 186a (Ho, J., dissenting). Indeed, "by [the Fifth Circuit's] logic, *any* agency subdelegation of rulemaking power is permissible." Pet. App. 186a. Such a rule "would render the nondelegation doctrine a dead letter." Pet. App. 187a. It would be the equivalent of saying "that Congress can never violate the nondelegation doctrine, because the American people can always petition Congress to pass a new law and claw back its lawmaking power from an agency." Pet. App. 187a.

Because the Fifth Circuit's decision creates splits with both the D.C. and Second Circuits, this Court should grant the Petitioner-States a writ of certiorari to

address the manner and extent to which federal agencies can delegate their rulemaking and approval authority to private parties.

II. The Fifth Circuit's Dismissal of Petitioner-States' APA Challenges as Time-Barred Warrants This Court's Review.

This Court should also grant review of the Fifth Circuit's conclusion that Petitioner-States' challenge to the Certification Rule is time-barred because the Actuarial Standards Board waited more than six years to exercise the power that HHS improperly delegated to it. Because the Fifth Circuit's decision declaring this challenge time-barred allows agencies and private parties to shield such unconstitutional delegations from judicial and creates a circuit split, that decision warrants this Court's review. *See* SUP. CT. R. 10(a), (c).

A. The Fifth Circuit's ruling creates a trap that allows agencies to evade judicial review of unlawful actions.

In addition to their constitutional claims, Plaintiff-States brought both substantive and procedural APA challenges to the application of the HIPF to States through the Certification Rule. States' Principal C.A. Br. 37-44. The Fifth Circuit concluded that these challenges were time-barred because it viewed the only relevant agency action as the promulgation of the Certification Rule itself in 2002. Pet. App. 15a-17a (panel op.). The Fifth Circuit's opinion creates a trap for States and improperly shields federal administrative agencies from judicial review. This Court should grant the petition for a writ of certiorari to address this important issue about the availability of review for unconstitutional agency delegations.

There are two basic problems with the Certification Rule: it allows a private party to issue binding federal law, and it allows the agency to exceed its statutory power by imposing a tax on States from which they were exempted, ACA § 9010(c)(2)(B).[9] The Certification Rule created the possibility of such injuries when it was promulgated in 2002. But there was no binding definition of "actuarial soundness"—and thus arguably no injury from the improper delegation—until 2015. ROA.3087. And there was no HIPF—and therefore certainly no injury from improper application of the HIPF—until at least 2010.[10] Any lawsuit before such time would likely have been dismissed for lack of Article III jurisdiction. *See Lopez v. City of Houston*, 617 F.3d 336, 341-42 (5th Cir. 2010). And now, under the Fifth Circuit's rule, lawsuits after these events are time-barred.

Such a rule encourages unlawful behavior. As a matter of administrative law, it is improper for an executive agency to adopt a placeholder rule that requires additional substantive rules to give it practical meaning. *E.g.*, *United States v. Picciotto*, 875 F.2d 345, 347-48 (D.C. Cir. 1989). Yet, according to the Fifth Circuit, there is nothing that a regulated party may do about it so long as the agency takes more than six years to give that rule

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[9] Though the HIPF is not currently in effect, the federal government could impose any number of new obligations on States by imposing them on MCOs and then forcing States to pay for them through the Certification Rule. Under the Fifth Circuit's view, the States would be able to do nothing about it because the Certification Rule *still* would have been promulgated more than six years ago.

[10] The HIPF went into effect in fee year 2014, 26 C.F.R. § 57.4(a)(3), but was assessed based on an insurer's market share the previous year. ACA § 9010(b). Regardless, Plaintiff-States brought suit less than six years after the HIPF became effective.

content. That is not the law in other circuits, which recognize that "[a] plaintiff cannot be expected to anticipate all possible future challenges to a rule and bring them within six years of the rule's promulgation, before a later agency action applying the earlier rule leads to an injury." *Cal. Sea Urchin Comm'n v. Bean*, 828 F.3d 1046, 1049-50 (9th Cir. 2016). The Fifth Circuit's contrary rule creates a circuit split this Court should resolve. *See* SUP. CT. R. 10(a).

B. The Fifth Circuit's ruling is incorrect and inconsistent with how other courts of appeals have analyzed the finality of agency actions.

This Court should grant review of the Fifth Circuit's dismissal of the Petitioner-States' APA claims because the Fifth Circuit's conclusions are inconsistent with the record, with the Fifth Circuit's own opinion (and other Fifth Circuit opinions), and with how other courts have defined final agency action.

No one disputes that APA claims are subject to a six-year statute of limitations. 28 U.S.C. § 2401(a). Any challenge to the procedures by which the rule was adopted thus became untimely in 2008. *Wind River Mining Corp. v. United States*, 946 F.2d 710, 715 (9th Cir. 1991); *Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985).[11] States may still challenge the legality of the Certification Rule, however, if it has been applied to them within the last six years. *See, e.g.*, *Dunn-McCampbell Royalty*

[11] Petitioner-States were unable to find any caselaw from this Court that directly addressed this question. Given the frequency of APA claims, the absence of governing authority about when such actions accrue is itself reason to grant review. SUP. CT. R. 10(c). As does the amount of money in question. STEPHEN M. SHAPIRO, ET AL., SUPREME COURT PRACTICE 269-70 (10th ed. 2013).

Interest, Inc. v. Nat'l Park Serv., 112 F.3d 1283, 1287 (5th Cir. 1997).

The Fifth Circuit acknowledged that this law applies. Pet. App. 15a. The Fifth Circuit acknowledged that HHS reviewed Petitioner-States' Medicaid contracts using the Certification Rule within six years of when Petitioner-States filed their original complaint. *See* Pet. App. 14a-15a. And the Fifth Circuit acknowledged that CMS issued a 2015 guidance document instructing States to comply with ASOP 49 going forward. Pet. App. 17a; *see* ROA.3243. The district court concluded that these were final agency actions restarting the statute of limitations. Pet. App. 70a-73a. In particular, the guidance document removed any discretion that actuaries and States previously had to exclude the HIPF from States' capitation rates. Pet. App. 72a-73a. The Fifth Circuit disagreed because, in its view, "[a]ctuarially sound capitation rates have consistently required" the States to account for the HIPF since 2002. Pet. App. 17a. The approval of the contracts themselves, the Fifth Circuit concluded, also failed to restart the clock because HHS's actions neither created new legal obligations nor bound Petitioner-States. Pet. App. 16a.

The Fifth Circuit's decision on this issue has four major flaws.

First, the record belies the Fifth Circuit's conclusion. The Certification Rule was adopted in 2002 specifically because HHS was not able to promulgate "prescriptive standards" of "actuarial soundness" in this context. ROA.1411. Its reliance on the Actuarial Standards Board drew immediate criticism from members of Congress for the agency's "fail[ure] to define ambiguous terms, fail[ure] to require provision of necessary information, and general[] fail[ure] to regulate." ROA.1064. The GAO

similarly criticized HHS in 2010 for lack of a "working definition" of actuarial soundness "that applie[d] to actuarial work performed to comply" with the Certification Rule. ROA.3087. It was only in response to the GAO's criticism that HHS demanded that the Actuarial Standards Board adopt what became ASOP 49. ROA.3162.

Second, the Fifth Circuit's conclusion is inconsistent with other portions of its own opinion. In addressing Petitioner-States' standing, the Fifth Circuit recognized that ASOP 49 removes any discretion about *how* the rates account for the HIPF. Pet. App. 13a. That is, before ASOP 49 actuaries had some discretion regarding if and how much of the HIPF would be transferred to States. ROA.2592 (stating only that "the fee may be considered"). Defendants' own expert admitted that following ASOP 49, actuaries had no discretion. *See* ROA.1694. States had to either pay 100% of the HIPF, *e.g.*, ROA.1732, 1797, 2072, or forfeit Medicaid funding, 42 C.F.R. § 438.6 (2002). The same action that conferred standing also represented a final action for the purposes of the statute of limitations. *Cf. U.S. Army Corps of Eng'rs v. Hawkes Co.*, 136 S. Ct. 1807, 1813-15 (2016) (holding that final jurisdictional determinations issued by the Army Corps of Engineers are final agency actions).

Third, the Fifth Circuit's decision creates intra-Circuit disagreement. Indeed, just last year in *Texas v. EEOC*, 933 F.3d 433 (5th Cir. 2019), the Fifth Circuit held that an agency guidance document that "withdraws an entity's previously-held discretion . . . alters the legal regime, binds the entity, and thus qualifies as final agency action." *Id.* at 442 (quoting *Scenic Am., Inc. v. U.S. Dep't of Transp.*, 836 F.3d 42, 56 (D.C. Cir. 2016)). Such an action restarts the limitations period. *Dunn-*

McCampbell, 112 F.3d at 1287; *Louisiana v. U.S. Army Corps of Eng'rs*, 834 F.3d 574, 583 (5th Cir. 2016).

Fourth, and most importantly, the Fifth Circuit's decision created conflict with decisions from this Court, *Hawkes*, 136 S. Ct. at 1813-15, and other circuit courts, *e.g.*, *Cal. Sea Urchin Comm'n*, 828 F.3d at 1049-50; *Nat'l Envtl. Dev. Ass'ns Clean Air Project v. EPA*, 752 F.3d 999, 1003 (D.C. Cir. 2014). Such conflicts merit review by this Court to ensure the APA's finality requirements remain "'flexible' and 'pragmatic.'" *Qureshi v. Holder*, 663 F.3d 778, 781 (5th Cir. 2011) (quoting *Abbott Labs. v. Gardner*, 387 U.S. 136, 149-50 (1967)).

CONCLUSION

The petition for a writ of certiorari should be granted. The Court should consider Petitioner-States' challenge to the Certification Rule and reverse the Fifth Circuit on the merits. The Fifth Circuit's rulings regarding the HIPF statute should be vacated.

Respectfully submitted.

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APPENDIX

APPENDIX A

REVISED February 12, 2021
IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

United States Court of Appeals
Fifth Circuit
FILED
April 6, 2021
Lyle W. Cayce
Clerk

No. 18-10545

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

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 7:15-CV-151

Before BARKSDALE, HAYNES, and WILLETT, Circuit Judges.

HAYNES, Circuit Judge:

We withdraw our prior opinion of July 31, 2020, *Texas v. Rettig*, 968 F.3d 402 (5th Cir. 2020), and substitute the following.

This case involves constitutional challenges to Section 9010 of the Affordable Care Act (the "ACA") and statutory and constitutional challenges to a U.S. Department of Health and Human Services ("HHS") administrative rule (the "Certification Rule"). Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska (the "States") sued the United States and its relevant agencies and officials (collectively, the "United States"), claiming that the Certification Rule and Section 9010 were unlawful. Both parties moved for summary judgment, and the district court granted both motions in part. The parties then cross-appealed. On the jurisdictional claims, we AFFIRM the district court's ruling that the States had standing, but we REVERSE the district court's ruling that the States' Administrative Procedure Act ("APA") claims were not time-barred and DISMISS those claims for lack of jurisdiction. On the merits, we AFFIRM the district court's judgment on the Section 9010 claims; however, we REVERSE the district court's judgment that the Certification Rule violated the nondelegation doctrine and RENDER judgment in favor of the United States. Because we hold that neither the Certification Rule nor Section 9010 are unlawful, we VACATE the district court's grant of equitable disgorgement to the States.

I. Background

A. Regulatory Background

In 1965, the Medicaid Act[1] "established the Medicaid program as a joint Federal and State program for providing financial assistance to individuals with low incomes to enable them to receive medical care." *See* Medicaid Program; Medicaid Managed Care: New Provisions, 67 Fed. Reg. 40,989, 40,989 (June 14, 2002) [hereinafter "2002 Final Rule"]. The federal government "provid[es] matching funds to State agencies to pay for a portion of the costs of providing health care to Medicaid beneficiaries."[2] *Id.*

States have two options for providing care to Medicaid beneficiaries: a "fee-for-service" model and a managed-care model. *Id.* Under the fee-for-service model, a doctor who treats a Medicaid beneficiary submits a reimbursement request to the state Medicaid agency. *Id*. The state pays the bill after confirming the individual's eligibility and need for service. *See id*. Then the state seeks reimbursement from the federal government for a percentage of the cost. *See* 42 U.S.C. § 1396b(a).

Under the more widely used managed-care model, the state pays a third-party health insurer ("managed-care organization" or "MCO") a monthly premium (the "capitation rate") for each Medicaid beneficiary the MCO covers, and the MCO provides care to the beneficiary. 2002 Final Rule, 67 Fed. Reg. at 40,989.

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[1] 42 U.S.C. §§ 1396–1396w-5.

[2] Medicaid beneficiaries are those "individuals eligible for and receiving Medicaid benefits." 2002 Final Rule, 67 Fed. Reg. at 40,989.

States may receive reimbursement from the federal government for some percentage of the capitation rate so long as the underlying MCO contract is "actuarially sound." *See* 42 U.S.C. § 1396b(m)(2)(A)(iii).

As states began moving away from the fee-for-service model, HHS recognized that its definition of "actuarial soundness"—based on the cost of services under a fee-for-service model—was untenable. *See* 2002 Final Rule, 67 Fed. Reg. at 41,000 (stating that "there [was] an increasing number of States that lack[ed] recent [fee-for-service] data to use for rate setting"). It thus promulgated a final rule redefining "actuarial soundness" in 2002. *Id.* at 41,079–80 (redefining "actuarial soundness"). Under this new rule, capitation rates must satisfy three requirements to be actuarially sound. First, the rates must "[h]ave been developed in accordance with generally accepted actuarial principles and practices," 42 C.F.R. § 438.6(c)(1)(i)(A) (2002), which,[3] as explained by the actuarial office within HHS that reviews state-MCO contracts, requires accounting for all reasonable, appropriate, and attainable costs. Second, the rates must be "appropriate for the populations to be covered, and the services to be furnished under the contract." *Id.* § 438.6(c)(1)(i)(B). Third, the rates must satisfy the Certification Rule;[4] that

[3] In 2016, HHS recodified the actuarial soundness requirements and the Certification Rule in 42 C.F.R. §§ 438.2, 438.4(a). Because the States challenge the 2002 version of the Certification Rule, which was in effect in 2015, and because the definitions relevant to the States' claims are unchanged, we follow the district court and the parties in discussing this version of the regulation.

[4] The Certification Rule at issue here is solely 42 C.F.R. § 438.6(c)(1)(i)(C), the certification component of the actuarial soundness definition. The States' operative complaint and motion

is, they must "[h]ave been certified, as meeting the requirements of this [provision], by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board [(the "Board")]." *Id.* § 438.6(c)(1)(i)(C).

In 2010, Congress enacted the ACA, comprised by the Patient Protection and Affordable Care Act ("PPACA"), Pub. L. No. 111-148, 124 Stat. 119 (2010), and the Health Care and Education Reconciliation Act of 2010 ("HCERA"), Pub. L. No. 111-152, 124 Stat. 1029 (2010). The ACA made two changes to the regulatory scheme requiring states that requested Medicaid reimbursements for their MCO contracts to provide actuarially sound capitation rates. First, Congress imposed a new cost on certain MCOs: a federal health-insurance provider tax (the "Provider Fee"). *See* PPACA § 9010, 124 Stat. at 865, *amended by* PPACA § 10905, 124 Stat. at 1017, *amended by* HCERA § 1406, 124 Stat. at 1066.[5] This Provider Fee must be paid annually by covered entities—"any entity which provides health

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for summary judgment objected to only that subsection. They made no mention of the other requirements. Moreover, in a motion for leave to file a second amended complaint, the States specified that the Certification Rule defined actuarial soundness as meeting the actuarial standards set by a private association of actuaries.

We clarify this point because the district court incorrectly determined that the Certification Rule at issue encompassed all three requirements. *See Texas v. United States (Texas I)*, 300 F. Supp. 3d 810, 822 (N.D. Tex. 2018). On appeal, the States also seem to have confused which HHS regulation they were contesting, first referring to only subsection (c)(1)(i)(C) but later lumping in subsection (A) as well.

[5] Section 9010 has not been codified in the United States Code and thus does not exist in one consolidated location.

insurance for any United States health risk," excluding governmental entities.[6] *Id.* § 9010(c)(1), (c)(2)(B), 124 Stat. at 866. Second, Congress amended the Medicaid Act to expressly require that capitation rates included in state-MCO contracts be actuarially sound. *Id.* § 2501(c)(1)(C), 124 Stat. at 308; 42 U.S.C. § 1396b(m)(2)(A)(xiii) ("[C]apitation rates . . . shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates[.]"). What remained unchanged was that actuarially sound capitation rates required accounting for all reasonable, appropriate, and attainable costs. Thus, when the Internal Revenue Service (the "IRS") began collecting the Provider Fee from covered entities in 2014, *see* PPACA § 9010(a), 124 Stat. at 865, states with MCO contracts were required to account for the Provider Fee to meet the actuarial soundness requirement of the Medicaid Act, *see* 42 U.S.C. § 1396b(m)(2)(A)(iii).

In 2015, the Board, an independent organization that sets appropriate standards for actuarial practices in the United States, published *Actuarial Standard of Practice 49: Medicaid Managed Care Capitation Rate Development and Certification* ("ASOP 49"). ACTUARIAL STANDARDS BD., ACTUARIAL STANDARD OF PRACTICE NO. 49: MEDICAID MANAGED CARE CAPITATION RATE DEVELOPMENT AND CERTIFICATION (2015) [hereinafter ASOP 49]. ASOP 49 provides

[6] There is an exclusion for governmental entities, "except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323." PPACA § 9010(c)(2)(B), 124 Stat. at 866. However, this exception is not relevant here.

"guidance for actuaries preparing, reviewing, or giving advice on capitation rates for Medicaid programs, including those certified in accordance with 42 CFR 438.6(c)." *Id.* at iv. Medicaid capitation rates are actuarially sound if they "provide for all reasonable, appropriate, and attainable costs," which "include . . . government-mandated assessments, fees, and taxes." *Id.* at 2.

In summary, for states to receive federal reimbursement under the managed-care model, their MCO contracts must be approved by HHS as actuarially sound. *See* 42 U.S.C. § 1396b(m)(2)(A)(iii); 42 C.F.R. § 438.6(c)(1)(i). To be actuarially sound, the capitation rate must account for all costs MCOs bear when providing care to Medicaid beneficiaries. *See* 2002 Final Rule, 67 Fed. Reg. at 41,000. When Congress enacted the ACA in 2010, the amount of money states paid MCOs as part of their capitation rate changed: In contracts with MCOs subject to the Provider Fee, states must account for the Provider Fee in their capitation rate to satisfy HHS's actuarial-soundness requirement. ASOP 49 states that the "costs" include government-mandated taxes. ASOP 49 at 2.

B. Procedural Background

The States sued the United States, claiming that the Certification Rule and Section 9010 were unconstitutional and/or unlawful. *See Texas v. United States* (*Texas I*), 300 F. Supp. 3d 810, 820 (N.D. Tex. 2018). Regarding the Certification Rule, they claimed that the rule violated the nondelegation doctrine from Article I, section 1, of the U.S. Constitution and that HHS violated the APA on multiple grounds. *See id.* at 826. Regarding Section 9010, they claimed that the

statute violated the Spending Clause of the U.S. Constitution and the doctrine of intergovernmental tax immunity under the Tenth Amendment. *See id.* at 826, 854.

Both parties moved for summary judgment. *See id.* at 826. The United States argued that the States lacked Article III standing for their claims, the States' APA claims were time-barred, and the States' arguments failed on the merits. *See id.* The district court granted both parties' motions in part. *Id.* at 821. It held that the States had standing and that their APA claims were not barred by the six-year statute of limitations. *Id.* at 834, 840. On the merits of the States' Certification Rule claims, the district court held that the rule violated the nondelegation doctrine but otherwise complied with the APA. *Id.* at 848, 850–851. On the merits of the States' Section 9010 claims, the district court held that Congress did not violate the Spending Clause or the Tenth Amendment. *Id.* at 854, 856.

The district court thus set aside the Certification Rule. *Id.* at 856–57. It then granted the States equitable disgorgement of their Provider Fee payments under the APA, resulting in a final judgment against the United States for more than $479 million. *See Texas v. United States*, 336 F. Supp. 3d 664, 675 (N.D. Tex. 2018). Both parties timely appealed.

II. Standard of Review

We review a district court's grant of summary judgment de novo. *Amerisure Ins. Co. v. Navigators Ins. Co.*, 611 F.3d 299, 304 (5th Cir. 2010). "On cross-motions for summary judgment, we review each party's motion independently, viewing the evidence and inferences in the light most favorable to the nonmoving party." *Id.*

(citation omitted). Summary judgment is proper when "there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a).

III. Discussion

The parties contest the constitutionality and lawfulness of the Certification Rule and the constitutionality of Section 9010. We hold that both the Certification Rule and Section 9010 are constitutional and lawful; as a result, there can be no equitable disgorgement, regardless of whether such a remedy would be otherwise appropriate. We address each issue in turn.

A. The Certification Rule Claims

The States' challenge to the Certification Rule is based upon a sequence of events they allege is impermissible. Through the Certification Rule, HHS gave authority to the Board to promulgate binding rules through Actuarial Standards of Practice ("ASOPs"). Before it published ASOP 49 in 2015, the Board provided only a nonbinding "practice note" that permitted, but did not require, actuaries to consider fourteen separate factors in assessing expected MCO revenues and expenses under contracts with state Medicaid agencies, including any "state-mandated assessment and taxes." MEDICAID RATE CERTIFICATION WORK GROUP, ACTUARIAL STANDARDS BD., ACTUARIAL CERTIFICATION OF RATES FOR MEDICAID MANAGED CARE PROGRAMS 8–9 (2005). According to the States, ASOP 49 introduced the requirement that actuarially sound capitation rates account for government-

mandated taxes.[7] The States thus contend that the Certification Rule unlawfully delegates to the Board the task of formulating, and making binding decisions about the applicability of, rules governing States' access to Medicaid funds. The States further argue that HHS's incorporation of ASOP 49 in the Certification Rule violated the APA in two respects: (1) the rule exceeded HHS's statutory authority, and (2) HHS adopted the rule without notice and comment.

The United States contends that we lack jurisdiction because the States lack standing to challenge the Certification Rule and because their APA claims were barred by the statute's six-year statute of limitations. On the merits, the United States argues that the States' Certification Rule challenges are premised on a misunderstanding of Section 9010 and the Certification Rule. It claims that the Board did not change the definition of actuarial soundness, but instead HHS permissibly chose to incorporate the Board's guidance on the subject.

Thus, at issue here are two jurisdictional questions: whether the States have standing and, if so, whether their APA claims are time-barred. If we have jurisdiction, we must next address the parties' merits claims: whether the Certification Rule violates the nondelegation doctrine, and whether HHS violated the APA. We hold that the States have standing for their Certification Rule claims but that their APA claims are

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[7] This is an incorrect statement of the facts. HHS's Office of the Actuary stated that actuarially sound capitation rates have consistently required that all reasonable appropriate, and attainable costs be covered by rates which includes all taxes, fees, and assessments.

time-barred which, in this context, is a jurisdictional issue. We therefore address the merits of only the States' nondelegation argument and hold that the Certification Rule is constitutional.

1. Standing

To satisfy Article III's standing requirement, plaintiffs must demonstrate (1) an injury that is (2) fairly traceable to the defendant's allegedly unlawful conduct and that is (3) likely to be redressed by the requested relief. *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 560–61 (1992). "The party invoking federal jurisdiction bears the burden of establishing these elements." *Id.* at 561 (citations omitted). At the summary judgment stage, plaintiffs "must set forth by affidavit or other evidence specific facts, which . . . will be taken to be true," to support each element. *Id.* (internal quotation marks and citation omitted). If one plaintiff has standing for a claim, then Article III is satisfied as to all plaintiffs. *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006) (citations omitted). We review standing issues de novo. *Nat'l Rifle Ass'n of Am., Inc. v. McCraw*, 719 F.3d 338, 343 (5th Cir. 2013) (citation omitted).

Accepting their factual allegations, summarized above, as true, we hold that the States satisfy the three requirements for standing. First, the States alleged a particular injury in fact: having to pay millions of dollars in Provider Fees despite the ACA's explicit exemption for governmental entities. Second, the States' injury is arguably traceable to the Certification Rule. They contend that before the Board published ASOP 49, which is applied to the States via the Certification Rule, actuaries were advised that their capitation rate analysis must comport with state and federal law and that before

Congress enacted the ACA, federal taxes were minor and not separately considered. ASOP 49, the States say, required them to pay the Provider Fee as part of their actuarially sound capitation rates. Though the facts underlying this argument of how the capitation rates worked under the Certification Rule before and after ASOP 49 are contested, we assume the States' view of the facts to be true for purposes of standing. *See Lujan*, 504 U.S. at 561. The attacks on ASOP 49, which have been applied to the States through the Certification Rule, are the core of this argument. Third, the States have alleged that their injury is likely to be redressed by invalidating the Certification Rule. They allege that before ASOP 49's adoption and application to the States via the Certification Rule, states still had the legal option to exclude the Provider Fee from capitation rates in their contracts with MCOs. Thus, they argue that in the rule's absence, states could not lose Medicaid funding for refusing to pay the Provider Fee "by virtue of that rule." *See Larson v. Valente*, 456 U.S. 228, 242 (1982) (holding that setting aside an allegedly unlawful statutory provision that compels plaintiffs to register and report redresses the plaintiffs' alleged injury of registering and reporting because, even though the plaintiffs could be compelled to register and report through another statutory provision, they will no longer be compelled to do so under the statutory provision at issue). Were we to rule in their favor, the Certification Rule would be invalidated and ASOP 49's explicit requirement to pay the Provider Fee would be removed.

The United States counters that the States' injury would not be redressed by invalidating the Certification Rule because States are required to account for the

Provider Fee under 42 U.S.C. § 1396b(m)(2)(A)(iii). Indeed, as the United States notes, the States were still required to account for the Provider Fee under § 1396b after the district court invalidated the Certification Rule. Notably, the States don't challenge § 1396b here.[8]

However true the United States's argument may be, the invalidation of the Certification Rule (and thereby, the removal of requiring compliance with ASOP 49) nonetheless would remove one explicit requirement to pay the Provider Fee. To be sure, the States may still be required to pay the Provider Fee under § 1396b, but this statutory injury is not complained of here. *Barrett Comput. Servs., Inc. v. PDA, Inc.*, 884 F.2d 214, 218 (5th Cir. 1989) ('[S]tanding concerns the right of a party to bring a *particular* suit." (emphasis added)). Here, the States allege they were directly forced to pay the Provider Fee per ASOP 49 and the Certification Rule. *Larson*, 456 U.S. at 242–43 (finding standing when appellants contested a "rule [that] was the sole basis for" the "discrete injury" that "gave rise to the present suit"). As such, the States attack an injury caused by the Certification Rule. Therefore, though the States may still have to pay the Provider Fee under § 1396b, success here will nonetheless remove one of two legal barriers to defeating this obligation—in other words, the States will no longer "be required to [pay the Provider Fee] by virtue of [ASOP 49 and the Certification Rule]." *Id.* at 242. Taking the States' factual allegations to be true, *see*

[8] The States have filed a second lawsuit, this time claiming that § 1396b(m)(2)(A)(iii) is being improperly interpreted and seeking to enjoin the IRS from collecting the Provider Fee from them. Complaint at 15, *Texas v. United States* (*Texas II*), No. 4:18-CV-00779 (N.D. Tex. Sept. 20, 2018), ECF No. 1.

Lujan, 504 U.S. at 561, we conclude that the States have alleged that the injury complained of in this case is redressable with a favorable decision. In sum, we hold that the States have standing to raise their Certification Rule claims. (Again, focusing solely on whether, assuming the facts in the States' favor, there is a traceable, redressable injury in fact.)

2. Statute of Limitations

However, we lack jurisdiction to address the States' APA claims because they are time-barred. APA challenges are governed by 28 U.S.C. § 2401(a), which provides that "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." The United States enjoys sovereign immunity unless it consents to suit, "and the terms of its consent circumscribe our jurisdiction." *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1287 (5th Cir. 1997) (citation omitted). "The applicable statute of limitations is one such term of consent," so, unlike the ordinary world of statutes of limitations, here the failure to sue the United States within the limitations period deprives us of jurisdiction. *Id.*

HHS published the Certification Rule in 2002, thirteen years before the States filed their complaint. *See* 2002 Final Rule, 67 Fed. Reg. at 40,989. However, 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. To sustain such a challenge, the claimant must show some direct, final agency action involving the particular plaintiff within six years of filing suit." *Dunn-McCampbell*, 112 F.3d at 1287. An agency's action is

direct and final when two criteria are satisfied. "First, the action must mark the 'consummation' of the agency's decisionmaking process." *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997) (citation omitted). "[S]econd, the action must be one by which rights or obligations have been determined, or from which legal consequences will flow." *Id.* at 178 (quotation omitted). These rights, obligations, or legal consequences must be new. *Nat'l Pork Producers Council v. U.S. E.P.A.*, 635 F.3d 738, 756 (5th Cir. 2011).

The district court concluded that HHS took three "direct, final agency actions" in 2015 against the States and that those actions triggered a new six-year statute of limitations period. *Texas I*, 300 F. Supp. 3d at 839 (citation omitted). But, as the United States argues, none of these actions were direct and final.

First, the district court pointed to a 2015 letter sent by HHS to the Texas Medicaid Director approving Texas's amended MCO contract, which included Provider Fees in the capitation rates for additional groups of Medicaid beneficiaries. *Id.* This letter does not show that HHS was issuing a new ruling requiring Texas to include Provider Fees in its capitation rates. Further, Texas paid costs associated with Provider Fees for the 2013 calendar year even though the 2015 letter applied only from May 1, 2015 to August 31, 2015. Thus, even before the letter, Texas accounted for the Provider Fee in its capitation rates. The letter did not mark a change to Texas's obligation under the Certification Rule.

Second, the district court stated that the government's collection of the Provider Fee through the States' 2015 capitation rate constituted direct, final agency action. *Id.* But, as explained above, the IRS does

not collect the Provider Fee directly from states. The government's decision to collect from MCOs is not a "direct . . . action involving the [States]." *See Dunn-McCampbell*, 112 F.3d at 1287. As such, this argument does not support the district court's conclusion.

Third, the district court stated that HHS's 2015 guidance document "for use in setting [capitation] rates . . . for any managed care program subject to the actuarial soundness requirements" obligated the States to include the cost of the Provider Fee in their capitation rate calculations in 2015. *Texas I*, 300 F. Supp. 3d at 839–40 (citation omitted). Once again, the guidance document did not create any new obligations or consequences; it restated that for capitation rates to be actuarially sound, they had to be consistent with ASOPs, including ASOP 49. But this requirement has existed since HHS promulgated the Certification Rule. *See* 2002 Final Rule, 67 Fed. Reg. at 41,097 (requiring that capitation rates be "certified . . . by actuaries who . . . follow the practice standards established by the Actuarial Standards Board"). The publication of ASOP 49 in 2015 did not create any new obligation or legal consequence either. Actuarially sound capitation rates have consistently required that all reasonable, appropriate, and attainable costs be covered by rates; this includes all taxes, fees, and assessments.

We conclude that HHS took no direct, final agency action in 2015 to create a new obligation. The States identified no other such action that occurred after 2009 (when the six-year statute of limitations expired). We thus reverse the district court's judgment on the States' APA claims and dismiss those claims as time barred.

3. Nondelegation Doctrine

Because we lack jurisdiction over the States' APA claims, the only claim we address on the merits is whether HHS unlawfully delegated authority to the Board when it promulgated the Certification Rule. The United States argues that the Certification Rule was not an unlawful delegation because HHS simply "prescribed the conditions" necessary to receive federal funds. *See Currin v. Wallace*, 306 U.S. 1, 16 (1939) (brackets omitted). The States disagree, arguing that the Certification Rule impermissibly gave the Board and its actuaries—private actors—a discretionary veto over HHS's approval of States' Medicaid contracts, as well as the power to define the content of a federal law as it applies to someone else. The district court held that the Certification Rule unlawfully vested in the Board and its actuaries the legislative power to set rules on actuarial soundness and to veto executive action that does not comply with such rules. *Texas I*, 300 F. Supp. 3d at 843–48. We hold that it did not.

A federal agency may not "abdicate its statutory duties" by delegating them to a private entity. *See Sierra Club v. Lynn*, 502 F.2d 43, 59 (5th Cir. 1974). But an agency does not improperly subdelegate its authority when it "reasonabl[y] condition[s]" federal approval on an outside party's determination of some issue; such conditions only amount to legitimate requests for input. *See, e.g., U.S. Telecom Ass'n v. FCC*, 359 F.3d 554, 566–67 (D.C. Cir. 2004). Therefore, the primary inquiry here is whether HHS's requirements—that state-MCO contracts be certified by a qualified actuary and that the Board's practice standards be followed—were

reasonable conditions for approving the contracts. *See id.* at 567.

A condition is reasonable if there is "a reasonable connection between the outside entity's decision and the federal agency's determination." *Id.* By way of example, the Third Circuit has upheld a U.S. Department of Homeland Security's ("DHS's") regulation requiring H-2B visa employers to first obtain a temporary labor certification from the U.S. Department of Labor ("DOL"). *La. Forestry Ass'n v. Sec'y U.S. Dep't of Labor*, 745 F.3d 653, 672–73 (3d Cir. 2014). In so doing, the Third Circuit observed that there was a reasonable connection in DHS conditioning an H-2B visa on a certification from DOL: Congress charged DHS with admitting aliens into the United States to perform temporary work that cannot be performed by unemployed persons in this country, *id.* at 672 (citing 8 U.S.C. §§ 1101(a)(15)(H)(ii)(b), 1184(c)(1)), and DOL could help in that analysis by bringing to bear its "institutional expertise in labor and employment matters," *La Forestry Ass'n*, 745 F.3d at 673.[9]

[9] The Tenth Circuit, in an unpublished opinion, held opposite to the Third Circuit and concluded that DHS subdelegated authority to DOL. G.H. *Daniels III & Assocs., Inc. v. Perez*, 626 F. App'x 205, 211 (10th Cir. 2015). It determined that DOL's certification was not a condition for granting agency approval because DOL has the final say when it denies a certification. *Id.* But that is the nature of conditions: any condition, if not satisfied, prevents federal approval. By the Tenth Circuit's logic, it seems that every third-party condition for granting federal agency approval is a subdelegation. That result is impossible to square with the very existence of a condition analysis. *See U.S. Telecom*, 359 F.3d at 565–68. The Third Circuit's reasoning is therefore more persuasive.

The Certification Rule's conditions for actuarial soundness, like the DHS conditions addressed by the Third Circuit,[10] are reasonable. Congress requires capitation rates to be actuarially sound, as defined by HHS. *See* 42 U.S.C. § 1396b(m)(2)(A)(xiii). HHS imposed the Certification Rule as a condition for actuarial soundness. 42 C.F.R. § 438.6(c)(1)(i)(C). Certification by a qualified actuary who applies the Board's standards is reasonably connected to ensuring actuarially sound rates because the Board and a qualified actuary have institutional expertise in actuarial principles and practices. Indeed, HHS simply incorporated the Board's actuarial standards into its Certification Rule, a common and accepted practice by federal agencies. *See Am. Soc'y for Testing & Materials v. PublicResourceOrg, Inc.*, 896 F.3d 437, 442 (D.C. Cir. 2018) (noting that federal agencies have incorporated by reference over 1,200 standards established by private organizations);[11] *Amerada Hess Pipeline Corp. v. F.E.R.C.*, 117 F.3d 596, 601 (D.C. Cir. 1997) (holding that a federal agency did not abdicate its authority by adopting generally accepted accounting principles, noting that it would be anomalous to accord agency deference when an agency invented

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[10] Although the Certification Rule differs from the DHS condition in Louisiana Forestry insofar as the Certification Rule incorporates the standards of and requires approval by private entities, this private/public distinction is not relevant to our analysis. *See U.S. Telecom*, 359 F.3d at 566 (rejecting the argument that the "limitations on an administrative agency's power to subdelegate might be less stringent if the delegee is a sovereign entity rather than a private group"). *Louisiana Forestry* therefore remains on-point and instructive.

[11] Therefore, accepting the States' argument would jeopardize over a thousand regulations promulgated by federal agencies.

standards but not when an agency's expertise led the agency to incorporate standards endorsed by experts in the field). Thus, as the United States remarked, "HHS could achieve *exactly the same result* by promulgating regulations that adopted the substance of the . . . Board's standards." Accordingly, we hold that the Certification Rule's actuarial certification requirement and incorporation of the Board's practice standards are reasonable conditions, not subdelegations of authority.

But, even assuming arguendo that HHS subdelegated authority to private entities, such subdelegations were not unlawful. Agencies may subdelegate to private entities so long as the entities "function subordinately to" the federal agency and the federal agency "has authority and surveillance over [their] activities." *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 399 (1940); *cf. Lynn*,[12] 502 F.2d at 59 (holding that total delegation or "rubber stamping" is impermissible). An agency retains final reviewing authority if it "independently perform[s] its reviewing, analytical and judgmental functions." *Lynn*, 502 F.2d at 59. We have therefore held, for instance, that a federal agency's requirement that depreciation expenses reflect "state regulator approved depreciation rates" was not an unlawful subdelegation because the agency "exercised its role when it initially reviewed and accepted the . . .

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[12] *See also R.H. Johnson & Co. v. SEC*, 198 F.2d 690, 695 (2d Cir. 1952) (holding that an agency did not unconstitutionally subdelegate powers to a private entity because the agency retained power to approve or disapprove rules and to review disciplinary actions); *Nat'l Park & Conservation Ass'n v. Stanton*, 54 F. Supp. 2d 7, 19 (D.D.C. 1999) ("Delegations by federal agencies to private parties are, however, valid so long as the federal agency or official retains final reviewing authority." (citations omitted)).

incorporati[on] [of] the state agencies' depreciation rates."[13] *La. Pub. Serv. Comm'n v. F.E.R.C.*, 761 F.3d 540, 551–52 (5th Cir. 2014). The D.C. Circuit has even come to similar results with respect to approvals hinging on the work of private actuarial entities like those at issue in this case. *Tabor v. Joint Bd. for Enrollment of Actuaries*, 566 F.2d 705, 708 & n.5 (D.C. Cir. 1977) (holding that an agency may subdelegate certain components of actuary certification for administering federal pension plans to a private agency because the certification process was "superintended by the [agency] in every respect," insofar as the agency ultimately certified each actuary).[14]

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[13] We also noted that the federal agency would "continue to exercise oversight of the state rates in a Section 206 complaint proceeding," which provides that any entity that wants to change the depreciation rates may seek modification with the agency through a Section 206 filing. *La. Pub. Serv. Comm'n*, 761 F.3d at 552. States retain a similar recourse here: any state dissatisfied with the Board's practice standards can petition HHS for "amendment[] or repeal" of the Certification Rule's requirement that the Board's practice standards be followed. *See* 5 U.S.C. § 553(e).

[14] Applying similar reasoning, the D.C. Circuit also upheld an agency regulation that permitted nonprofit organizations to stage political candidacy debates so long as they "use[d] pre-established objective criteria to determine which candidates may participate in a debate." *Perot v. FEC*, 97 F.3d 553, 556, 559–60 (D.C. Cir. 1996) (per curiam) (quoting 11 C.F.R. § 110.13). Although the agency gave private entities "the latitude to choose their own 'objective criteria,'" such private entities acted at their peril if they did not first secure an agency advisory opinion that their criteria were satisfactory. *Perot*, 97 F.3d at 560. The court thus determined that "[t]he authority to determine what the term 'objective criteria' means rest[ed] with the agency" and held that the agency did not unconstitutionally subdelegate legislative authority. *Id.*

Here, HHS's subdelegation of certain actuarial soundness requirements to the Board did not divest HHS of its final reviewing authority. HHS "reviewed and accepted" the Board's standards. *See La. Pub. Serv. Comm'n*, 761 F.3d at 552; *accord* 2002 Final Rule, 67 Fed. Reg. at 40,998. Further, HHS has the ultimate authority to approve a state's contract with MCOs; certification is a small part of the approval process. To obtain HHS approval of its capitation rate for reimbursement purposes, a state sends its MCO contract to the appropriate HHS Regional Office. If the state provides all required documentation, the Office of the Actuary ("OACT"), an office within HHS, will begin its actuarial review. OACT reviews the contract by looking at all of the assumptions, data, and methodology in the rate certification to ensure the certification is consistent with actuarial principles and methods. If OACT determines that the capitation rates are actuarially sound, it will write a memo confirming this conclusion and send the contract to HHS's Center for Medicaid and CHIP (Children's Health Insurance Program) Services[15] for final review. The Center will then review the rate certification and OACT's memo and approve the contract if it finds no issues. The contract approval process is closely "superintended by [HHS] in every respect." *See Tabor*, 566 F.2d at 708 n.5. Therefore, even assuming arguendo that HHS subdelegated certain actuarial

[15] The Center for Medicaid and CHIP Services is the component of HHS that is "responsible for the various components of policy development and operations for Medicaid, [CHIP], and the Basic Health Program . . . ." *See Organization*, CTRS. FOR MEDICARE & MEDICAID SERVS., http://www.medicaid.gov/about-us/organization/index.html (last visited July 17, 2020). In that regard, the Center oversees state-MCO contract approvals.

soundness requirements to third parties, we hold that HHS's subdelegations were lawful.

B. Section 9010 Claims[16]

The States raise two constitutional challenges against Section 9010. They claim that it violates the Spending Clause and the Tenth Amendment doctrine of intergovernmental tax immunity. We address each claim in turn and hold that Section 9010 does not violate either constitutional provision.

1. Spending Clause

The parties contest whether the Spending Clause applies to Section 9010 at all. The United States argues that Section 9010 is instead a constitutional tax that Congress imposed under its taxing power, which fully resolves the Spending Clause claim. The States argue that the Provider Fee, as applied to them, functions as a condition on spending and thus implicates the Spending Clause. We hold that the Provider Fee is a constitutional tax that fully resolves the States' Spending Clause claim and does not impose a condition on spending.

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[16] While the United States does not contest standing on this, we note that the States have standing for their Provider Fee claims. *See Adarand Constructors, Inc. v. Mineta*, 534 U.S. 103, 110 (2001) (per curiam) (citation omitted) (holding that courts must examine standing sua sponte if it has erroneously been assumed below). The States allege that they were injured when they were forced to pay the Provider Fee. This injury is traceable to the United States's allegedly unlawful conduct of enforcing Section 9010 after Congress imposed the Provider Fee as part of the ACA. *See* PPACA § 9010(a), 124 Stat. at 865. Invalidating the Provider Fee would thus redress the States' claimed injury.

For a payment requirement to qualify as a tax, it must "produce[] at least some revenue for the Government." *Nat'l Fed'n of Indep. Bus. v. Sebelius* (*NFIB*), 567 U.S. 519, 564 (2012). In addition, the Supreme Court has identified three factors to be considered in determining whether a payment requirement is a tax rather than a penalty: (1) whether the tax is enforced by the IRS; (2) whether the tax "impose[s] an exceedingly heavy burden"; and (3) whether the tax has a scienter requirement, which is typical of a penalty. *Id.* at 565–66. The Provider Fee produces revenue for the United States and satisfies at least two of the three factors.[17] The Provider Fee is enforced by the IRS, *see* 26 C.F.R. § 57.8, and applies to any covered entity regardless of scienter, PPACA § 9010(a), 124 Stat. at 865. Indeed, several Supreme Court justices have noted that the Provider Fee is a tax. *See NFIB*, 567 U.S. at 694, 698 (Scalia, Kennedy, Thomas & Alito, JJ., dissenting) (identifying Section 9010 as an "excise tax"). So have the parties.

Section 9010's constitutionality as a legitimate tax fully resolves the States' Spending Clause claim. *See id.* at 561, 563 (holding that even though the ACA's individual mandate was unconstitutional under the Commerce Clause, it would uphold the mandate if it were constitutional under the taxing clause). Although the States argue that Section 9010 imposes a condition on their Medicaid funding, we conclude that it does not. *See*

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[17] The record does not indicate what percentage of a covered entity's net revenue is allocated to paying the Provider Fee. Thus, we cannot evaluate whether the Provider Fee "impose[s] an exceedingly heavy burden," *see NFIB*, 567 U.S. at 565, but the absence of such evidence does not support the States' argument.

PPACA § 9010(a), 124 Stat. at 865. The specific Medicaid funding condition that the States contest is in the Medicaid Act. 42 U.S.C. § 1396b(m)(2)(A)(iii) (requiring that for states to receive Medicaid reimbursement, their expenditures "for payment . . . under a prepaid capitation basis . . . for services provided by any entity . . . [must be] made on an actuarially sound basis"). The States do not contest the constitutionality of this section,[18] and they thus do not have a Spending Clause claim. In sum, we hold that the Provider Fee is a constitutional tax that does not violate the Spending Clause.

2. Tenth Amendment—Intergovernmental Tax Immunity

Although a constitutional tax properly enacted through Congress's taxing power is generally not subject to other constitutional provisions, the Tenth Amendment doctrine of intergovernmental tax immunity imposes two limitations when the federal government imposes an indirect tax, like Section 9010, on states. *See South Carolina v. Baker*, 485 U.S. 505, 523 (1988).[19] First, the tax must not discriminate against states or those with whom they deal. *Id.*

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[18] Indeed, they conceded as much at oral argument.

[19] A tax is imposed directly on states only "when the levy falls on the [states themselves], or on an agency or instrumentality so closely connected to" the states that the agency or instrumentality cannot be viewed as separate from the states. *Baker*, 485 U.S. at 523 (internal quotation marks and citation omitted). MCOs are not so closely connected to the states that they cannot be viewed as separate from them. *See* PPACA § 9010(c)(1), 124 Stat. at 866 (defining a "covered entity" as "any entity which provides health insurance for any United States health risk").

Second, the "legal incidence" of the tax may not fall on states. *United States v. Fresno Cty.*, 429 U.S. 452, 459 (1977). We hold that Section 9010 satisfies both requirements.

a. Discrimination Against Entities

The Provider Fee is nondiscriminatory because it is imposed on "any entity which provides health insurance," subject to certain non-state-based exclusions. PPACA § 9010(c), 124 Stat. at 866. It does not impose the Provider Fee on only states, nor on only those MCOs that deal with states. Thus, there is no unlawful discrimination, meaning MCOs contracting with states may impose "part or all of the financial burden" of the Provider Fee on the States. *See Baker*, 485 U.S. at 521 (citations omitted).

The States make two arguments on this point, both of which are misplaced. First, the States argue that the Provider Fee discriminates against them because states are the only entities that run Medicaid programs and are the only government entities that stand to lose their exemption under Section 9010(c)(2)(B) as a result of the actuarial-soundness requirement. But the discrimination inquiry asks who Congress targets, not who ultimately bears the economic burden of paying the tax. *See id.* (stating that the Supreme Court has "completely foreclosed any claim that the nondiscriminatory imposition of costs on private entities that pass them on to States . . . unconstitutionally burdens state . . . functions"); *Washington v. United States*, 460 U.S. 536, 543–44 (1983) (holding that the discrimination analysis does not consider whether the tax burden would necessarily shift to state actors).

Second, the States argue that the Provider Fee discriminates against them because the fee has a disproportionate economic impact on them. They claim that because their contracts with MCOs have historically low profit margins, the MCOs pass the entire economic burden of the Provider Fee on to the states. They thus argue that states shoulder a harsher economic burden than other MCOs, which could afford to pay a portion of the Provider Fee.

Washington, which the States cite as support, holds that whether an unfair economic burden is discriminatory depends on "the whole tax structure of the state." 460 U.S. at 545 (citation omitted). In that case, the Supreme Court held that the state's tax did not single out contractors who worked for the United States for discriminatory treatment because the "tax on federal contractors [was] part of the same [tax] structure, and imposed at the same rate, as the tax on the transactions of private landowners and contractors." *Id.* Here, the Provider Fee is similarly imposed at the same rate for all entities, so there is no unfair economic burden. *See* PPACA § 9010(b)(1), 124 Stat. at 865. We thus hold that the Provider Fee is nondiscriminatory.

b. Legal Incidence

We also hold that the legal incidence of the Provider Fee does not fall on states. Legal incidence is determined by the "clear wording of the statute," not "by who is responsible for payment to the state of the exaction." *United States v. State Tax Comm'n of Miss.*, 421 U.S. 599, 607–08 (1975) (cleaned up). For example, a state tax statute that directs each vendor in the state to "add to the sales price and [to] collect from the purchaser the full amount of the tax imposed" is a statute that "imposes the

legal incidence of the tax upon the purchaser" because the text of the statute indisputably provides that the tax "must be passed on to the purchaser." *First Agric. Nat'l Bank of Berkshire Cty. v. State Tax Comm'n*, 392 U.S. 339, 347 (1968) (citations omitted).

Here, as the States concede, Congress did not intend to tax States because the statute's "clear wording" shows that Congress clearly and expressly excluded states from the Provider Fee. *See* PPACA § 9010(c)(2)(B), 124 Stat. at 866; *accord State Tax Comm'n of Miss.*, 421 U.S. at 607. It is also clear and "indisputable" that Section 9010 "by its terms" does not pass on the Provider Fee to states. *See First Agric. Nat'l Bank*, 392 U.S. at 347. Thus, the legal incidence of the Provider Fee does not fall on states.

The States misunderstand the meaning of legal incidence. They argue that the legal incidence falls on them because all of the economic burden of the Provider Fee is charged to the States. But, as stated above, the question is not who practically bears the responsibility for paying the tax. *See State Tax Comm'n of Miss.*, 421 U.S. at 607–08; *see also Baker*, 485 U.S. at 521 (citations omitted) (upholding a nondiscriminatory tax collected from private parties as constitutional "even though . . . all of the financial burden f[ell] on the other government"). The States also argue that because the legal consequence of not paying the Provider Fee falls on them, so too does its legal incidence; if they do not pay the Provider Fee, then they lose Medicaid funding. Assuming arguendo that the States' interpretation of healthcare law is correct, the Supreme Court explicitly held that legal incidence is not defined as "the legally enforceable, unavoidable liability for nonpayment of [a]

tax." *State Tax Comm'n of Miss.*, 421 U.S. at 607 (citation omitted).

In sum, we conclude that the Provider Fee does not discriminate against states or those with whom they deal because it is imposed on any entity that provides health insurance (with certain exclusions). We also conclude that the legal incidence of the Provider Fee does not fall on the states because Congress expressly excluded states from paying the fee. Accordingly, we hold that Section 9010 does not violate the Tenth Amendment doctrine of intergovernmental tax immunity.

IV. Conclusion

For the foregoing reasons, we AFFIRM the district court's ruling that the States had standing. But we REVERSE the district court's ruling that the States' APA claims were not time-barred and DISMISS the States' APA claims for lack of jurisdiction. On the merits, we AFFIRM the district court's judgment that Section 9010 does not violate the Spending Clause or the Tenth Amendment, but we REVERSE the district court's judgment that the Certification Rule violates the nondelegation doctrine and RENDER judgment in favor of the United States. We thus VACATE the district court's grant of equitable disgorgement,[20] as there is nothing to remedy

[20] Therefore, we do not reach the issues surrounding the validity of such a remedy in this context.

APPENDIX B

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

STATE OF TEXAS, et al.,	§	
	§	
Plaintiffs,	§	
	§	
v.	§	**Civil Action**
	§	**No. 7:15-cv-00151-O**
United State of America, et al.,	§	
	§	
	§	
Defendants.	§	

MEMORANDUM OPINION AND ORDER

This case is about the lawfulness of a tax in the Patient Protection and Affordable Care Act ("ACA") and of a regulation that the United States Department of Health and Human Services ("HHS") uses to implement it. The ACA imposed a tax on medical providers but exempted the states from paying it. Notwithstanding Congress's direction in the ACA, the HHS regulation effectively requires the states to pay this tax. Plaintiffs now challenge both the tax and the regulation. Because Plaintiffs have standing to challenge both, the Court must decide the legality of each.

The Court concludes that the challenged ACA tax is lawful, offending neither the structure nor substance of the Constitution. But the HHS regulation violates the non-delegation doctrine, delegating to a private entity the authority to decide who must pay this tax. Pursuant

to that unlawful delegation, the private entity decreed that the states must pay this tax, contrary to Congress's express directive. HHS's unlawful delegation enabled a private entity to effectively rewrite the ACA, wrongfully forcing Plaintiffs to pay this tax. It is therefore the regulation—not the tax—that harms Plaintiffs. For the reasons that follow, the Court will **GRANT in part** Plaintiffs' claims challenging the regulation and declare the offending regulation "contrary to constitutional right, power, privilege, or immunity," and "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . ." 5 U.S.C. § 706(2)(B)–(C). The Court will **DENY** Plaintiffs' claims challenging the tax.[1]

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[1] Before the Court are Plaintiffs' Motion for Summary Judgment and Brief and Appendix in Support (ECF Nos. 53–54), filed January 6, 2017; Defendants' Motion for Summary Judgment and Response in Opposition to Plaintiffs' Motion for Summary Judgment and Brief and Appendix in Support (ECF Nos. 62–63), filed June 5, 2017; Plaintiffs' Reply in Support of their Motion for Summary Judgment and Response in Opposition to Defendants' Motion for Summary Judgment (ECF No. 66), filed June 23, 2017; and Defendants' Reply in Support of their Motion for Summary Judgment (ECF No. 67), filed July 13, 2017. Defendants filed an additional Response to Plaintiffs' Motion for Summary Judgment (ECF No. 64) that appears identical to the Brief in Support of Defendants' Motion for Summary Judgment (ECF No. 63).

Also before the Court are Defendants' Motion to Strike Plaintiffs' Expert Designations and Brief in Support (ECF Nos. 68–69), filed July 13, 2017; Plaintiffs' Motion to Strike Defendants' Experts Golden and Truffer and Brief in Support (ECF Nos. 70–71), filed July 13, 2017; Plaintiffs' Response in Opposition to Defendants' Motion to Strike (ECF No. 72), filed August 3, 2017; Defendants' Response in Opposition to Plaintiffs' Motion to Strike (ECF No. 73), filed August 3, 2017; Plaintiffs' Reply in Support of their Motion to Strike (ECF No. 74), filed August 9, 2017; and

Accordingly, having considered the motions, related briefing, and applicable law, the Court finds that Plaintiffs' Motion for Summary Judgment (ECF No. 53) should be and is hereby **GRANTED in part and DENIED in part**; and Defendants' Motion for Summary Judgment (ECF No. 62) should be and is hereby **GRANTED in part and DENIED in part**.[2]

I. BACKGROUND

Plaintiffs (alternatively, "Plaintiff States") are the States of Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin. Am. Compl. 1, ECF No. 19. Defendants are the United States of America (the "Government"); the United States Department of Health and Human Services; Alex Azar, in his official capacity as Secretary

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Defendants' Reply in Support of their Motion to Strike (ECF No. 75), filed August 17, 2017.

On October 25, 2017, the lead counsel for Plaintiffs and Defendants appeared at a hearing on their motions and presented oral arguments. Elec. Min. Entry, ECF No. 81. On November 1, 2017, the Court ordered supplemental briefing on the timeliness of Plaintiffs' Administrative Procedure Act claims. Nov. 1, 2017 Order, ECF No. 82. The parties filed supplemental briefs. Before the Court are Plaintiffs' Supplemental Brief in Support of their Motion for Summary Judgment (ECF No. 83), filed November 13, 2017; Defendants' Response to Plaintiffs' Supplemental Brief in Support of their Motion (ECF No. 84), filed November 22, 2017; and Plaintiffs' Supplemental Reply in Support of their Motion (ECF No. 86), filed November 27, 2017.

[2] The Court finds that Defendants' Motion to Strike Plaintiffs' Expert Designations (ECF No. 68) should be and is hereby **DENIED** because Plaintiffs' challenged experts are qualified under Rule 702. *See* FED. R. EV. 702. The Court finds that Plaintiffs' Motion to Strike Defendants' Experts (ECF No. 70) should be and is hereby **DENIED** because Defendants' failure to comply with Rule 26(a) was harmless. *See* FED. R. CIV. P. 26(a).

of HHS[3]; the United States Internal Revenue Service (the "IRS"); and David Kautter, in his official capacity as Acting Commissioner of the IRS.[4] *Id.* at 1–2. Plaintiffs allege that Defendants, in violation of the ACA, the Administrative Procedure Act (the "APA"), and the United States Constitution, require them to pay the ACA's Health Insurance Providers Fee (the "HIPF") to the managed care organizations (the "MCOs") who contract with them to service their Medicaid recipients. *Id.* at 3–19.

In the ACA, Congress expressly exempted states from paying the HIPF. ACA § 9010(c)(2)(B) (2010); *see* 26 C.F.R. § 57.2(b)(2)(ii)(B). This effectively changed in March of 2015, when the Actuarial Standards Board (the "ASB")—a private organization that sets practice standards for private actuaries certified by the American Academy of Actuaries (the "AAA")—enacted Actuarial

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[3] Plaintiffs initially sued Sylvia Burwell in her official capacity as Secretary of HHS. *See* Compl., ECF No. 1. On January 24, 2018, the United States Senate confirmed Alex Azar as Secretary of HHS. Daniella Diaz, *Senate Confirms HHS Secretary Nominee Alex Azar*, CNN POLITICS (Jan. 24, 2018, 3:01 PM), https://www.cnn.com/2018/01/24/politics/alex-azar-confirmation-department-of-health-and-human-services/ index.html.

[4] Plaintiffs initially sued John Koskinen in his official capacity as Commissioner of the IRS. *See* Compl., ECF No. 1. Commissioner Koskinen left the office at the completion of his term on November 12, 2017, and pursuant to a Presidential designation, Acting Commissioner David Kautter assumed the office as an interim replacement. Alexis Leonidis, *White House Names Treasury's David Kautter as Interim IRS Head*, BLOOMBERG POLITICS (Oct. 26, 2017, 8:36 AM), https://www.bloomberg.com/news/articles/2017-10-26/white-house-names-treasury-s-david-kautter-as-interim-irs-head.

Standard of Practice Number 49 ("ASOP 49").[5] ASOP 49 forbids AAA actuaries from certifying any Medicaid contract between a state and an MCO *unless* the contract *requires* the state to pay the HIPF to the MCO. *See* ASOP 49 § 3.2.12(d).[6] Without this AAA certification, the Centers for Medicare & Medicaid Services ("CMS")—a component of HHS—will not approve the MCO contract. *See* 42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002) [hereinafter "the Certification Rule"].[7] If CMS does not approve the contract, the state becomes ineligible for Medicaid funding. *See* 42 U.S.C. § 1396b(m)(2)(iii). The end result is that by delegating this certification power to the ASB, HHS effectively requires states to pay the HIPF—even though Congress exempted them from doing so—or risk losing Medicaid funds.[8]

The ACA, the HIPF, and the Certification Rule interact with several public health programs. The first of these programs actually began in 1965, when Congress

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[5] ACTUARIAL STANDARDS BOARD, *Actuarial Standard of Practice No. 49: Medicaid Managed Care Capitation Rate Development and Certification* (Mar. 2015), http://www.actuarialstandardsboard.org/wp-content/uploads/2015/03/asop049_179.pdf.

[6] AAA actuaries must keep all ASOPs or face professional discipline. Pls.' App. 197, 1102, ECF No. 54-1.

[7] The Certification Rule is now codified at 42 C.F.R. §§ 438.2–438.4.

[8] The states also contract with MCOs to deliver Child Health Insurance Program ("CHIP") services, and another HHS regulation requires an AAA actuary to certify CHIP MCO contracts in accordance with the Certification Rule. *See* 42 C.F.R. § 457.1203. States must therefore pay the HIPF in their CHIP MCO contracts as well, or risk losing CHIP funding. Because Medicaid and CHIP operate virtually identically in respect to this litigation, all references to Medicaid shall also include CHIP.

enacted, and President Lyndon Johnson signed into law, the Medicaid program. *See* Social Security Amendments Act of 1965, Pub. L. 89-97, 79 Stat. 286 (1965). Medicaid subsidizes states to provide healthcare to low-income families; children; related caretakers of dependent children; pregnant women; people aged 65 years and older; and adults and children with disabilities. *See* 42 U.S.C. §§ 1396–1396w. To receive Medicaid subsidies, states must provide coverage to a federally mandated category of individuals according to a federally approved state plan. *See* 42 U.S.C. § 1396a; 42 C.F.R. §§ 430.10–430.12. Plaintiffs participate in the program, providing Medicaid services and receiving Medicaid subsidies. *See* 79 Fed. Reg. 3385. Plaintiffs provide these services at substantial cost. *See, e.g.*, Pls.' App. 1168–74, ECF No. 54-1. For example, in 2015 Texas spent 28.6% of its budget on Medicaid, serving 4.06 million Texans—around one in seven members of its population.[9] The other Plaintiff States likewise provide Medicaid to millions of their citizens at the cost of a considerable portion of their annual budgets. *See* Pls.' Br. Supp. Summ. J. 8 n.23–29, ECF No. 54 (citing data) [hereinafter "Pls.' Br."].[10]

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[9] TEXAS HEALTH AND HUMAN SERVS. COMM'N, TEXAS MEDICAID AND CHIP IN PERSPECTIVE: 11TH ED., 1–5 (Feb. 2017), *available at* https://hhs.texas.gov/sites/default/files//documents/laws-regulations/reports- presentations/2017/medicaid-chip-perspective-11th-edition/11th-edition-complete.pdf.

[10] In 1997, Congress enacted, and President Bill Clinton signed into law, the CHIP program. *See* Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251. CHIP subsidizes states to provide healthcare to certain uninsured children and pregnant women. *See* 42 U.S.C. § 1397aa. Plaintiffs participate in CHIP, providing CHIP

When Plaintiffs first began implementing the Medicaid program, they primarily relied on fee-for-service providers ("FFSPs") to deliver Medicaid services. *See* Pls.' App. 120, 133, 291, 485, 1008, 1162–63, ECF No. 54-1. Over time, however, Plaintiffs discovered that managed care organizations were more efficient and less expensive. *See, e.g.*, *id.* at 120. In a managed care arrangement, the state enters into a contract with an MCO, wherein the MCO agrees to deliver healthcare services to citizens of the state, and in exchange, the state pays the MCO a fixed monthly fee per covered individual, known as a "capitation rate." *Id.* at 1168.

In order to realize the benefits and savings of managed care, Plaintiffs began a long-term transition from FFSPs to MCOs. *See id.* at 120, 133, 291, 485, 1008, 1162–63. Texas began this transition in 1993. *Id.* at 1006. By the end of 2005, 40% of Texas's Medicaid beneficiaries received services through MCOs, and by 2012, that percentage reached 80%. *Id.* at 1007. When Plaintiffs filed this suit in 2015, Texas MCOs served around 87% of Texas's Medicaid population. *Id.* Texas anticipates that this year MCOs will serve 93% of its Medicaid population. *Id.* at 1007–08. Each Plaintiff now provides a substantial portion of their Medicaid services through MCOs. *See id.* at 120, 133, 291, 485, 1008, 1162–63.[11] Plaintiffs have saved hundreds of millions of dollars by transitioning to MCOs. *See id.* at 121, 133–34, 291–92,

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services and receiving CHIP subsidies. *See* 79 Fed. Reg. 3385. Plaintiffs provide CHIP services to hundreds of thousands of children and pregnant women at substantial cost to each of their annual budgets. *See* Pls.' Mot. Supp. Summ. J. 8 n.21–29, ECF No. 54 (citing data).

[11] Plaintiffs primarily use MCOs to deliver CHIP services as well. *See, e.g.*, Pls.' App. 133, 291, 1009, ECF No. 54-1.

493–94, 1010, 1163. In January 2015, HHS announced in a press release—titled "Better Care. Smarter Spending. Healthier People: Why It Matters"—that it too would transition to MCOs. *Id*. at 13–14.

In 1981, Congress passed, and President Ronald Reagan signed into law, legislation requiring MCO capitation rates to be "actuarially sound." Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, 95 Stat. 357, 814 (1981) (codified at 42 U.S.C. § 1396b(m)(2)(A) (1981)).[12] HHS did not interpret the meaning of "actuarially sound" until 2002, when it promulgated the Certification Rule. This rule defined "actuarially sound" in the following way:

> (i) *Actuarially sound capitation rates* means capitation rates that—
>
> (A) Have been developed in accordance with generally accepted actuarial principles and practices;
>
> (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
>
> (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

See 42 C.F.R. § 438.6(c)(i)(A)–(C) (2002) (emphasis in original). Thus, under the Certification Rule, "actuarially sound capitation rates" are capitation rates certified by

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[12] Congress also authorized the HHS Secretary to promulgate rules and regulations to implement the actuarial-soundness requirement. *See* 42 U.S.C. § 1302(a).

an AAA actuary who, following the ASB's practice standards, determines that the rate has "been developed in accordance with generally accepted actuarial principles and practices." *Id.*

The AAA is a private, membership-based professional organization that exists to set qualification, practice, and professional standards for credentialed actuaries.[13] The AAA sets these standards through the ASB, another independent, private organization.[14] The ASB establishes and improves standards of actuarial practice by enacting Actuarial Standards of Practice ("ASOPs") to identify what AAA actuaries should consider, document, and disclose when performing an actuarial assignment.[15] In 2005, the AAA defined "actuarially sound" capitation rates as including *inter alia* state taxes—but not federal taxes.[16] In 2013, the ASB enacted ASOP 1, explaining that "the phrase 'actuarial soundness' has different meanings in different contexts . . . ."[17]

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[13] *About Us*, AMERICAN ACADEMY OF ACTUARIES, http://www.actuary.org/content/about-us.

[14] *How Does The Academy Maintain Standards of Professionalism for Actuaries?*, AMERICAN ACADEMY OF ACTUARIES, http://www.actuary.org/content/how-does-academy-maintain-standards-professionalism-actuaries.

[15] *About ASB*, ACTUARIAL STANDARDS BOARD, http://www.actuarialstandardsboard.org/about-asb/.

[16] AMERICAN ACADEMY OF ACTUARIES, *Health Practice Council Practice Note: Actuarial Certification of Rates for Medicaid Managed Care Programs* (Aug. 2005), http://www.actuary.org/files/publications/Practice_Note_Actuarial_Certification_Rates_for_Medicaid_Managed_Care_Programs_aug2005.pdf.

[17] ACTUARIAL STANDARDS BOARD, *Actuarial Standard of Practice No. 1: Introductory Actuarial Standard of Practice* (Mar.

In 2010, Congress passed, and President Barack Obama signed into law, the ACA. The Patient Protection and Affordable Care Act, Pub. L. 111-148, 124 Stat. 119–1025 (2010). The ACA requires health insurance providers who are "covered entities" to pay the HIPF to the IRS. *See* ACA § 9010. A covered entity must pay a portion of the HIPF proportionate to the provider's share of net premiums for the previous year. *See id.* The first HIPF payments came due on September 30, 2014. Pls.' App. 96, ECF No. 54-1. The total amount of the fee for all covered entities combined was $8 billion in 2014 and increased to $14.3 billion in 2018. *See* 26 C.F.R. § 57.4(a)(3). Advocates for enacting the HIPF argued that the ACA would increase enrollment for MCOs, that this increase would significantly raise profits, and that the MCOs would pay the HIPF out of their increased profits. *See* Pls.' App. 19, ECF No. 54-1.[18]

The ACA explicitly excludes states from the definition of "covered entities," thereby exempting them from paying the HIPF. ACA § 9010(c)(2)(B). Because the ACA protects states from paying the HIPF, Plaintiffs did not initially pay the HIPF in their capitation rates when the IRS first began collecting the HIPF from MCOs in 2014. *See* Pls.' App. 1168–70, ECF No. 54-1 ("For fiscal year 2014, Texas did not include [the HIPF] in its appropriations . . . Texas did not reimburse MCOs for the 2014 HIPF until fiscal year 2015."). In

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2013), http://www.actuarialstandardsboard.org/wp-content/uploads/2013/10/asop001_ 170.pdf.

[18] Certain MCOs are exempt from the HIPF, including non-profit MCOs that receive more than 80 percent of their gross revenues from federal government programs targeting low-income, elderly, or disabled populations. *See* 26 C.F.R. § 57.2(b)(2)(iii).

2014, private actuaries—following the AAA's 2005 definition of "actuarially sound" and the ASB's 2013 definition in ASOP 1—certified those MCO contracts, and HHS approved them. In October of 2014, HHS issued a guidance document stating its belief that the states should include the HIPF in their MCO capitation rates.[19] But HHS did not say that the Certification Rule required states to pay the HIPF. *See* 2014 MCO Guide (explaining that states have "flexibility" to pay the HIPF through retroactive adjustments to their capitation rates, provided the initial and subsequent capitation rates are "actuarially sound").

Then in March 2015, the ASB enacted ASOP 49, which stated:

> The actuary should include an adjustment for any taxes, assessments, or fees that the MCOs are required to payout [sic] of the capitation rates. If the tax, assessment, or fee is not deductible as an expense for corporate tax purposes, the actuary should apply an adjustment to reflect the costs of the tax.

ASOP 49 § 3.2.12(d). Since the HIPF is a non-deductible tax,[20] ASOP 49 effectively required states to pay MCOs the full amount of the HIPF in their capitation rates, because an AAA actuary could no longer certify the capitation rate as actuarially sound unless it did so. In

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

[20] ACA § 9010(f); 26 C.F.R. § 57.8.

September 2015, HHS issued a guidance document embracing ASOP 49 and declaring that the Certification Rule required AAA actuaries to certify that state capitation rates met ASOP 49's requirements.[21]

After the ASB enacted ASOP 49, the states capitulated, included the HIPF in their capitation rates, and budgeted for the HIPF. *See* Pls.' App. 137, 1164, 1170, ECF No. 54-1. In 2015, Texas appropriated $79,685,024.00 to pay the HIPF for fiscal year 2014, $16,906,502.00 for fiscal year 2015, and $244,219,902.00 for fiscal years 2016 and 2017. *Id.* at 1170–72. Over the next decade, the federal government will collect between $13 and $14.9 billion in HIPF revenue from the combined payments of all fifty states.[22]

On October 22, 2015, Plaintiffs filed suit, attacking the lawfulness of the HIPF itself, as well as the Certification Rule that enabled the ASB to impose the HIPF on the states through ASOP 49. Compl, ECF No. 1.[23] Plaintiffs seek various injunctive and declaratory

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[21] U.S. DEP'T OF HEALTH AND HUMAN SERVS., CTRS. FOR MEDICARE & MEDICAID SERVS., 2016 MEDICAID MANAGED CARE RATE DEVELOPMENT GUIDE (Sept. 2015) [hereinafter "2015 MCO Guide"], *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/2016-medicaid-rate-guide.pdf.

[22] *See* John D. Meerschaert and Mathieu Doucet, *PPACA Health Insurer Fee: Estimated Impact on State Medicaid Programs and Medicaid Health Plans*. MILLIMAN CLIENT REPORT, Jan. 31, 2012, at 2–3, *available at* https://kaiserhealthnews.files.wordpress.com/2012/02/ppaca-health-insurer-fee-estimated-impact-on-medicaid.pdf.

[23] In accordance with Plaintiffs' Amended Complaint and summary judgment briefing, the Court interprets the HIPF's "implementing rule" to be 42 C.F.R. § 438.6 (2002) (recodified at 42 C.F.R. §§ 438.2–438.4).

remedies to relieve them from the burden of paying the HIPF. *See* Am. Compl. 27–29, ECF No. 19.[24]

II. LEGAL STANDARD

A. Federal Rule of Civil Procedure 56(a)

The Court may grant summary judgment where the pleadings and evidence show "that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." FED. R. CIV. P. 56(a). "[T]he substantive law will identify which facts are material." *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). A genuine dispute as to any material fact exists "if the evidence is such that a reasonable jury could return a verdict for the nonmoving party." *Id.* The movant must inform the Court of the basis of its motion and demonstrate from the record that no genuine dispute as to any material fact exists. *See Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986).

When reviewing the evidence on a motion for summary judgment, the Court must decide all reasonable doubts and inferences in the light most favorable to the non-movant. *See Walker v. Sears, Roebuck & Co.*, 853 F.2d 355, 358 (5th Cir. 1988). The court cannot make a credibility determination in light of conflicting evidence or competing inferences. *Anderson*, 477 U.S. at 255. If there appears to be some support for disputed allegations, such that "reasonable minds could differ as to the import of the evidence," the Court must deny the motion. *Id.* at 250.

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[24] The Court granted Defendants' motion to dismiss Plaintiffs' claim for a HIPF refund but allowed the remaining claims to proceed. Aug. 4, 2016 Order 48–49, ECF No. 34.

III. ANALYSIS

Plaintiffs move for summary judgment, claiming that: (1) the statutory provision enacting the HIPF violates Article I's Spending Clause and the Tenth Amendment [the "HIPF claims"]; and (2) the Certification Rule violates Article I's Vesting Clause, the APA, and the ACA [the "Certification Rule claims"]. *See* Pls.' Br. 21–42, ECF No. 54. Defendants also move for summary judgment on all counts, claiming that: (1) Plaintiffs lacks Article III standing; (2) sovereign immunity bars Plaintiffs' Certification Rule claims; (3) the Anti-Injunction Act (the "AIA") bars Plaintiffs' HIPF claims; (4) the HIPF is valid under Article I's Taxing Clause; and (5) the Certification Rule is valid under *Chevron*. *See* Defs.' Br. Supp. Mot. Summ. J. 9–50, ECF No. 63 [hereinafter "Defs.' Br."]. The Court will address each of these arguments in turn, beginning with the preliminary question whether there is subject matter jurisdiction to consider any of Plaintiffs' claims.

A. Subject Matter Jurisdiction

Article III confines the federal judicial power to "cases" and "controversies." U.S. CONST. art. III, § 2. The case or controversy requirement ensures that the federal judiciary respects "the proper—and properly limited—role of the courts in a democratic society." *DaimlerChrysler Corp. v. Cuno*, 547 U.S. 332, 341 (2006) (quotation marks omitted). The Court must first assess jurisdiction, for "without proper jurisdiction, a court cannot proceed at all . . . ." *Steel Co. v. Citizens* for a Better Env't, 523 U.S. 83, 84 (1998). The party invoking federal jurisdiction must demonstrate that a constitutional case or controversy exists as to each claim

asserted. *See Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561 (1992).

Defendants argue that: (1) there is no Article III case or controversy here because Plaintiffs either have no injury, manufactured the injury, or request remedies that will not redress the injury; (2) the AIA bars Plaintiffs' HIPF claims because their requested remedies would enjoin the collection of federal taxes; and (3) sovereign immunity bars Plaintiffs' Certification Rule claims because Plaintiffs brought them outside the APA's six-year statute of limitations. Defs.' Br. 9–21, ECF No. 63.

1. Article III Standing

The Court will first consider whether Plaintiffs have Article III standing. To establish Article III standing, a plaintiff must show: (1) an injury in fact that is (2) fairly traceable to the defendant's challenged conduct, and that (3) a favorable judicial decision will likely redress the injury. *Lujan*, 504 U.S. at 560–61. A plaintiff must support each standing element "with the manner and degree of evidence required at the successive stages of the litigation." *Id.* at 561. "[T]he presence of one party with standing is sufficient to satisfy Article III's case-or-controversy requirement." *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 53 n.2 (2006). To determine whether Plaintiffs have standing here, the Court will evaluate the State of Texas and its claims.

a. Injury in Fact

A plaintiff must show that it has suffered an "injury in fact," which is "an invasion of a legally protected interest" that is "concrete and particularized" and "actual or imminent, not conjectural or hypothetical."

Spokeo, Inc. v. Robbins, 136 S. Ct. 1540, 1548 (2016) (quoting *Lujan*, 504 U.S. at 560). For an injury to be "concrete" it must "actually exist," meaning it is "real" and "not abstract." *Spokeo*, 136 S. Ct. at 1548. For an injury to be "particularized" it must "affect the plaintiff in a personal and individual way." *Spokeo*, 136 S. Ct. at 1548. Defendants argue that the Certification Rule did not injure Plaintiffs because it imposed no monetary cost and preserved an economically sustainable MCO market. *See* Defs.' Br. 14–16, ECF No. 63. Plaintiffs argue that the Certification Rule—in conjunction with ASOP 49—injured them by requiring them to pay the HIPF in violation of the ACA. *See* Pls.' Br. 12–14, ECF No. 54.

ASOP 49 requires Texas to pay the HIPF in its MCO capitation rates in order to obtain a private actuarial certification, ASOP 49 § 3.2.12(d), and the Certification Rule prevents CMS from approving any MCO contract without this certification. *See* 42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002); *see also* Defs.' App. 155, ECF No. 63-1 ("[T]he state actuary *must* certify the rates or rate ranges . . . *After ensuring . . . that it contains the rate certification* . . . the [CMS Regional Office] forwards the contract package to [CMS]." (emphasis added)). The Certification Rule therefore gives Texas two choices: include the HIPF in its capitation rates or lose Medicaid funds. *See* 42 U.S.C. § 1396b(m)(2)(iii).[25] In response to this Hobson's choice, Texas appropriated millions of dollars to pay the HIPF. *See* Pls.' App. 1170–72, ECF No. 54-1 This injury is real

[25] On December 18, 2015, Congress enacted a one-year moratorium on collecting the HIPF in 2017. Consolidated Appropriations Act, 2016, Pub. L. No. 114-133, 129 Stat. 2242, 3037–38 (2015). This moratorium is no longer in effect.

and affects Texas as an individual state. Texas has shown an injury-in-fact.

"Once injury is shown, no attempt is made to ask whether the injury is outweighed by benefits the plaintiff has enjoyed from" the injurious action. *Texas v. United States*, 809 F.3d 134, 155–56 (5th Cir. 2015), *as revised* (Nov. 25, 2015), *aff'd by an equally divided court*, 136 S. Ct. 2271 (2016) (per curiam) (quotation marks omitted). The benefits of an injury only negate standing in unique circumstances where "[t]he costs and benefits [arise] out of the same transaction." *Id.* at 156 (citing *Henderson v. Stalder*, 287 F.3d 374, 379–81 (5th Cir. 2002) (holding that taxpayers could not demonstrate a monetary injury-in-fact where the state produced a pro-life license plate and required users of the license plate pay an additional fee that covered its costs)). Without this "tight[ ] nexus," the Court will not consider whether the benefits resulting from an injury negate standing. *See id.* (citing *Henderson*, 287 F.3d at 379–81).

Defendants argue that unless Texas includes the HIPF in its MCO capitation rates, its MCO contracts will be—in an objective sense—actuarially unsound and financially unsustainable. *See* Defs.' Br. 15, ECF No. 63.[26] Even if this were true, the potential benefit of

[26] Notwithstanding this contention, Defendants simultaneously maintain that Plaintiffs could soften the burden of the HIPF by bargaining with the MCOs, i.e., by pressuring the MCOs either to lower their capitation rates outright or to become non-profits to reduce costs and thereby reduce rates. *See* Defs.' Br. 12, 14, ECF No. 63. Defendants cannot have it both ways. Either an economically sound MCO market requires Plaintiffs to pay the full amount of the HIPF, or Plaintiffs can bargain with and thereby convince MCOs to pass on less of the HIPF in their capitation rates. In any case, the fact remains that Congress declared that the states

contracting with MCOs at some distant point in the future—because the MCOs did not bear the burden of the HIPF and consequently did not go out of business—does not arise "out of the same transaction" as Texas's 2015 HIPF payments. *Cf. Texas*, 809 F.3d at 156; *Henderson*, 287 F.3d at 379–81. The Court finds that any future benefit to paying the HIPF does not negate Texas's injury-in-fact.

b. Fairly Traceable to Defendants' Challenged Conduct

A plaintiff's injury must also be "fairly traceable" to the challenged action. *Lujan*, 504 U.S. at 561. Plaintiffs here challenge the Certification Rule (42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002)) and the HIPF (ACA § 9010(f)). Defendants argue that Plaintiffs' claimed injury is not fairly traceable to the HIPF because Plaintiffs can avoid the HIPF entirely by transitioning back to FFSPs, HIPF-exempt non-profit MCOs, or some combination of the two. Defs.' Br. 9–14, ECF No. 63. Plaintiffs contend that HIPF-exempt MCOs alone cannot provide adequate Medicaid coverage to everyone in the state, and that transitioning back to FFSPs would be costly and harmful to them and their Medicaid recipients. Pls.' Br. 12–19, ECF No. 54.

"[T]he possibility that a plaintiff could avoid injury by incurring other costs does not negate standing." *Texas*, 809 F.3d at 156–57. In *Texas*, the plaintiff states challenged the federal government's DAPA[27] program

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should not pay the HIPF. As such, forcing Plaintiffs to pay the HIPF in violation of this Congressional command is an injury-in-fact.

[27] Deferred Action for Parents of Americans and Lawful Permanent Residents. *Texas*, 809 F.3d at 146.

that gave lawful presence to 4.3 million illegal aliens. *Id.* at 148. Because DAPA would have required the plaintiff states to incur significant costs by issuing driver's licenses to DAPA beneficiaries, the Fifth Circuit held that the plaintiff states suffered an injury-in-fact. *Id.* at 155. The Government argued that these costs were not "fairly traceable" to DAPA because "the state[s] could avoid injury by not issuing licenses to illegal aliens or by not subsidizing its licenses." *Id.* at 156. The Fifth Circuit emphatically rejected this argument. It noted that while Texas could avoid financial loss by requiring applicants to pay the full cost of the licenses, "it could not avoid injury altogether." *Id.* The threat of paying the cost of the licenses would coerce the Texas into changing its laws—which is itself a harm. *See id.* Holding that Article III does not require a state government to change its laws to avoid an injury, the Fifth Circuit explained:

> Indeed, treating the availability of changing state law as a bar to standing would deprive states of judicial recourse for many *bona fide* harms. For instance, under that theory, federal preemption of state law could never be an injury, because a state could always change its law to avoid preemption. But courts have often held that states have standing based on preemption. And states could offset almost any financial loss by raising taxes or fees. The existence of that alternative does not mean they lack standing.

Id. at 156–57 (footnotes omitted).

Defendants employ the same impermissible argument here. They contend that Plaintiffs could avoid the HIPF entirely by transitioning to FFSPs and HIPF-exempt MCOs. Defs.' Br. 9–14, ECF No. 63. But such a

transition would require Texas to alter its Medicaid contracts, restructure its Medicaid appropriations, and reshape its Medicaid policies. *Texas* holds that Article III's case or controversy requirement does not oblige a plaintiff state to make such changes. *Cf.* 809 F.3d at 156–57.

Defendants also claim that Plaintiffs have manufactured their injury because every year after Congress passed the ACA, Plaintiffs increasingly moved away from FFSPs toward MCOs. Defs.' Br. 11–13, ECF No. 63.[28] While it is true that Texas is increasing its reliance on MCOs, it is doing so as part of a long-term transition that predates the ACA and the 2002 Certification Rule. In 1993, in order to realize the superior benefits of managed care, Texas began to transition from FFSPs to MCOs. *See* Pls.' App. 1006–08, ECF No. 54-1. Now Texas provides somewhere between 80% and 93% of its Medicaid services through MCOs. *See id.* at 1007–08.[29] Defendants have not shown that Texas transitioned to MCOs to manufacture an injury.[30]

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[28] Defendants here essentially argue that Plaintiffs failed to mitigate the harm. Failure to mitigate is an affirmative defense that the defendant must plead in his answer. *E.E.O.C. v. Serv. Temps Inc.*, 679 F.3d 323, 334 n.30 (5th Cir. 2012). Defendants have not done so here. *See* Ans. 16–17, ECF No. 43.

[29] Moreover, HIPF payments did not come due until September 30, 2014, and the ASB did not enact ASOP 49 until 2015. During this five-year period, the Certification Rule did not require Texas to account for the HIPF in its capitation rates. Accordingly, from 2010 to 2015, Texas continued its transition toward managed care without the expectation that doing so would require it to pay the HIPF.

[30] While advancing this theory, Defendants at one point mischaracterized the evidence and erroneously claimed that Louisiana began transitioning to MCOs in 2016, Defs.' Br. 12, ECF

Defendants also argue—erroneously—that under *Texas*, "an injury is self-inflicted and insufficient to confer standing where, as here, a federal policy leaves the option to 'achieve[ ] their policy goal in myriad ways.'" Defs.' Br. 13 n.8, ECF No. 63 (quoting *Texas*, 809 F.3d at 159). Defendants reach this conclusion by quoting a portion of the *Texas* opinion comparing the harm caused by DAPA to the manufactured harm in *Pennsylvania v. New Jersey*, 426 U.S. 660 (1976). *See id.* In *Pennsylvania*, the plaintiff states challenged the defendant states' laws increasing taxes on nonresident income. 426 U.S. at 661–64. Because the plaintiffs gave their residents credits for taxes paid to other states, the defendants' tax increases also increased the plaintiffs' tax credits, causing the plaintiffs to lose revenue. *Id.* The Supreme Court held that this injury was self-inflicted because the plaintiff states established their tax credits knowing that the credits could fluctuate based on the tax decisions of other states. *See id.* at 664. "[T]he plaintiff states in *Pennsylvania v. New Jersey* could have achieved their policy goal in myriad ways, such as basing their tax credits on residents' out-of-state incomes instead of on taxes actually paid to other states." *Texas*, 809 F.3d at 159. In other words, "the pressure that Pennsylvania faced to change its laws was self-inflicted." *Id.* at 157 n.63. *Texas* did not hold that plaintiff states, who have done nothing to inflict harm on themselves, must change their laws to avoid a harm if there are "myriad ways" to do so.[31]

No. 63, when Louisiana's transition to MCOs actually began in 2012. Pls.' App. 300, ECF No. 54-1

[31] Such an exception would swallow the rule, because in practically every area of legislation, states have "myriad ways" to

Not only does *Texas* not require a state to change its laws to avoid a harm, Plaintiffs have shown that they are unable to do so here. First, Texas cannot rely exclusively on HIPF-exempt non-profit MCOs because Texas already contracts with all of the HIPF-exempt MCOs in the state and those MCOs are incapable of servicing the entire state alone. *See* Pls.' App. 1043–44, ECF No. 54-1 ("[U]ltimately non-profit coverage of every county's population is not feasible."). And even if it were possible for Texas to rely entirely on the few HIPF-exempt MCOs operating in Texas, doing so would be risky. Because the healthcare market is in a state of flux, *see* Pls.' App. 122, ECF No. 54-1, there is a danger that some of those MCOs might leave the market, which would cause many people to lose Medicaid services entirely.

Nor can Texas avoid their injury by transitioning back to FFPSs. Plaintiffs have saved hundreds of millions of dollars by moving to MCOs. *See* Pls.' App. 121, 133–34, 291–92, 493–94, 1010, 1163, ECF No. 54-1. Texas reduced its healthcare costs by six percent in the year 2013 alone. *See id.* at 1010. Returning to FFPSs would therefore substantially increase healthcare and administrative costs for Texas. *See id.* It would injure Texas's citizens, as managed care now provides better healthcare services to its Medicaid recipients. *See id.* And it would take time. As Plaintiffs' counsel observed at the summary judgment hearing, it took Texas more than two decades to switch to MCOs, and switching back to rely exclusively on FFSPs would take years. *See* October

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change their laws without compromising their overarching policy goals.

25, 2017 Hr'g Tr. 10:14–22, ECF No. 85.[32] During this transition, the Certification Rule—in conjunction with ASOP 49—would still require Texas to pay the HIPF.

With these facts in mind, Texas has even bleaker options here than it did in the *Texas* case. In *Texas*, the Government claimed that the plaintiff states could avoid an injury by changing their laws to stop subsidizing driver's licenses. *Texas*, 809 F.3d at 156. Here, the Government claims that Plaintiff States could avoid paying millions of dollars to cover the HIPF by changing their laws to pay millions of dollars to transition over many years back to an outdated healthcare model.[33] Texas will pay a significant monetary price no matter what choice it makes.

For these reasons, Defendants' citation to *Clapper v. Amnesty Int'l USA*, 568 U.S. 398 (2013) is inapposite. In *Clapper*, respondents asserted that they suffered ongoing injuries fairly traceable to a surveillance statute because the threat of surveillance required them to take "costly and burdensome measures to protect the confidentiality of their communications." 568 U.S. at 415. The Supreme Court rejected this argument and held that a plaintiff "cannot manufacture standing merely by inflicting harm on themselves based on their fears of hypothetical future harm that is not certainly impending." *Id.* at 416. As the analysis above demonstrates, this case is readily distinguishable. Here,

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[32] Louisiana fully transitioned to MCOs within six years. Pls.' App. 291, ECF No. 54-1. The length of transition back to FFSPs for each Plaintiff would likely depend on a host of factors and circumstances.

[33] Recognizing the superiority of managed care, even the Government is transitioning from FFSPs to MCOs. Pls.' App. 13–14, ECF No. 54.

the harm of paying the HIPF is neither future nor hypothetical; it is certain and has already happened. And Plaintiff States have not inflicted the harm on themselves.

Finally, Defendants argue that Plaintiffs' theory of standing has no principled limit because it would allow states to sue the federal government for any tax that resulted in a downstream increase in the cost of Medicaid. Defs.' Br. 10, ECF No. 63. The Court is unpersuaded by this argument, as the Fifth Circuit considered and rejected an almost identical argument in *Texas*. 809 F.3d at 161–62 ("The United States submits that Texas's theory of standing is flawed because it has no principled limit. In the government's view, if Texas can challenge DAPA, it could also sue to block . . . any federal policy that adversely affects the state . . . ."). The Court's finding of standing in this case announces no new interpretations of, or exceptions to, the Supreme Court's standing doctrines, and as such, it does not undermine Article III's case or controversy requirement in any way.

There is therefore no genuine dispute of material fact that the HIPF—as imposed on the states through the Certification Rule and ASOP 49—injures the Plaintiffs, and that to avoid this injury Plaintiffs would have to change their laws and incur additional costs—both of which constitute additional, independent injuries. Because the Court finds that Plaintiffs' injury is not manufactured, Plaintiffs' injury is fairly traceable to Defendants' challenged conduct: the HIPF and the Certification Rule.

c. Redressable by Favorable Judicial Decision

Plaintiffs must show that a favorable judicial decision will likely redress their injury. *Lujan*, 504 U.S. at 561.

To redress an injury, the judicial remedy must "personally . . . benefit [the plaintiff] in a tangible way . . . ." *Warth v. Seldin*, 422 U.S. 490, 508 (1975). Defendants have injured Plaintiffs by legally coercing them into paying the HIPF—a tax from which Plaintiffs are statutorily exempt. *See supra* Part III.A.1.a–b. To redress this injury, Plaintiffs ask the Court to invalidate the HIPF and the Certification Rule. Am. Compl. 27–29, ECF No. 19. The Court will next consider whether these requested remedies, if granted, will likely redress Plaintiffs' injury.

First, if the Court invalidates the HIPF, the Government will no longer be able to collect the HIPF from MCOs. Plaintiffs would then be free to stop accounting for the HIPF in their MCO capitation rates, and private actuaries could certify those rates excluding the HIPF as actuarially sound under ASOP 49. *See* ASOP 49 § 3.2.12(d) (requiring capitation rates to include all non-deductible taxes). Private actuaries may ultimately withhold their certification, and CMS its final approval, for reasons unrelated to the HIPF. But the Certification Rule would no longer *require* Plaintiffs to pay the HIPF—as the ACA envisions—in order for Plaintiffs to obtain Medicaid funds. The Court finds that this remedy would redress Plaintiffs' injury.

Second, if the Court invalidates 42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002)—the Certification Rule's interpretation of "actuarially sound" capitation rates—the law would no longer require Plaintiffs to pay the HIPF in their capitation rates in order to obtain CMS approval.[34] This remedy, like the one before it, would

[34] Invalidating the Certification Rule's definition of "actuarially sound" would also invalidate any guidance documents interpreting

relieve Plaintiffs' legal obligation to pay the HIPF in order to receive Medicaid funds. This would also redress Plaintiffs' injury. Defendants argue that, even without the Certification Rule, the statutory mandate that capitation rates be "actuarially sound" would still require Plaintiff States to include the HIPF in their rates. *See* Defs.' Br. 26, ECF No. 63. But the HIPF did not exist when Congress enacted the "actuarially sound" requirement in 1981, and when it enacted the ACA in 2010, Congress—presumably aware of the "actuarially sound" requirement—plainly exempted the states from paying this tax. *See* 42 U.S.C. § 1396b(m)(2)(A).

Finally, if the Court only invalidates 42 C.F.R. § 438.6(c)(1)(i)(C) (2002)—the portion of the Certification Rule requiring a private actuarial certification of MCO capitation rates—the law would give Plaintiffs freedom to negotiate to exclude the HIPF from their rates and give CMS freedom to approve those rates. Like the other remedies, the Court finds that this too would redress Plaintiffs' injury.

It might be objected that if the Court only invalidates 42 C.F.R. § 438.6(c)(1)(i)(C) (2002), there remains a possibility that CMS will conclude, on a case-by-case basis, that capitation rates excluding the HIPF have not "been developed in accordance with generally accepted actuarial principles and practices," as required by 42 C.F.R. § 438.6(c)(1)(i)(A) (2002). Indeed, HHS has stated in multiple guidance letters that it prefers for states to include the HIPF in their capitation rates. First, in 2014, HHS issued a guidance letter encouraging states to do so. *See* 2014 MCO Guide; *supra* note 19. Then in 2015,

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the Certification Rule, such as the 2014 and 2015 MCO Guides. *See supra* notes 19, 21.

HHS issued another guidance letter, referencing its 2014 letter and reiterating its view that states should pay the HIPF. *See* 2015 MCO Guide; *supra* note 21. Moreover, CMS now uses ASOP 49 to make internal determinations on whether MCO capitation rates are actuarially sound. *See* Defs.' App. 156, ECF No. 63-1. If HHS prefers for states to pay the HIPF in their capitation rates, and CMS uses ASOP 49 to evaluate capitation rates, it is possible that CMS will ultimately disapprove future capitation rates that do not include the HIPF.

Notwithstanding this possibility, the Court nonetheless finds that invalidating 42 C.F.R. § 438.6(c)(1)(i)(C) (2002) would redress Plaintiffs' injury. The law explicitly exempts states from paying the HIPF, ACA § 9010(c)(2)(B) (2010), and the Court must "presume that agencies will follow the law." *Pit River Tribe v. U.S. Forest Serv.*, 615 F.3d 1069, 1082 (9th Cir. 2010). The Court presumes, therefore, that CMS will not—in defiance of Congressional intention—condition Medicaid funds on whether Plaintiffs include the HIPF in their capitation rates.[35] CMS may continue to use ASOP 49 to make internal decisions whether capitation rates are "actuarially sound," but it cannot—and presumably will not—use ASOP 49 to ignore the ACA's statutory exemption and require Plaintiffs to pay the HIPF. Whether CMS will in due course approve every capitation rate excluding the HIPF is unclear from the

[35] Defendants have not rebutted this presumption with evidence showing that CMS is committed to disapproving any capitation rates excluding the HIPF as *ipso facto* contrary to "generally accepted actuarial principles and practices." 42 C.F.R. § 438.6(c)(1)(i)(A) (2002). Indeed, when the first HIPF payments came due in 2014, CMS approved such rates.

facts before the Court—that it may do so in some or all cases is enough to establish redressability.

Plaintiffs also fall within the "procedural right" exception to the redressability requirement. Under this exception, "The person who has been accorded a procedural right to protect his concrete interests can assert that right without meeting all the normal standards for redressability and immediacy." *Lujan*, 504 U.S. at 572 n.7 (1992). For example, a person "living adjacent to the site for proposed construction of a federally licensed dam has standing to challenge the licensing agency's failure to prepare an environmental impact statement, even though he cannot establish with any certainty that the statement will cause the license to be withheld . . . ." *Id.* Similarly here, if the Court only invalidates 42 C.F.R. § 438.6(c)(1)(i)(C) (2002), Plaintiffs cannot establish with certainty that CMS will ultimately approve their capitation rates excluding the HIPF. But Plaintiffs assert a procedural right: their statutory exemption from paying the HIPF. ACA § 9010(c)(2)(B) (2010); *see* 26 C.F.R. § 57.2(b)(2)(ii)(B). By challenging the Certification Rule's certification requirement, "plaintiffs are seeking to enforce a procedural requirement"—their HIPF exemption—"the disregard of which could impair a separate concrete interest of theirs"—namely, their interest in not paying the HIPF, changing their laws to budget for the HIPF, or raising taxes to fund the HIPF. *Cf. Lujan*, 504 U.S. at 572. Accordingly, even if the Court's invalidation of 42 C.F.R. § 438.6(c)(1)(i)(C) (2002) would not satisfy "normal standards for redressability," it would redress Plaintiffs' injury under *Lujan*.

There is therefore no genuine dispute of material fact that a favorable judicial decision invalidating either the HIPF or the Certification Rule would redress Plaintiffs' injury. The Court finds that Plaintiffs have shown redressability.

d. Prudential Standing

The Court also considers *sua sponte* whether Plaintiffs have satisfied prudential standing. The Supreme Court "interpreted § 10(a) of the APA to impose a prudential standing requirement in addition to the requirement, imposed by Article III of the Constitution, that a plaintiff has suffered an injury in fact." *Nat'l Credit Union Admin. v. First Nat'l Bank & Trust Co.*, 522 U.S. 479, 488 (1998). "For a plaintiff to have prudential standing under the APA, 'the interest sought to be protected by the complainant [must be] arguably within the zone of interests to be protected or regulated by the statute . . . in question." *Id.* (quoting *Ass'n of Data Processing Serv. Orgs., Inc. v. Camp*, 397 U.S. 150, 152 (1970)) (alterations in original). The "zone of interests" test applies "[i]n cases where the plaintiff is not itself the subject of the contested regulatory action," and it only "denies a right of review if the plaintiff's interests are . . . marginally related to or inconsistent with the purposes implicit in the statute . . . ." *Clarke v. Secs. Indus. Ass'n*, 479 U.S. 388, 399 (1987). This test is "not meant to be especially demanding" and the Court applies it in keeping with Congress's intent that agency action is presumptively reviewable. *Texas*, 809 F.3d at 162 (quoting *Clarke*, 479 U.S. at 399).

Plaintiffs bring several APA claims challenging the Certification Rule's interpretation of "actuarially sound," which enabled the ASB to impose the HIPF on

Plaintiffs. Am. Compl. 19–27, ECF No. 19. Plaintiffs are the subject of this contested regulatory action. *Cf. Clarke*, 479 U.S. at 399. And Plaintiffs' asserted interest—exemption from paying the HIPF—is within the zone of interests Congress meant to protect or regulate by enacting the HIPF, because the ACA expressly exempts states from paying the HIPF, and the Certification Rule allowed the ASB to nullify that exemption. *Cf. Nat'l Credit Union Admin.*, 522 U.S. at 488. Accordingly, the Court finds that there is no genuine dispute of material fact that Plaintiffs have prudential standing under the APA.

Because Plaintiffs have shown Article III and prudential standing, the Court **DENIES** Defendants' Motion for Summary Judgment (ECF No. 62) as to standing.

2. Anti-Injunction Act

The Court will next consider whether the AIA bars Plaintiffs claims. Defendants argue that the AIA deprives the Court of jurisdiction because Plaintiffs seek to prevent collection of a tax. Defs.' Br. 16–22, ECF No. 63. The AIA states, "[N]o suit for the purpose of restraining the assessment or collection of any tax shall be maintained in any court by any person, whether or not such person is the person against whom such tax was assessed." 26 U.S.C. § 7421(a). The AIA divests the court of jurisdiction over any claim—including constitutional claims—brought by any person that would affect the IRS's ability to assess and collect anyone's taxes. *See Alexander v. Americans United Inc.*, 416 U.S. 752, 759 (1974). Regardless of the HIPF's label as a "fee," because the ACA treats the HIPF as a tax for purposes of the Internal Revenue Code (the "IRC"), ACA

§ 9010(f)(1), the AIA applies to Plaintiffs' claims. *See Nat'l Fed'n of Indep. Bus. v. Sebelius*, 567 U.S. 519, 544–45 (2012) [hereinafter *NFIB*] (concluding that the AIA applies to an exaction that the enacting statute treats as a tax for purposes of the IRC).[36] Because Plaintiffs' HIPF claims would restrain the assessment and collection of a tax, the Court must determine whether its jurisdictional bar extends to Plaintiffs' HIPF claims.

Plaintiffs claim that the AIA is inapplicable because states are not "person[s]" under the statute. Pls.' Reply 13, ECF No. 66. To determine whether Congress intended states to be "person[s]" under the AIA, the Court must begin with the text of the statute and ascertain its plain meaning by considering its language and design as a whole. *See K Mart Corp. v. Cartier, Inc.*, 486 U.S. 281, 291 (1988). The Court first considers whether the statute defines its terms. *Cf. United States v. Santos*, 553 U.S. 507, 511 (2008) (considering first the statutory definitions). The AIA itself does not define "person." *See* 26 U.S.C. § 7421. However, the AIA is codified in the IRC, and the IRC's general definitional provision states, "The term 'person' shall be construed to mean and *include* an individual, a trust, estate, partnership, association, company or corporation." 26 U.S.C. § 7701(a)(1) (emphasis added). When a statutory definition "includes" enumerated examples, those examples are illustrative, not exhaustive. *Christopher v. SmithKline Beecham Corp.*, 567 U.S. 142, 162 (2012). Because the list of entities in § 7701(a)(1) is illustrative,

[36] Plaintiffs previously argued that the HIPF is a fee, not a tax, and the Court deferred a ruling on the issue. Aug. 4, 2016 Order 22–23, ECF No. 34. Plaintiffs now agree with Defendants that the HIPF is a tax. Pls.' Br. 3, ECF No. 54.

the IRC's definition section could include states as "person[s]" under the AIA.

"When a term is undefined, we give it its ordinary meaning." *Santos*, 553 U.S. at 511. A legal "person" is typically an entity "recognized by law as having the rights and duties of human beings." BLACK'S LAW DICTIONARY 1178 (9th ed. 2004); *see also* WEBSTER'S THIRD NEW INTERNATIONAL DICTIONARY 1686 (1971) (defining "person" as "a human being, a body of persons, or a corporation, partnership, or other legal entity that is recognized by law as the subject of rights and duties."). Because the law often recognizes states as having the rights and duties of human beings, the Court finds that "person[s]" under the AIA include states. *see, e.g., Estate of Wycoff v. Comm'r*, 506 F.2d 1144, 1151 (10th Cir. 1974) (holding that the term "person" in § 7701(a)(1) includes the states); *See generally South Carolina v. Regan*, 465 U.S. 367 (1984) (assuming that states are persons under the IRC for purposes of the AIA). It also harmonizes with Supreme Court decisions holding that states are "persons" under other IRC provisions that do not explicitly define "person" to include states. *See Sims v. United States*, 359 U.S. 108, 112 (1959) (holding that 26 U.S.C. § 6332(b)'s definition of "person" applied to the State of West Virginia); *Ohio v. Helvering*, 292 U.S. 360, 368 (1934) (holding that 26 U.S.C. § 205's definition of "person" applied to the State of Ohio), *overruled on other grounds by Garcia v. San Antonio Met. Transit Auth.*, 469 U.S. 528 (1985). Accordingly, the Court finds that Congress intended the AIA to apply to the states.

Plaintiffs argue, however, that under *South Carolina v. Regan* the AIA does not bar their suit because they have no adequate, alternative judicial remedy to contest

the HIPF. Pls.' Reply 12–13, ECF No. 66.[37] In *Regan*, South Carolina sought injunctive relief to protect its bondholders from an allegedly unconstitutional federal tax on state bond interest. 465 U.S. at 371. The Supreme Court held that the AIA did not bar South Carolina's suit. *Id.* at 381. First, the Supreme Court recognized that "Congress intended the [AIA] to bar a suit only in situations in which Congress had provided the aggrieved party with an alternative legal avenue by which to contest the legality of a particular tax." *Id.* at 373. Second, "Congress did not intend the [AIA] to apply where an aggrieved party would be required to depend on the mere possibility of persuading a third party to assert [its] claims." *Id.* at 381. Because the federal government assessed the disputed tax against the bondholders and imposed no direct tax liability on South Carolina, the state had no legal forum to challenge the tax and had to depend on the mere possibility of persuading its bondholders to assert its claims. *Id.* at 380–81. The Supreme Court held that the AIA did not apply under these circumstances. *Id.*

However, an "alternative remedy" exists—and the AIA applies—where a plaintiff can seek judicial review of the tax in an alternative forum. *See id.* at 374–82 (citing cases holding that the AIA applies where plaintiffs can bring a refund suit); *see also Debt Buyers' Ass'n v. Snow*, 481 F. Supp. 2d 1, 10 (D.D.C. 2006) ("In this case, an alternative legal remedy exists . . . [because

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[37] Plaintiffs do not claim the AIA's statutory exceptions or the *Williams Packing* exception. *See* Pls.' Reply 12–13, ECF No. 54; *see also* 26 U.S.C. § 7421(a) (citing statutory exceptions to the AIA); *Enochs v. Williams Packing & Navigation Co., Inc.*, 370 U.S. 1, 7 (1962) (describing an exception to the AIA).

the plaintiff] will have a legal forum in the form of penalty-refund litigation . . . ."); *Nat'l Fed. Republican Assemblies v. United States*, 148 F. Supp. 2d 1273, 1283 (S.D. Ala. 2001) (finding the AIA does not apply because the taxpayer "does not have a 'pay and sue' option and cannot challenge a deficiency assessment in Tax Court").

Plaintiffs argue that because the Court dismissed their claim for a HIPF refund, they have no alternative remedy and therefore fall under the *Regan* exception. Pls.' Reply 12, ECF No. 66. The Court agrees. Under the ACA, the sole avenue for challenging the HIPF is a "civil action[ ] for refund" by a covered MCO. ACA § 9010(f)(1). Plaintiffs cannot challenge the HIPF under the ACA because they are states, not MCOs. Plaintiffs therefore have no alternative judicial remedy beyond the present action. Apart from the *Regan* exception, Plaintiffs would be "required to depend on the mere possibility of persuading [the MCOs] to assert [their] claims." *Regan*, 365 U.S. at 381.

Defendants respond that Plaintiffs have an alternative remedy because (1) they could have challenged the Certification Rule when HHS enacted it in 2002 or (2) they could have petitioned HHS to amend the Certification Rule to exempt Plaintiffs from paying the HIPF. Defs.' Reply 8, ECF No. 67. Defendants' first argument fails because at the time HHS enacted the Certification Rule, the HIPF did not exist, and moreover, Plaintiffs could not have anticipated that a federal agency, HHS—much less a private organization, the ASB—would require them to pay a tax that Congress expressly exempted them from paying. Defendants' second argument fails because petitioning an agency to change its regulation is not an alternative form of judicial

review. *Cf. Regan*, 465 U.S. at 374–82 (concluding that the AIA does not apply if the plaintiff has no alternative judicial forum wherein to seek relief). The *Regan* exception is borne in part out of a due process concern for the availability of judicial review. *See id.* at 375 (explaining that the AIA does not violate due process because taxpayers can ordinarily bring a refund suit, and that "our conclusion might well be different if the aggrieved party ha[s] no access to judicial review" (quotation marks omitted)).

Finally, even if the AIA did apply in this case, it would only bar Plaintiffs' HIPF claims, not their Certification Rule claims. Plaintiffs challenge the Certification Rule on the ground that it shifted the financial burden of the HIPF from the MCOs to the states by requiring states to include the HIPF in their MCO capitation rates. Plaintiffs accordingly seek declaratory relief that the Certification Rule violates the APA and the U.S. Constitution. Pls.' Am. Compl. 27, ECF No. 19. Plaintiffs do not assert these Certification Rule claims or seek this declaratory relief "for the purpose of restraining the assessment or collection of any tax," 26 U.S.C. § 7421(a), but rather to ensure that the proper entity pays the full amount of the disputed tax.

The Court finds no genuine dispute of material fact that the *Regan* exception applies to Plaintiffs' HIPF claims and that the AIA does not apply to Plaintiffs' Certification Rule claims. Accordingly, the AIA does not deprive the Court of jurisdiction over any of Plaintiffs' claims. The Court **DENIES** Defendants' Motion for Summary Judgment (ECF No. 62) as to the AIA.

3. Statute of Limitations

The Court will next consider whether Plaintiffs' APA claims are time-barred and therefore barred by sovereign immunity. The APA waives sovereign immunity for persons legally wronged, adversely affected, or aggrieved by "agency action," who seek non-monetary relief. 5 U.S.C. § 702; *see Norton v. S. Utah Wilderness All.*, 542 U.S. 55, 61 (2004). Because the APA lacks a specific statutory limitations period, APA challenges are "governed by the general statute of limitations provision of 28 U.S.C. § 2401(a), which provides that every civil action against the United States is barred unless brought within six years of accrual." *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1286 (5th Cir. 1997). Sovereign immunity bars any APA suit against an agency after this six-year period. *Id.* at 1287. This limitations period ordinarily begins to run when the agency publishes the regulation in the Federal Register. *Id.* But if the agency "applies" the rule to the plaintiff through "final" agency action, that application of the rule creates a new cause of action under the APA and triggers a new six-year limitations period. *See id.* at 1287–88; *see also Texas v. United States*, 749 F.2d 1144, 1146 (5th Cir. 1985) ("[A]dministrative rules and regulations are capable of continuing application . . . ."). Within this new six-year limitations period the plaintiff may challenge the agency's statutory and constitutional authority for applying the rule. *Dunn-McCampbell*, 112 F.3d at 1287–88.

Defendants argue that Plaintiffs' Certification Rule claims are time-barred because HHS published the Certification Rule in the Federal Register in 2002, the six-year limitations period lapsed in 2008, and Plaintiffs

filed suit seven years later in 2015. *See* Defs.' Br. 39–43, ECF No. 63. In response, Plaintiffs identify several agency actions that they contend are "final" actions that apply the Certification Rule to Plaintiffs and trigger a new six-year period, including most pertinently:

> 1. On July 17, 2015, CMS approved Texas's MCO contract including the HIPF in its capitation rates pursuant to ASOP 49 because CMS determined that the contract complied with the Certification Rule.
>
> 2. In September 2015, HHS released a guidance document that stated, "Actuaries are *required* to follow all Actuarial Standards of Practice; *particularly* . . . ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification). ASOP 49 . . . is especially relevant because it focuses on . . . the requirements under 42 C.F.R. § 438.6 [the Certification Rule]."

Pls.' Suppl. Br. 3–6, ECF No. 83 (emphasis added).

Defendants argue that these facts are insufficient to trigger a new six-year limitations period. *See* Defs.' Resp. Suppl. Br. 6–8, ECF No. 84. Specifically, Defendants argue that under *Dunn-McCampbell*, a new six-year limitations period only begins if Plaintiffs petition HHS to alter or rescind the Certification Rule, and HHS either denies the petition or enforces the Certification Rule in response to the petition. *See id.* at 2–4, 8–11. Because Plaintiffs never petitioned HHS, Defendants argue that the aforementioned agency actions were neither "final" nor "directly" applied to Plaintiffs. *See id.* at 5–7.

But *Dunn-McCampbell* did not, as Defendants claim, hold that an agency must act on a plaintiff's petition for

relief from a rule in order for that action to be "final" and to "directly" apply to the plaintiff. Rather, *Dunn-McCampbell* held that *any* "application of a rule to a party" triggers a new six-year limitations period, so long as it is "final." *See* 112 F.3d at 1287–88. *Dunn-McCampbell* cited three examples of final agency action applying a rule directly to a party: *Wind River*, *Public Citizen*, and *Texas*. *See id.* at 1287. In the first two examples—*Wind River* and *Public Citizen*—the plaintiffs petitioned the agency for relief from the regulation, and the agency denied the petition. *See Wind River Mining Corp. v. United States*, 946 F.2d 710, 715–16 (9th Cir. 1991); *Public Citizen v. Nuclear Regulatory Com'n*, 901 F.2d 147, 152–53 (D.C. Cir. 1990). *Dunn-McCampbell* concluded that such denials were "final" and "direct" agency actions against the plaintiff that "create[d] a new cause of action under the APA." 112 F.3d at 1287. In the third example—*Texas*—the plaintiff did not petition the agency for relief from the regulation; instead, the agency, in lieu of a third-party petition, issued an order requiring the plaintiff to comply with the regulation. *See Texas v. United States*, 730 F.2d 409, 411–12 (1984). *Dunn-McCampbell* concluded that this, too, was a "direct" and "final" agency action against the plaintiff triggering a new six-year limitations period. 112 F.3d at 1287.

Applying *Wind River*, *Public Citizen*, and *Texas*, the Fifth Circuit held that if Dunn-McCampbell "w[as] able to point to such an application of the regulations here, *or* if [it] had petitioned the National Park Service to change the 9B regulations and been denied," it could sue within six years of the agency's application of the rule or denial of the petition. *Id.* at 1287–88 (emphasis added). In other

words, as long as the agency took "final" action directly against the plaintiff, that agency action—not the plaintiff's petition—created a new six-year limitations period. *See Dunn-McCampbell*, 112 F.3d at 1287–88. Because Dunn-McCampbell could not point to a single final agency action applying the contested regulation directly to it, the court held that its claims were time-barred. *See id.*

Since *Dunn-McCampbell*, the Supreme Court has clarified that "final agency action" exists under two conditions: "'First, the action must mark the consummation of the agency's decisionmaking process—it must not be of a merely tentative or interlocutory nature. And second, the action must be one by which rights or obligations have been determined, or from which legal consequences will flow.'" *U.S. Army Corps of Engineers v. Hawkes Co.*, 136 S. Ct. 1807, 1813 (2016) (quoting *Bennett v. Spear*, 520 U.S. 154, 177–78 (1997)).[38] Agency action satisfies the first *Hawke*s prong if it is no longer "advisory in nature" but is instead "definitive [in] nature." *Id.* at 1813–14. Agency action satisfies the second *Hawkes* prong if it "gives rise to 'direct and appreciable legal consequences' . . . ." *Id.* at 1814

[38] The Fifth Circuit decided *Dunn-McCampbell* prior to *Bennett* and *Hawkes* and therefore applied the Supreme Court's then four-factor test to determine finality from *Abbott Labs. v. Gardner*, 387 U.S. 136 (1967). *See Dunn-McCampbell*, 112 F.3d at 1288 (citing *Abbott Labs.*, 387 U.S. at 149–53). *Bennett* subsequently "distilled" these four factors into "two conditions": whether the agency action is consummate and legally consequential. *Hawkes*, 136 S. Ct. at 1813 (quoting *Bennett*, 520 U.S. at 177–78).

(quoting *Bennett*, 520 U.S. at 178).[39] Under *Hawkes*, an agency's internal decision to collect debt payments from a debtor is "final" action against the debtor—even if the debtor has not petitioned the agency to suspend collection and the agency has not informed the debtor of its decision. *See Salazar v. King*, 822 F.3d 61, 64–72, 82–84 (2d Cir. 2016) (citing *Bennett*, 520 U.S. at 177–78). Moreover, an agency guidance document that reflects a "settled agency position" that the entire agency intends to follow in its enforcement of its regulations, and that gives "marching orders" to a regulated entity, is "final" agency action against the regulated entity—even if the document contains boilerplate denying its legal effect. *See Appalachian Power Co. v. E.P.A.*, 208 F.3d 1015, 1020–23 (D.C. Cir. 2000).

The undisputed evidence shows that HHS took at least three "direct, final agency actions" against Plaintiffs, triggering several new six-year statute of limitations periods. *Cf. Dunn-McCampbell*, 112 F.3d at 1287–88.

First, in July 2015, after Texas capitulated to ASOP 49 by including the HIPF in its MCO capitation rates, CMS sent a letter to the Texas Medicaid Director approving Texas's MCO contract because CMS determined that Texas had complied with the Certification Rule. Pls.' App. 513–14, ECF No. 54-1. CMS's approval of this MCO contract was neither tentative, interlocutory, nor advisory, but a consummate act that marked the conclusion of CMS's review process. *Cf. Hawkes*, 136 S. Ct. at 1813–14. CMS's approval also

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[39] The Court's ultimate determination of finality is "'flexible' and 'pragmatic.'" *Qureshi v. Holder*, 663 F.3d 778, 781 (5th Cir. 2011) (quoting *Abbott Labs.*, 387 U.S. at 149–50).

resulted in direct and appreciable legal consequences for Texas, namely, certifying the state's compliance with the Certification Rule, thereby entitling the state to receive Medicaid subsidies. *Cf. id*. Defendants argue that this approval letter is not "direct" and "final" agency action because it does not mention the state's compliance with ASOP 49 in particular—only with the Certification Rule in general. Defs.' Br. 42, ECF No. 63. But Plaintiffs are not challenging ASOP 49. Plaintiffs are challenging the Certification Rule, and CMS's approval letter constituted a "direct" and "final" agency action applying the Certification Rule to Texas. *Cf. Dunn-McCampbell*, 112 F.3d at 1287–88.

Second, Plaintiffs capitulated to ASOP 49 and paid the HIPF in their 2015 capitation rates. Pls.' App. 137, 1164, 1170, ECF No. 54-1. The Government then collected the HIPF from Plaintiffs' MCOs with the knowledge and expectation that Plaintiffs were paying the HIPF in order to comply with the Certification Rule. *See* 2015 MCO Guide (informing states that, in order to obtain an actuarial certification under the Certification Rule, they must follow ASOP 49 and pay the HIPF in their capitation rates). Therefore, when the Government collected the HIPF from Plaintiffs' MCOs, it consummated its decision to apply the Certification Rule and ASOP 49 directly to Plaintiff States, requiring Plaintiffs to pay the HIPF in order to receive Medicaid subsidies. *Cf. Salazar*, 822 F.3d at 64–72, 82–84 (holding that an agency's internal decision to continue collecting loans generates "legal consequences" for the borrowers, because it leaves the borrowers with a continuing "legal obligation to make payments" and the agency with continuing legal authority to "garnish wages or direct tax

refund offsets"). This "final" action collecting the HIPF stands in marked contrast to the total agency and plaintiff inaction in *Dunn-McCampbell*, where the agency did not apply its regulation to plaintiff's property and where the existence of the regulation merely "deterred" plaintiff from leasing its property. *See Dunn-McCampbell*, 112 F.3d at 1285–86. Here, the Government's collection of the HIPF is more like the collection of a debt in *Salazar* than the total agency inaction in *Dunn-McCampbell*. This is "final" action directly applying the Certification Rule to Plaintiffs. *Cf. Hawkes*, 136 S. Ct. at 1813–14; *Dunn-McCampbell*, 112 F.3d at 1287–88.

Third, in September 2015, HHS released a guidance document (the "Guide") "for use in setting [capitation] rates . . . for any managed care program subject to the actuarial soundness requirements in 42 C.F.R. § 438.6 [the Certification Rule]." 2015 MCO Guide. The Guide purported to give "more detailed" guidance than prior documents in order to evoke "more consistent and complete" compliance from the states. *Id.* The Guide declared that HHS "expect[s]" states to include the "the information outlined in this guide" in their capitation rate proposals to CMS "so that CMS can determine . . . if the capitation rates are appropriate . . . ." *Id.* The Guide further decreed, "Actuaries are *required* to follow all Actuarial Standards of Practice; *particularly* . . . ASOP 49 (Medicaid Managed Care Capitation Rate Development and Certification)." *Id.* (emphasis added). As if to put a fine point on its definitive, normative embrace of ASOP 49, HHS identified ASOP 49 as "especially relevant" because it established what states and MCOs must include in their capitation rates in order

for actuaries to approve them as "actuarially sound" under the Certification Rule. *Id.* Moreover, the Guide did not even contain a pretext of boilerplate language denying its legal effect on the states. *See id.* It therefore reflected HHS's "settled position" on the meaning of the Certification Rule and, pursuant to that rule, gave "marching orders" to Plaintiff States to include the HIPF in their MCO capitation rates. *Cf. Appalachian Power Co.*, 208 F.3d at 1020–23. The Guide was neither tentative, advisory, nor remote in its application—rather, it was consummate and definitive, creating direct and immediate legal consequences for Plaintiff States. *Cf. Hawkes*, 136 S. Ct. at 1813–14. Accordingly, it constituted "final" agency action applying the Certification Rule directly to Plaintiffs. *Cf. Dunn-McCampbell*, 112 F.3d at 1287–88.

There is no genuine dispute of material fact that Plaintiffs filed suit on October 22, 2015, less than six years after HHS took at least three different "final" agency actions directly applying the Certification Rule to Plaintiffs. Because Plaintiffs' Certification Rule claims are not time-barred, the Court **DENIES** Defendants' Motion for Summary Judgment (ECF No. 62) as to sovereign immunity.

B. Non-Delegation Claim (Count V)

Having found jurisdiction, the Court will now consider Plaintiffs' substantive claims, beginning with Plaintiffs' Certification Rule claims (Counts II, III, and V) before moving to Plaintiffs' HIPF claims (Counts I, IV, VI, VIII, IX, and X). In first addressing Plaintiffs' Certification Rule Claims, the Court will begin with Plaintiffs' constitutional claim that the Certification Rule violates the non-delegation doctrine (Count V), then

consider Plaintiffs' statutory claims that the Certification Rule violates the APA (Counts II, III, and V).

Plaintiffs argue that the Certification Rule gives the ASB and its actuaries "a discretionary veto" over CMS's approval of Plaintiffs' Medicaid contracts and is therefore an unconstitutional delegation of legislative power to a private entity. *See* Pls.' Br. 35–37, ECF No. 54. Defendants respond that the Certification Rule only gives the ASB and its actuaries an advisory role that is not a legislative delegation, but rather a permissible enlistment of technical expertise. *See* Defs.' Br. 34–38, ECF No. 63.[40]

1. History and Usage of the Non-Delegation Doctrine

Because litigants infrequently invoke the non-delegation doctrine, a review of its history is in order. This doctrine stems from the very first clause of the Constitution, which reads: "All legislative Powers . . . shall be vested in a Congress of the United States." U.S. CONST. art. I, § 1, cl. 1. "The Congress is not permitted to abdicate or to transfer to others the essential legislative functions with which it is thus vested." *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 529 (1935); s*ee Wayman v. Southard*, 10 Wheat. 1, 42–43 (1825) (Marshall, C.J.). An essential legislative function is the establishment of "standards of legal obligation." *Schechter Poultry*, 295 U.S. at 530; *see Dep't of Transp.*

[40] The APA requires this Court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . contrary to constitutional right, power, privilege, or immunity . . . ." 5 U.S.C. § 706(2)(B).

v. Ass'n of Am. R.R.s, 135 S. Ct. 1225, 1242 (2015) (Thomas, J., concurring) (describing an essential legislative function as "the formulation of generally applicable rules of private conduct"). This structural feature of the Constitution—vesting Congress alone with the unalienable power to make prospective and generally applicable rules of conduct—exists to protect democratic deliberation, executive accountability, and individual liberty. *See Ass'n of Am. R.R.s*, 135 S. Ct. at 1237 (Alito, J., concurring) ("Our Constitution, by careful design, prescribes a process for making law, and within that process there are many accountability checkpoints. It would dash the whole scheme if Congress could give its power away to an entity that is not constrained by those checkpoints.").

The vesting of legislative power in a distinct political body is a stumbling block to modern intellectuals and a stone rejected by the builders of the federal bureaucracy, but it has been and remains a cornerstone in the constitutional architecture of free government. The fountainheads of Western jurisprudence—the Hebrew, Greek, and Roman civilizations—understood "that a ruler must be subject to the law in exercising his power and may not govern by will alone," a principle which "presupposes at least two distinct operations, the making of law, and putting it into effect." *Ass'n of Am. Railroads*, 135 S. Ct. at 1242 (Thomas, J., concurring) (quotation marks omitted) (describing the Greco-Roman origins of Western rule of law); *see generally* RUSSELL KIRK, THE ROOTS OF AMERICAN ORDER (4th ed. 2003) (describing the Hebraic origins of Western rule of law). Building on this ancient principle, the English formally separated the legislative and executive powers, with

Parliament zealously guarding the legislative power from kingly encroachments. *See Ass'n of Am. Railroads*, 135 S. Ct. at 1242–43. By the time of the American Revolution, both John Locke and William Blackstone concluded that this separation was not merely convenient in avoiding tyranny, but a necessary feature of any government ruled by laws and not men. *See id.* at 1243–44. These ideas found an abiding voice in the United States Constitution. As James Madison explained,

> [T]he legislative, executive, and judiciary departments ought to be separate and distinct . . . No political truth is certainly of greater intrinsic value, or is stamped with the authority of more enlightened patrons of liberty, than [the separation of powers] . . . The accumulation of all powers, legislative, executive, and judiciary, in the same hands, whether of one, a few, or many, and whether hereditary, selfappointed, or elective, may justly be pronounced the very definition of tyranny.

THE FEDERALIST NO. 47. The vesting of legislative power in Congress alone, and its corollary doctrine of non-delegation, is enshrined in our charter because the framers, drawing from the deep wells of their Western heritage, recognized it as an axiom of just government. *Cf.* THE FEDERALIST NO. 51 ("It may be a reflection on human nature, that such devices should be necessary to control the abuses of government. But what is government itself, but the greatest of all reflections on human nature?").

When Congress creates law, it must often delegate a degree of policy judgment to an administrative agency constitutionally vested with executive power and tasked

with executing the law. *See Whitman v. Am. Trucking Ass'ns*, 531 U.S. 457, 474–75 (2001) (quoting *Mistretta v. United States*, 488 U.S. 361, 416 (1989) (Scalia, J., dissenting)). Executive agency rulemaking may therefore at times resemble lawmaking, but an agency's exercise of policy judgment in applying the law is in actuality an executive function. *see City of Arlington v. F.C.C.*, 569 U.S. 290, 305 n.4 (2013) ("Agencies make rules . . . and conduct adjudications . . . and have done so since the beginning of the Republic. These activities take 'legislative' and 'judicial' forms, but they are exercises of—indeed, under our constitutional structure they must be exercises of—the 'executive Power.'"). In order to enforce the non-delegation doctrine, courts must distinguish between unlawful delegations of legislative power and lawful delegations of policy judgment. *See Marshall Field & Co. v. Clark*, 143 U.S. 649, 693–94 (1892) ("The first cannot be done; to the latter no valid objection can be made."); *See also Panama Ref. Co. v. Ryan*, 293 U.S. 388, 421 (1935) (holding that courts must make this distinction "if our constitutional system is to be maintained"). Courts infrequently enforce the doctrine because it is inherently difficult to draw this distinction and identify an unlawful legislative delegation by Congress to an executive agency. *See Ass'n of Am. R.R.s*, 135 S. Ct. at 1237 (Alito, J., concurring).

"When it comes to [a legislative delegation to] private entities, however, there is not even a fig leaf of constitutional justification. Private entities are not vested with 'legislative Powers.' Nor are they vested with the 'executive Power,' which belongs to the President." *Id.* at 1237 (Alito, J., concurring) (citations omitted). Legislative delegation to a private entity is not

only easier to identify, it is "unknown to our law, and is utterly inconsistent with the constitutional prerogatives and duties of Congress." *Schechter Poultry*, 295 U.S. at 537. It is "legislative delegation in its most obnoxious form; for it is not even delegation to an official or an official body, presumptively disinterested, but to private persons whose interests may be and often are adverse to the interests of others . . . ." *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936). Only a government, deriving its powers from the consent of the governed, may justly establish legal rules of conduct for the nation. *Cf. id.* ("[I]n the very nature of things, one person may not be intrusted with the power to regulate the business of another . . . .").

While legislative delegations to executive agencies threaten liberty by undermining democratic accountability and short-circuiting bicameralism and presentment, *Ass'n of Am. R.R.s*, 135 S. Ct. at 1237 (Alito, J., concurring), legislative delegations to private entities are even more dangerous. They create a double layer of unaccountability, whereby legislative power—rightly exercised only by Congress—is passed by Congress to an unelected agency, and then by the agency to an unelected private entity. That private entity is not subject to term limits, appropriations, impeachment, or removal, and neither holds a commission nor takes an oath to uphold the Constitution. *See id.* at 1235 (Alito, J., concurring) ("Both the Oath and Commission Clauses confirm an important point: Those who exercise the power of Government are set apart from ordinary citizens. Because they exercise greater power, they are subject to special restraints. There should never be a

question whether someone is an officer of the United States . . . .").

Indeed, private lawmakers may, by virtue of their *sui generis*, quasi-public office, evade traditional avenues of judicial review. If private lawmakers are constitutional entities, they may enjoy sovereign immunity as quasi-governmental actors. *Cf. Lebron v. Nat'l R.R. Passenger Corp.*, 513 U.S. 374, 392 (1995) (observing that Amtrak, as a quasi-public entity, does not enjoy sovereign immunity from suit because a federal statute explicitly waives it). If so, aggrieved parties will be unable to challenge the private lawmaker's actions under the APA, because the plain text of the statute waives sovereign immunity for suits against an "agency"—not a private lawmaker. *See* 5 U.S.C. § 702. Moreover, even if it were possible to bring an APA claim against a private lawmaker, those suits would be time-barred in six years. *See* 28 U.S.C. § 2401(a). After the initial six-year limitations period lapsed, only subsequent action *by an agency* ratifying the private lawmaker's decision would make that decision reviewable. *See Dunn-McCampbell*, 112 F.3d at 1287. After six years, private lawmakers could alter the rights and duties of their fellow private citizens with impunity. These legal insulations from judicial scrutiny would create a powerful incentive for agencies, under the guise of seeking private expertise, to delegate increasing amounts of decision-making authority to private entities who could escape the constitutional check of litigation.

Private lawmaking is also incompatible with a free society. *Cf. State of Washington ex rel. Seattle Title Tr. Co. v. Roberge*, 278 U.S. 116, 122 (1928) (holding that the exercise of private legislative authority over another

person deprives that person of liberty without due process of law). Legislative delegation to private entities enables and incentivizes self-interested persons not to legislate for the common good, but to seek personal gain by placing arbitrary conditions on the liberty of their adversaries. *See Carter Coal*, 298 U.S. at 311 ("[I]t is not even delegation to an official or an official body, presumptively disinterested, but to private persons whose interests may be and often are adverse to the interests of others in the same business."); s*ee also Schechter Poultry*, 295 U.S. at 537 ("[W]ould it be seriously contended that Congress could delegate its legislative authority to trade or industrial associations or groups so as to empower them to enact the laws they deem to be wise and beneficent for the rehabilitation and expansion of their trade or industries? . . . The answer is obvious."). It is true that private lawmakers may be "familiar with the problems of the[ ] enterprises" that they are tasked to regulate, but not only does this fail as a constitutional justification, s*ee Schechter Poultry*, 295 U.S. at 537, it creates an even greater moral hazard—a fact that only heightens the urgency of judicial correction. *See Carter Coal*, 298 U.S. at 311.

2. The Certification Rule's Legislative Delegation

The following undisputed evidence demonstrates that the Certification Rule is a delegation of legislative power to a private entity in violation of Article I's Vesting Clause. First, Medicaid requires that capitation rates be "actuarially sound." *See* 42 U.S.C. § 1396b(m)(2)(A)(iii), (xiii). The Certification Rule then interprets this statutory provision in the following way:

> (i) *Actuarially sound capitation rates* means capitation rates that—
>
> (A) Have been developed in accordance with generally accepted actuarial principles and practices;
>
> (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; *and*
>
> (C) Have been *certified, as meeting the requirements of this paragraph (c), by actuaries who* meet the qualification standards established by the American Academy of Actuaries and *follow the practice standards established by the Actuarial Standards Board.*

42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002) (emphasis added).

The Certification Rule defines one ambiguous phrase, "actuarially sound," with another ambiguous phrase, "generally accepted actuarial principles and practices." *Id.* While it does not define "generally accepted actuarial principles and practices," it requires a private entity—an AAA actuary, who follows the practice standards of the ASB—to certify that a capitation rate meets "generally accepted actuarial principles and practices." *Id.* The Certification Rule therefore only allows HHS to approve a capitation rate as "actuarially sound" under the statute if one of the ASB's actuaries certifies—in accordance with the ASB's private interpretation of the Certification Rule—that the capitation rate satisfies "generally accepted actuarial principles and practices." *Id.* It follows, then, that the Certification Rule empowers the ASB to establish a controlling interpretation and definition of a legal

condition to receiving Medicaid subsidies (the "rulemaking power"), and to prevent HHS from approving any capitation rate that deviates from this private legal standard (the "veto power").

The Certification Rule thus delegated two distinct and essential legislative functions: the power to establish prospective, generally applicable rules of conduct, and the power to veto executive action that does not comply with those rules. *See Ass'n of Am. R.R.s*, 135 S. Ct. at 1242 (Thomas, J., concurring) (describing an essential legislative function as "the formulation of generally applicable rules of private conduct"); *I.N.S. v. Chadha*, 462 U.S. 919, 952–53 (1983) (describing the veto of executive action as "legislative in its character and effect"). Each delegation violates Article I's exclusive vesting of "all" legislative power in Congress. U.S. CONST. art. I, § 1, cl. 1; s*ee Whitman*, 531 U.S. at 472 ("This text permits no delegation of those powers . . . .").

If there is any doubt that in 2002 the Certification Rule delegated legislative power to the ASB, the subsequent history of the ASB defining "actuarially sound" to exclude the HIPF, HHS approving MCO contracts without the HIPF, and the ASB then re-defining "actuarially sound" to include the HIPF, dispel it. First, in 2005, the AAA defined "actuarially sound" capitation rates as including *inter alia* state taxes—but not federal taxes. Pls.' App. 98, ECF No. 54-1; s*ee supra* note 16. Then in 2013, the ASB published ASOP 1, which declared, "[T]he phrase 'actuarial soundness' has different meanings in different contexts . . . ." *Id.* at 99; s*ee supra* note 17. Perhaps because the ASB did not clearly require that capitation rates include federal taxes, or maybe because the ACA expressly excluded

states from paying the HIPF,[41] in 2014, HHS assured states that they would have "flexibility" to decide whether to include the HIPF in their capitation rates. *See* 2014 HIPF Guide. Plaintiffs did not pay the HIPF when it first came due in 2014, and HHS approved their contracts. *See* Pls.' App. 1168–70, ECF No. 54-1.

But in March 2015, the ASB's "Medicaid Rate Setting and Certification Task Force"[42] changed course and promulgated ASOP 49, which stated:

> The actuary should include an adjustment for any taxes, assessments, or fees that the MCOs are required to payout [sic] of the capitation rates. If the tax, assessment, or fee is not deductible as an expense for corporate tax purposes, the actuary should apply an adjustment to reflect the costs of the tax.

ASOP 49 § 3.2.12(d). Since the HIPF is a non-deductible tax,[43] ASOP 49 effectively declared that states must reimburse MCOs the full amount of the HIPF in their capitation rates in order for AAA actuaries to certify their rates under the Certification Rule. HHS then embraced these new ASB standards for compliance with the Certification Rule and affirmed in a guidance document that the states must comply with them. *See* 2015 MCO Guide. The undisputed evidence accordingly shows that ASB has dictated prospective, generally

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[41] ACA § 9010(c)(2)(B); 26 C.F.R. § 57.2(b)(2)(ii).

[42] The Court observes that the ASB felt it appropriate to muster, not an "Advisory Committee," but a "Task Force," to generate a document that in many respects has the appearance, structure, and tenor of a statutory or regulatory enactment. *See* Pls.' App. 225–57, ECF No. 54-1.

[43] ACA § 9010(f); 26 C.F.R. § 57.8.

applicable rules of conduct for meeting a legal condition to Medicaid subsidies. Indeed, because the Certification Rule delegates to the ASB power to prevent CMS from approving any MCO contract that deviates from its standards, HHS is obliged to follow the ASB's enactments—even when the ASB effectively rewrites the ACA, forcing the states to pay a tax when Congress has expressly forbidden the federal government to collect it from them. HHS's delegation of legislative power to the ASB therefore requires HHS to obey the ASB even over the express commands of Congress—which, in the final analysis, is the only proper legislative body in this entire scheme.

Defendants argue that the Supreme Court rejected a similar non-delegation claim in *Currin v. Wallace*, 306 U.S. 1 (1939). Defs.' Br. 35–36, ECF No. 63. In *Currin*, the challenged statute empowered the Secretary of Agriculture to designate tobacco markets for regulation, but provided that the Secretary's regulation would only go into effect if two-thirds of the tobacco growers in that designated market voted to approve the designation. *Id.* at 6. The Supreme Court held that this was not a legislative delegation. *Id.* at 15–16. Rather, Congress had "merely placed a restriction upon its own regulation by withholding its operation as to a given market 'unless two-thirds of the growers voting favor it.' . . . This is not a case where a group of producers may make the law and force it upon a minority . . . ." *Id.* at 15 (citing *Carter Coal*, 298 U.S. at 310, 318). The Supreme Court reached the same conclusion in a factually similar case decided the same term. *See United States v. Rock Royal Co-op.*, 307 U.S. 533, 574–78 (1939) (holding that "a requirement of such approval [by a private vote] would not be an

invalid delegation" because "Congress had the power to put [the Secretary's] Order into effect without the approval of anyone" (citing *Currin*, 306 U.S. at 15)).

These cases are distinguishable. In *Currin* and *Rock Royal*, the private voters could not exercise their veto authority unless the Secretary acted first. The laws empowered the Secretary of Agriculture to take certain regulatory actions and only empowered private entities to veto those actions once the Secretary took the initiative to do them. By contrast here, the Certification Rule grants the ASB, a private entity, interpretive power to establish prospective, generally applicable standards for establishing actuarially sound capitation rates, as well as power to prevent (through their private actuaries) CMS from approving any capitation rate proposal that does not abide by their binding standards. Importantly, the ASB's legislative powers operate on the states and the MCOs before HHS takes any action—indeed, independent of any HHS action—because the ASB enacts its rules, and their actuaries decide whether to certify an MCO contract pursuant to those rules, before the states even submit their MCO contracts to CMS for approval. Therefore, this case does not involve, as in *Currin* or *Rock Royal*, Congress empowering HHS to initially declare an MCO contract "actuarially sound," and then empowering the ASB to subsequently veto the agency's determination. This is instead a case of legislative delegation, where HHS has empowered the ASB to unilaterally and prospectively "make the law and force it upon" others. *Currin*, 306 U.S. at 15.[44]

[44] The delegation discussions in *Currin* and *Rock Royal* may no longer be good law. To the extent those cases hold that a mere veto of executive action does not amount to private lawmaking power, a

Defendants also argue that the Certification Rule is not a legislative delegation because "CMS maintains and exercises complete authority to review all such contracts and rates and the actuarial soundness thereof, and approves or denies contracts and rates on the basis of its own review." Defs.' Br. 34–38, ECF No. 63 (citing Defs.' App. 154–59, ECF No. 63-1). Defendants cite several persuasive authorities holding that an agency does not delegate legislative power when it considers the advice of a private party in making its decisions—provided the agency retains ultimate authority to reject that advice. *See id.* at 34–38 (citing *Fisher v. Berwick*, 503 F. App'x 210, 214 (4th Cir. 2013); *Pittston Co. v. United States*, 368 F.3d 385, 395 (4th Cir. 2004); *Riverbend Farms, Inc. v. Madigan*, 958 F.2d 1479, 1488 (9th Cir. 1992); *Cospito v. Heckler*, 742 F.2d 72 (3d Cir. 1984)). It is true that CMS conducts its own review to determine whether MCO capitation rates are "actuarially sound," but the Certification Rule plainly requires that the ASB's actuaries first certify those rates in order for CMS to approve them. *See* 42 C.F.R. § 438.6(c)(1)(i)(C) ("*Actuarially sound capitation rates* means capitation rates that . . . [h]ave been certified . . . by actuaries who . . . follow the practice standards established by the Actuarial Standards Board." (emphasis in original)). Moreover, Defendants' own expert testified that CMS

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subsequent and landmark decision by the Supreme Court calls this conclusion into question. *See Chadha*, 462 U.S. at 952–53 (holding that the veto of executive action is "legislative in its character and effect"); *see also Ass'n of Am. R.R.s*, 135 S. Ct. at 1253–54 (Thomas, J., concurring) (identifying *Currin* and *Rock Royal* as "questionable precedents" that are "directly contrary" to *Chadha*, "discredited," and "lack[ing] any force"). Regardless, here HHS delegated more than the mere *ex post* veto power that was at issue in those cases.

will not review an MCO contract unless and until an actuary has certified it:

> *[T]he state actuary must certify the rates or rate ranges* . . . . *Next*, a state sends a contract or contract amendment to the appropriate CMS Regional Office ("RO"), and the CMS actuarial review process begins. *After ensuring . . . that it contains the rate certification* . . . the RO forwards the contract package to the Center for Medicaid and CHIP Services (CMCS).

Defs.' App. 154–59 (Truffer Decl.), ECF No. 63-1 (e) (emphasis added). CMS will subsequently "render[ ] its own actuarial opinion as to whether the rates are actuarially sound," but only after a private actuary has certified them as such. *See id.* at 159. Truffer's testimony thus adheres to the Certification Rule's text and confirms its plain meaning, proving that CMS will only consider and approve an MCO contract *after* it is certified. And there is no evidence that CMS can or does entertain any MCO contract that is not certified by an AAA actuary.

The undisputed evidence therefore establishes that the ASB's private definition of "actuarial soundness" is, by virtue of the Certification Rule's legislative delegation, the baseline legal standard and regulatory floor that all MCO contracts must first clear to obtain CMS approval—regardless whether CMS erects additional or higher legal barriers in its own review process. CMS may disapprove an MCO contract that contains a private certification, but Truffer's testimony and the text of the regulation establish that CMS may not consider or approve an MCO contract without one.

The ASB's rulemaking and veto powers are therefore binding on CMS and not merely advisory.

Defendants further argue that ASOP 49 is advisory because a different ASOP—ASOP 41—provides that an actuary may permissibly deviate from an ASOP if the actuary "provid[es] an appropriate statement" of his rationale. Defs.' Br. 37 n.26, ECF No. 63. This argument also fails. ASOP 41 allows individual actuaries to establish their own prospective, generally applicable rules for setting capitation rates and—by the grace of the ASB—to use these rules to certify a capitation rate. Far from negating or diminishing the Certification Rule's initial delegation, this appears to constitute yet another delegation, now from a private organization (the ASB) to a private individual (an actuary).[45]

Finally, Defendants argue that HHS did not delegate legislative authority through the Certification Rule because the ASB and its actuaries are not "interested private parties" tasked with regulating business competitors. Defs.' Br. 37–38, ECF No. 63. It is true that Plaintiffs have not pointed to any evidence that the ASB and its actuaries "have a financial interest in the outcome of capitation-rate negotiations." *Id.* But even if they are unbiased, this does not, as Defendants contend, purge the legislative delegation of constitutional infirmity. Article I's Vesting Clause is a structural provision that prohibits legislative delegation with or without proof of

[45] Even if the ASB abjured its legislative power in ASOP 41 (it did not), this would not cure the unlawful delegation. *See Whitman*, 531 U.S. at 472 (2001) ("The very choice of which portion of the power to exercise . . . would *itself* be an exercise of the forbidden legislative authority." (emphasis in original)).

an additional constitutional harm.[46] The legislative delegation itself is the harm. *See Whitman*, 531 U.S. at 472. ("In a delegation challenge, the constitutional question is whether the statute has delegated legislative power to the agency.") The Court agrees that the delegation here could have been worse in both degree and effect, as the Supreme Court has previously struck down more extreme delegations. *See, e.g.*, *Schechter Poultry*, 295 U.S. at 529, 542 (striking down a private legislative delegation to enact "codes of fair competition" for business competitors); *Carter Coal*, 298 U.S. at 310–11 (striking down a private legislative delegation to enact labor regulations for business competitors). But it is not the quantitative volume of legislative delegation that establishes a constitutional violation; rather, the Constitution prohibits any delegation of what is qualitatively legislative power. *See* U.S. CONST. art. I, § 1, cl. 1 ("*All* legislative Powers . . . shall be vested in a Congress of the United States." (emphasis added)); *See also Whitman*, 531 U.S. at 472 ("[Article I] permits no delegation of [legislative] powers . . . .").

The Certification Rule raises constitutional questions "of the gravest character, and the court ha[s] given to them the most anxious and deliberate consideration." *Proprietors of Charles River Bridge v. Proprietors of Warren Bridge*, 36 U.S. 420, 536 (1837). Upon such consideration, it is evident that "the Supreme Court has

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[46] In an ironic turn, Defendants downplay the continuing authority of *Schechter Poultry* and *Carter Coal* by labeling them "*Lochner*-era cases," but then insist that *Carter Coal*'s non-delegation doctrine only applies where a legislative delegation also resembles economic class legislation. *See* Defs.' Br. 37–38, ECF No. 63.

never approved a regulatory scheme that so drastically empowers a private entity," *Ass'n of Am. Railroads v. U.S. Dep't of Transp.*, 721 F.3d 666, 671 (D.C. Cir. 2013) (Brown, J.), and the text of the Constitution expressly forbids this Court from doing so. The Court finds that there is no genuine dispute of material fact that the Certification Rule delegated legislative power to private entities in violation of Article I's Vesting Clause. *See* U.S. CONST art. I, § 1, cl. 1. Accordingly, the Court **GRANTS** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to their non-delegation claim in Count V and declares that 42 C.F.R. § 438.6(c)(1)(i)(C) is set aside as "contrary to constitutional right, power, privilege, or immunity . . . ." 5 U.S.C. § 706(2)(B). The Court **DENIES** Defendants' Motion for Summary Judgment (ECF No. 62) as to the non-delegation claim in Counts V.

C. APA Claims (Counts II, III, and V)

Plaintiffs allege that the Certification Rule violates the APA because: (1) it enabled the ASB to enact ASOP 49, thereby imposing the HIPF on the states; (2) it imposed the HIPF on the states without notice and comment, and (3) its imposition of the HIPF was arbitrary and capricious. Pls.' Br. 37–42, ECF No. 54.[47] Defendants respond that: (1) the Certification Rule is permissible under *Chevron* because Congress intended "actuarially sound" capitation rates to include taxes like the HIPF, and that interpretation is reasonable; (2) the Certification Rule always required paying the HIPF and therefore ASOP 49 did not require notice and comment;

[47] The Court construes Plaintiffs' challenge to "agency action" in Count V as a challenge to the Certification Rule. *See* Pls.' Am. Compl. 22–23, ECF No. 19.

and (3) the imposition of the HIPF was not arbitrary and capricious. Defs.' Br. 43–50, ECF No. 63.[48]

1. APA Statutory Authority Requirement

The Court will first consider whether the Certification Rule is a permissible interpretation of Medicaid's "actuarial soundness" requirement. "When a court reviews an agency's construction of the statute which it administers, it is confronted with two questions. First, always, is the question whether Congress has directly spoken to the precise question at issue. If the intent of Congress is clear, that is the end of the matter . . . ." *Chevron, U.S.A., Inc. v. Nat. Res. Def. Council, Inc.*, 467 U.S. 837, 842–43 (1984). However, if "the statute is silent or ambiguous with respect to the specific issue, the question for the court is whether the agency's answer is based on a permissible construction of the statute." *Id.*; *see also, e.g., Encino Motorcars, LLC v. Navarro*, 136 S. Ct. 2117, 2125 (2016) ("[A]t the second step the court must defer to the agency's interpretation if it is 'reasonable.'"). "[C]onsiderable weight should be accorded to an executive department's construction of a statutory scheme it is entrusted to administer . . . ." *Chevron*, 467 U.S. at 844.

Medicaid requires MCO capitation rates to be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii), (xiii). Congress, however, did not define "actuarially sound." *See id.* The words "actuarially sound" indicate

[48] The APA requires this Court to "hold unlawful and set aside agency action, findings, and conclusions found to be . . . arbitrary, capricious, an abuse of discretion, or otherwise not in accordance with law . . . [or] in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . ." 5 U.S.C. § 706(2)(A), (C).

that Congress intended capitation rates to be economically sustainable according to principles of actuarial science. However, Congress did not identify what actuarial principles ought to govern MCO capitation rates or how HHS ought to apply them to individual MCO contracts.[49] Because it is not clear from the text of the statute what costs the states and MCOs must include in their capitation rates in order for those rates to be sound according to principles of actuarial

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[49] The Supreme Court has twice identified such a textual ambiguity as an unconstitutional legislative delegation. For example, in *Schechter Poultry*, the Supreme Court held that a law empowering an agency to enact "codes of fair competition" delegated legislative power because it did not guide the agency's discretion with the common law of unfair competition or a similarly intelligible principle. *See* 295 U.S. at 528–42. And in *Panama Refining*, the Supreme Court held that a law empowering the President to interdict petroleum sales that exceeded state law quotas delegated legislative power because it did not guide the President's discretion with a Congressional policy. *See* 293 U.S. 414–30. Courts continue to grapple with this abiding constitutional doctrine. A concurring opinion in the recent "travel ban" litigation held that a statute empowering the President to suspend any entry of aliens "detrimental to the interests of the United States," without a saving construction, would be a legislative delegation because the statutory language would not guide the President's discretion. *See Int'l Refugee Assistance Project v. Trump*, No. 17-2231, 2018 WL 894413, at *33–38 (4th Cir. Feb. 15, 2018) (Gregory, C.J., concurring). *But see* Josh Blackman, *The Travel Ban, Article II, and the Nondelegation Doctrin*e, (Feb. 22, 2018, 9:00 AM) LAWFARE BLOG, https://www.lawfareblog.com/travel-ban-article-ii-and-nondelegation-doctrine ("There is, without question, an intelligible principle for the president to apply: The entry of the aliens must be 'be detrimental to the interests of the United States.'"). The Court will not address this issue because Plaintiffs do not claim that the "actuarially sound" language is a delegation. *See* Am. Compl. 19–29, ECF No. 19.

science, the Court finds that the phrase "actuarially sound" is ambiguous. Accordingly, the Court defers to the agency's interpretation of "actuarially sound" so long as its interpretation is reasonable. *Cf. Chevron*, 467 U.S. at 842–43.

> The Certification Rule interprets "actuarially sound" in the following way:
>
> > (i) *Actuarially sound capitation rates* means capitation rates that—
> >
> > (A) Have been developed in accordance with generally accepted actuarial principles and practices;
> >
> > (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; and
> >
> > (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002) (emphasis in original). The Court finds that HHS reasonably concluded that "actuarially sound" capitation rates are those rates that accord with actuarial principles that rise to the level of a professional consensus in the field of actuarial science. *See* 42 C.F.R. § 438.6(c)(1)(i)(A). The Court also finds HHS reasonably concluded that "sound" capitation rates are those rates that are "appropriate" for their respective populations. *See* 42 C.F.R. § 438.6(c)(1)(i)(B). Accordingly, the Court finds that

HHS's interpretation of Medicaid in 42 C.F.R. § 438.6(c)(1)(i)(A)–(B) is entitled to *Chevron* deference.

But HHS acted unreasonably when it concluded that "actuarially sound" capitation rates *must* be certified by an AAA actuary who follows the ASB's practice standards. *See* 42 C.F.R. § 438.6(c)(1)(i)(C). Just as courts must presume that a statute is constitutional, it is unreasonable for an agency to interpret a statute in a way that imputes to Congress an intent to violate the Constitution. *Cf. Adkins v. Children's Hosp. of the D.C.*, 261 U.S. 525, 544 (1923) ("This court, by an unbroken line of decisions from Chief Justice Marshall to the present day, has steadily adhered to the rule that every possible presumption is in favor of the validity of an act of Congress until overcome beyond rational doubt."). Because HHS's interpretation of "actuarially sound" in 42 C.F.R. § 438.6(c)(1)(i)(C) imputes to Congress an intent to unconstitutionally delegate legislative power to a private entity, *see supra* Part III.B, the Court finds that HHS's interpretation is unreasonable and not entitled to *Chevron* deference.

Accordingly, the Court finds that there is no genuine dispute of material fact that 42 C.F.R. § 438.6(c)(1)(i)(C) (2002) is "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . ." 5 U.S.C. § 706(2)(C). The Court **GRANTS** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to their statutory interpretation claim in Count V and declares that 42 C.F.R. § 438.6(c)(1)(i)(C) is set aside as "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . ." 5 U.S.C. § 706(2)(C). The Court **DENIES** Defendants' Motion for Summary Judgment

(ECF No. 62) as to the statutory interpretation claim in Counts V.

2. APA Notice and Comment Requirement

The Court will next consider whether the Certification Rule violated the APA's requirement of notice and comment. The APA requires notice and comment prior to the enactment of a "rule." *See* 5 U.S.C. § 553. The APA defines a "rule" as "the whole or a part of an agency statement of general or particular applicability and future effect designed to implement, interpret, or prescribe law or policy or describing the organization, procedure, or practice requirements of an agency . . . ." 5 U.S.C. § 551(4). "The notice-and-comment requirements apply . . . only to so-called 'legislative' or 'substantive' rules; they do not apply to 'interpretative rules, general statements of policy, or rules of agency organization, procedure, or practice.'" *Lincoln v. Vigil*, 508 U.S. 182, 196 (1993).

It is undisputed that HHS promulgated the Certification Rule through notice and comment. The Court therefore finds that the Certification Rule does not violate the APA's procedural requirements. Plaintiffs argue that the Certification Rule violates the APA because it enabled the ASB to enact ASOP 49, and HHS—without notice and comment—formally embraced ASOP 49 in their 2015 MCO Guide. *See* Pls.' Br. 37–40, ECF No. 54. In that case, however, the Guide would violate the APA—not the Certification Rule. Accordingly, the Court **DENIES** Plaintiffs' Motion for Summary Judgement (ECF No. 53) as to Count III and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Counts III.

3. APA Arbitrary and Capricious Requirement

The Court will next consider whether the Certification Rule was arbitrary and capricious. The Court determines whether an agency action is arbitrary and capricious "solely on the basis of the agency's stated rationale at the time of its decision." *Luminant Generation Co. v. U.S. E.P.A.*, 675 F.3d 917, 925 (5th Cir. 2012). Plaintiffs concede that they "don't challenge whether [the Certification Rule] was reasonable in 2002." Pls.' Reply 25, ECF No. 66. Therefore, Plaintiffs have not shown that the Certification Rule was arbitrary and capricious. The Court **DENIES** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to Count II and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Counts II.

D. Spending Clause Claims (Counts I, IV, and VIII)

The Court will next consider Plaintiffs' HIPF claims (Counts I, IV, VI, VIII, IX, and X), beginning with Plaintiffs' claim that the HIPF violates the Spending Clause (Counts I, IV, and VIII). Plaintiffs argue that the HIPF violates the Constitution's Spending Clause because the HIPF: (1) is impermissibly coercive; (2) fails to provide clear notice as a condition of federal funding; and (3) is unrelated to Medicaid. Pls.' Br. 21–28, ECF No. 54. Defendants argue that the HIPF does not violate the Spending Clause because: (1) Congress enacted the HIPF as a tax, not as a welfare program or as a condition on Medicaid; (2) the ASB imposed the HIPF on the states pursuant to long-standing Medicaid requirements; and (3) the HIPF reasonably relates to Medicaid by generating revenue for ACA programs. Defs.' Br. 24–28, ECF No. 63.

"The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the . . . general Welfare of the United States . . . ." U.S. CONST. art. I, § 8, cl. 1.[50] There is no dispute that the HIPF is a tax. The question remains whether the HIPF is also a coercive, surprising, or unrelated condition on spending in violation of the Spending Clause.

1. Impermissibly Coercive

The Court will first consider whether the HIPF is a coercive condition on spending. Plaintiffs claim that the threat of losing all of their federal Medicaid funds if they do not pay the HIPF makes the HIPF a coercive condition on spending. Pls.' Br. 25, ECF No. 54. Defendants respond that the HIPF is not a condition on Medicaid funding, and that even if it is a condition, it is not coercive under *NFIB*, 567 U.S. 519, because it is a tax, not a new welfare program. Defs.' Br. 24–27, ECF No. 63.

Congress may grant federal funds to the states and condition such grants upon the states "taking certain actions that Congress could not [otherwise] require them to take." *NFIB*, 567 U.S. at 576 (quotation marks omitted). But the Constitution places limits on Congress's power to use spending conditions to secure state compliance with federal objectives. *Id.* Important among them is the requirement that the states accept spending conditions "voluntarily." *Id.* at 577 (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). "Congress may use its spending power to

[50] The Court will hereinafter refer to the General Welfare Clause as the Spending Clause.

create incentives for States to act in accordance with federal policies. But when 'pressure turns into compulsion,' the legislation runs contrary to our system of federalism." *Id.* at 577–78 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)). "Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *Id.* at 577.

In *NFIB*, the Supreme Court considered whether the ACA's requirement that states dramatically expand Medicaid coverage[51] or forfeit all federal Medicaid funds was an unconstitutionally coercive condition on spending. *Id.* at 581–85. The Supreme Court invalidated the penalty for noncompliance, finding that "[t]he threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce" and was therefore impermissibly coercive. *Id.* at 581–82. The Medicaid expansion was so dramatic it was "in reality a new program . . . [not] a mere alteration of existing Medicaid." *Id.* at 582–84. While Congress could have offered increased Medicaid funding in exchange for continued participation in the Medicaid program, the Spending Clause did not allow Congress to condition

[51] Under the pre-ACA Medicaid program, states were required "to cover only certain discrete categories of needy individuals—pregnant women, children, needy families, the blind, the elderly, and the disabled." *NFIB*, 567 U.S. at 575 (citing 42 U.S.C. § 1396a(a)(10)). Under the post-ACA Medicaid expansion, states were required "to cover all individuals under the age of 65 with incomes below 133 percent of the federal poverty line." *Id.* (citing 42 U.S.C. § 1396a(a)(10)(A)(i)(VIII)).

existing Medicaid funds on participation in a new welfare program. *See id.* at 582–85.

It is true that, unlike the Medicaid expansion in *NFIB*, the HIPF is a tax and not a new welfare program. But this distinction is not dispositive. Because of the Certification Rule's legislative delegation to the ASB, *see supra* Part III.B—and the ASB's promulgation of ASOP 49—the HIPF is now functionally operating as a condition on Medicaid funds. Just as in *NFIB*, the Government here threatens to withhold all of Plaintiffs' Medicaid subsidies if Plaintiffs do not comply with a new and onerous federal condition. *NFIB* involves different facts, but its holding controls this case.

The fundamental question posed by *NFIB* in this case is whether Plaintiff States "voluntarily" accepted the spending condition. 567 U.S. at 577 (quoting *Pennhurst*, 451 U.S. at 17). The Court finds that if Congress conditions existing Medicaid funds on whether states pay a new and onerous federal tax that was not a part of the original Medicaid bargain—this condition would be coercive and violate the Spending Clause. This conclusion is consistent with the holding and underlying logic of *NFIB*, and a contrary finding would open the door to further constitutional violations. For if the Spending Clause allows the Government to impose new and onerous taxes as retroactive conditions on spending, Congress could evade the Tenth Amendment's intergovernmental tax immunity by enacting a "voluntary" tax on the states and attaching it as a spending condition. *See infra* Part III.E (discussing the Tenth Amendment's intergovernmental tax immunity). So long as Congress framed the tax as a "voluntary" alteration to a pre-existing spending deal, the states

would have to accept it, and pray the Government did not alter it any further.[52]

The Court finds, however, that Congress enacted the HIPF as a tax—an ordinary, unadorned tax—not as a condition on Medicaid funds. Indeed, the ACA expressly excludes the states from paying the HIPF. ACA § 9010(c)(2)(B). It would be improper for the Court to declare that a statute violates the Spending Clause as a coercive condition on spending when Congress plainly fashioned the statute so that it would not be a condition on spending—indeed, so that the states would not pay it at all. Plaintiffs' grievance is with HHS's legislative delegation to the ASB—empowering the ASB to issue legislative decrees that transformed the HIPF into a spending condition—not with Congress's routine exercise of the taxing power. Accordingly, the Court finds that the HIPF is not a coercive condition on spending in violation of the Spending Clause. The Court **DENIES** Plaintiffs' Motion for Summary Judgement (ECF No. 53) as to Count IV and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Counts IV.

2. Clear Notice

Plaintiffs also claim that the HIPF violates the Spending Clause because the Government did not give the states clear notice that it would condition federal Medicaid funds on paying the HIPF. *See* Pls.' Br. 26–28, ECF No. 54. Defendants respond that the requirement that states account for the HIPF in their capitation rates did not surprise Plaintiffs because it merely reflected a

[52] This deal would get worse all the time, as Congress would have an obvious incentive to manipulate this constitutional loophole and pilfer state coffers to fund ever-expanding federal priorities.

long-standing requirement in Medicaid that capitation rates be actuarially sound. Defs.' Br. 27–28, ECF No. 63.

"When Congress enacts legislation under its spending power, that legislation is 'in the nature of a contract: in return for federal funds, the States agree to comply with federally imposed conditions.'" *Jackson v. Birmingham Bd. of Educ.*, 544 U.S. 167, 181–82 (2005) (quoting *Pennhurst*, 451 U.S. at 17).[53] As such, "'[t]here can . . . be no knowing acceptance [of the terms of the contract] if a State is unaware of the conditions imposed by the legislation on its receipt of funds.'" *Id.* at 182 (quoting *Pennhurst*, 451 U.S. at 17) (alterations in original). The text of a statute must enable a state official to "clearly understand" the conditions the state is agreeing to when it accepts federal funds. *Arlington Cent. Sch. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296–97 (2006) (holding that the statutory provision at issue did not even hint that acceptance of federal funds was conditioned on a State reimbursing prevailing parties for expert fees).

Defendants claim that Plaintiffs received clear notice that the HIPF would be a condition on spending because prior to the ACA, states were required to account for other taxes in their capitation rates. *See* Defs.' Br. 28, ECF No. 63; Defs.' Reply 11–15, ECF No. 67. But the

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[53] Because spending programs forge what is in principle, if not in law, a contractual relationship between the states and the federal government, certain common law rules of contract govern their constitutionality. *See Jackson*, 544 U.S. at 181–82; *see also* Steven C. Begakis, *Rediscovering Liberty of Contract: The Unnoticed Economic Right Contained in the Freedom of Speech*, 50 LOY. L.A. L. REV. 57, 64–66, 84–85 (2017) (discussing the objective reality of contractual relationships, which exist independent from—and thereby justify and demand—the positive law's protection of them).

ACA explicitly exempts Plaintiffs from paying the HIPF. ACA § 9010(c)(2)(B). Defendants have pointed to no evidence that the Government ever required states to pay taxes in their capitation rates that the law expressly exempted the states from paying. Defendants correctly observe that Congress reserved the right to "alter" or "amend" the terms of the Medicaid program in the Medicaid statute, Defs.' Br. 26, ECF No. 67 (quoting 42 U.S.C. § 1304), but Plaintiffs could not have anticipated a requirement to pay the HIPF unless and until Congress amended the ACA to remove their statutory exemption.

This conclusion notwithstanding, the Spending Clause only requires that spending conditions give clear notice. *See Pennhurst*, 451 U.S. at 17. The HIPF is an ordinary tax and not a spending condition. *See supra* Part III.D.1. If the HIPF is not a spending condition, it cannot violate the Spending Clause's requirement that spending conditions give clear notice. Accordingly, the Court **DENIES** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to Count I and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Count I.

3. Relatedness

Finally, Plaintiffs claim that the HIPF, as a condition of Medicaid funding, is unrelated to the purpose of the Medicaid program because Congress spends the HIPF funds on ACA subsidies for non-Medicaid recipients. Pls.' Br. 26, ECF No. 54. Defendants respond that the ACA does not direct the use of HIPF funds in this way. Defs.' Br. 27, ECF No. 54.

A condition on spending must reasonably relate to the purpose for which the funds are spent. *South Dakota*

v. Dole, 483 U.S. 203, 207–08. In *Dole*, the Supreme Court held that Congress could condition highway funds on raising the minimum legal drinking age because regulating alcohol consumption was reasonably related to one of the main purposes of highway funding, namely safety in interstate travel. *Id.* at 208. Similarly here, Defendants have put forward evidence that the Government collects the HIPF into the general Treasury fund, Defs.' App. 10 (Golden Decl.), ECF No. 63-1, which Congress uses to fund all Government programs—including Medicaid. Because Congress uses the HIPF, at least in part, to fund Medicaid, the imposition of the HIPF as a condition on Medicaid reasonably relates to the Medicaid program.

Moreover, the Court finds that the HIPF is only operating as a condition on Medicaid by virtue of the Certification Rule's legislative delegation, *supra* Part III.B, and is not in itself a spending condition that implicates the Spending Clause. *Supra* Part III.D.1. Because the law exempts states from paying the HIPF, there is no genuine dispute of material fact that the HIPF is a constitutional tax and not a coercive, surprising, or unrelated condition on spending. Accordingly, the Court **DENIES** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to Count VIII and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Count VIII.

E. Tenth Amendment Claim (Counts VI and X)

Plaintiffs claim that the HIPF, facially and as applied, violates the Tenth Amendment's intergovernmental tax immunity. Pls.' Am. Compl. 23–

24, 26–27, ECF No. 19.[54] Plaintiffs argue that the HIPF discriminates against them as states and unduly interferes with their sovereign functions, even as the HIPF does not represent a traditional source of federal revenue. *See* Pls.' Br. 30–35, ECF No. 54. Defendants respond that the HIPF does not discriminate against a sovereign because its legal incidence falls on the MCOs, not the states. Defs.' Br. 29–34, ECF No. 63. Defendants also argue that Plaintiffs are precluded from arguing that the HIPF interferes with state sovereignty because Plaintiffs litigated and lost the issue on the merits in *Fla. ex rel. McCollum v. U.S. Dep't of Health & Human Servs*., 716 F. Supp. 2d 1120 (N.D. Fla. 2010). *Id*. at 33–34. The Court will consider Counts VI and X together, as the parties have done in their briefing. *See* Pls.' Br. 30–35, ECF No. 54; Defs.' Br. 29–34, ECF No. 63.

The Supreme Court first announced the doctrine of intergovernmental tax immunity in *McCulloch v. Maryland* where the Supreme Court held that the Supremacy Clause prohibited states from directly taxing the federal government. *See* 17 U.S. 316, 425–37 (1819). "Since *McCulloch*, [the Supreme Court] has adhered to the rule that States may not impose taxes directly on the Federal Government, nor may they impose taxes the legal incidence of which falls on the Federal Government." *United States v. Fresno Cty*., 429 U.S. 452, 459 (1977). "A tax is considered to be directly on the Federal Government only 'when the levy falls on the United States itself, or on an agency or instrumentality

[54] The Court previously dismissed Count X to the extent it sought a HIPF refund, but otherwise deferred a ruling on Defendants' motion to dismiss Count X. Aug. 4, 2016 Order 21, ECF No. 34.

so closely connected to the Government that the two cannot realistically be viewed as separate entities.'" *South Carolina v. Baker*, 485 U.S. 505, 523 (1988). The states may enact a tax on a private party, even if the economic burden falls entirely on the federal government, provided the tax "does not discriminate against the United States or those with whom it deals." *Id.* at 521, 523.

The Tenth Amendment reserves to the states a similar tax immunity. *See id.* at 518 n.11 ("[S]tate immunity arises from the constitutional structure . . . ."). "The rule with respect to state tax immunity is essentially the same" as federal tax immunity. *Id.* at 523. The only difference between federal and state tax immunity is that the federal government may collect certain taxes from the states directly—provided the tax does not discriminate against the states and those with whom they deal. *See id.* at 523, 523 n.14.[55] Thus, the central question in a state tax immunity cases is whether the tax "discriminates" against the sovereign—that is, whether the legal incidence of the tax falls solely upon the sovereign or the sovereign's functionaries, and not on any purely private entities. *See id.* at 517–23; *see also New York*, 326 U.S. at 587 (Stone, C.J., concurring) ("[T]he phrase 'non-discriminatory tax' . . . refer[s] to a tax laid on a like subject matter, without regard to the personality of the taxpayer . . . ."). An entity is not private if it "stand[s] in the [sovereign's] shoes," or is "so assimilated by the [sovereign] as to become one of its

[55] The Supreme Court in *Baker* briefly remarked that the federal government could collect "at least some" federal taxes directly from the states, but declined to elaborate what those taxes are. *See* 485 U.S. at 523, 523 n.14.

constituent parts." *United States v. New Mexico*, 455 U.S. 720, 736 (1982) (quotation marks omitted).

While the ASB—wielding delegated legislative power from HHS—effectively rewrote the ACA to require the states to pay the HIPF, *supra* Part III.B, the HIPF itself prohibits this very form of tax discrimination against a sovereign. Indeed, Congress discriminated in the opposite direction, levying the HIPF on private MCOs and explicitly exempting the states from paying it. ACA § 9010(c)(2)(B). Moreover, while MCOs work closely with the states, they are private businesses without government control or oversight. An MCO is not "so assimilated by the [state] as to become one of its constituent parts." *Cf. New Mexico*, 455 U.S. at 736 (noting that intergovernmental tax immunity does not apply to private contractors). Because Congress constructed the HIPF so that it would target the MCOs and not the states, the Court finds that the HIPF does not discriminate against the states in violation of state tax immunity.

It is possible that a non-discriminatory tax "may nevertheless so affect the State, merely because it is a State that is being taxed, as to interfere unduly with the State's performance of its sovereign functions of government." *New York*, 326 U.S. at 587 (Stone, C.J., concurring). Plaintiffs argue that the HIPF interferes with their sovereign functions because it forces the states to raise new taxes on their citizens to pay the HIPF, commandeering their legislators and executive officials to enact and enforce federal policy in violation of *Printz v. United States*, 521 U.S. 898, 925–33 (1997). *See* Pls.' Br. 34, ECF No. 54. Assuming *arguendo* that this argument is not precluded, the Court finds it unavailing.

There is indeed undisputed evidence in this case that the states had to reshape their annual budgets to account for the HIPF. *See, e.g.*, Pls.' App. 1169–71, ECF No. 54-1. But it was the ASB's imposition of the HIPF on Plaintiffs, not the HIPF itself, that precipitated Plaintiffs' legislative actions. *Supra* Part III.B. The Court finds that the HIPF, when properly applied only to the MCOs, imposes at most an incidental economic burden on Plaintiffs. Plaintiffs have not shown that this incidental burden unconstitutionally interferes with their sovereign functions.

Accordingly, the Court finds that there is no genuine dispute of material fact that the HIPF is constitutional under the Tenth Amendment. The Court **DENIES** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to Counts VI and X and **GRANTS** Defendants' Motion for Summary Judgment (ECF No. 62) as to Counts VI and X.

F. Permanent Injunction Claim (Count IX)

Plaintiffs also request a permanent injunction to prevent Defendants from prospectively collecting the HIPF because the HIPF is unlawful. *See* Pls.' Am. Compl. 26, ECF No. 19. To receive a permanent injunction, the movant must show *inter alia* actual success on the merits. *Doe v. KPMG, L.L.P.*, 325 F. Supp. 2d 746, 751 (N.D. Tex. 2004) (citing *Harris Cty. v. CarMax Auto Superstores, Inc.*, 177 F.3d 306, 312 (5th Cir. 1999)). Here Plaintiffs have not established actual success in challenging the legality of the HIPF. *Supra* Part III.D–E. Accordingly, the Court may not permanently enjoin federal officials from collecting the HIPF. The Court **DENIES** Plaintiffs' Motion for Summary Judgment (ECF No. 53) as to Count IX and

GRANTS Defendants' Motion for Summary Judgment (ECF No. 62) as to Count IX.

IV. CONCLUSION

For the foregoing reasons, the Court finds that Plaintiffs' Motion for Summary Judgment (ECF No. 53) should be and is hereby **GRANTED in part and DENIED in part**, and that Defendants' Motion for Summary Judgment (ECF No. 62) should be and is hereby **GRANTED in part and DENIED in part**. Because 42 C.F.R. § 438.6(c)(1)(i)(C) (2002)[56] delegates legislative power in violation of the United States Constitution and the APA, the Court declares that it[57] is set aside as "contrary to constitutional right, power, privilege, or immunity," and "in excess of statutory jurisdiction, authority, or limitations, or short of statutory right . . . ." 5 U.S.C. § 706(2)(B)–(C).

SO ORDERED on this **5th day of March, 2018**.

/s/ Reed O'Connor
Reed O'Connor
UNITED STATES DISTRICT JUDGE

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[56] "(i) *Actuarially sound capitation rates* means capitation rates that . . . (C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board." 42 C.F.R. § 438.6(c)(1)(i)(C) (2002) (emphasis in original).

[57] The offending provision is now codified at 42 C.F.R. §§ 438.2–438.4.

APPENDIX C

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

STATE OF TEXAS et al.,	§	
	§	
Plaintiffs	§	
	§	
v.	§	**Civil Action**
	§	**No. 7:15-cv-00151-O**
UNITED STATES OF AMERICA et al.,	§	
	§	
Defendants.	§	

MEMORANDUM OPINION AND ORDER

Before the Court are Defendants' Motion to Dismiss Plaintiffs' Amended Complaint and Brief in Support (ECF Nos. 26–27), filed April 1, 2016; Plaintiff States' Response to Defendants' Motion to Dismiss (ECF No. 29), filed April 25, 2016; and Defendants' Reply Brief in Support of Defendants' Motion to Dismiss Plaintiffs' Amended Complaint (ECF No. 32), filed May 18, 2016.

Having considered the motion, related briefing, and applicable law, the Court finds that Defendants' Motion should be and is hereby **GRANTED in part and DENIED in part**.

I. BACKGROUND

This case arises from Defendants' alleged mandate that Plaintiffs (alternatively, the "Plaintiff States") annually pay to managed care organizations ("MCOs")

the full multi-million dollar Health Insurance Providers Fee ("HIPF") the Patient Protection and Affordable Care Act ("ACA") imposes on MCOs. Am. Compl. ¶ 6, ECF No. 19. The following factual recitation is primarily taken from Plaintiffs' Amended Complaint. *See generally Id.* Plaintiffs are the States of Texas, Indiana, Kansas, Louisiana, Nebraska, and Wisconsin. *Id.* at 1. Defendants are the United States of America (hereinafter "the Government"), Sylvia Burwell ("Burwell"), in her official capacity as Secretary of Health and Human Services ("HHS"), the United States Internal Revenue Service (the "IRS"), and John Koskinen ("Koskinen"), in his official capacity as Commissioner of Internal Revenue. *Id.* at 1–2. The Court provides factual background on each relevant program or agency action below as set out in Plaintiffs' Amended Complaint. *See generally id.*

A. Medicaid Program

The United States Congress created the Medicaid program in 1965. See Social Security Amendments Act of 1965, Pub. L. 89-97, 79 Stat. 286 (1965); *Id.* ¶ 7. Federal and state governments jointly fund Medicaid, which provides healthcare to low-income families, children, related caretakers of dependent children, pregnant women, people age 65 and older, and adults and children with disabilities. Am. Compl. ¶¶ 7, 9, ECF No. 19 (citing 42 U.S.C. §§ 1396–1396w). To participate in Medicaid, states provide coverage to a federally mandated category of individuals according to a federally approved state plan. Am. Compl. ¶ 8, ECF No. 19. All 50 states participate in the Medicaid program, and all Plaintiff States have participated in Medicaid since shortly after

its creation. *Id.* ¶¶ 8–9. States may not limit the number of eligible people who can enroll. *Id.* ¶ 9.

The Plaintiff States spend a significant amount of money providing healthcare through the Medicaid program. *Id.* ¶ 10. For instance, Texas provides Medicaid services to around one in seven of Texas's total population, or 3.7 million of 26.4 million Texans, and Medicaid spending accounts for approximately 26% of Texas's total budget in fiscal year 2013 (and 28% of Texas's 2015 budget). *Id.* The remaining Plaintiffs also serve millions of individuals in their states and spend a considerable portion of their respective states' annual budgets on Medicaid. *See Id.*

B. Children's Health Insurance Program ("CHIP")

The United States Congress created CHIP in 1997. *Id.* ¶ 11 (citing Balanced Budget Act of 1997, Pub. L. 105-33, 111 Stat. 251). Federal and state governments jointly fund CHIP, which provides healthcare to uninsured children who do not qualify for Medicaid, but whose families cannot afford private insurance. Am. Compl. ¶¶ 11–12, ECF No. 19 (citing 42 U.S.C. § 1397aa). CHIP provides basic primary healthcare and other medically necessary services, such as dental care, to children, and certain services to pregnant women. *Id.* CHIP services are typically delivered by MCOs selected by the states through a competitive bidding process. *Id.* All of the Plaintiff States participate in CHIP. *Id.*

Providing healthcare through CHIP is a significant function of the Plaintiff States' governments. *Id.* ¶ 13. For example, as of June 2015, 333,000 Texas children were enrolled in CHIP. *Id.* The remaining Plaintiff States similarly report having tens or hundreds of

thousands of children and pregnant women who rely on CHIP services. *See Id.*

C. Plaintiff States' Use of MCOs to Participate in Medicaid and CHIP

Plaintiff States provide a significant portion of Medicaid and CHIP healthcare services through managed care arrangements. In a managed care arrangement, states enter into contracts with MCOs, whereby the organizations agree to deliver healthcare services in exchange for a fixed monthly payment, known as a "capitation payment" or "capitation rate." *Id.* ¶ 15. For example, in Texas, MCOs provided Medicaid services to around 87% of Texas's Medicaid population in fiscal year 2015, and payments to MCOs for Medicaid services totaled over $16 billion, which constitutes 17% of Texas's budget. *Id.* ¶ 16. The remaining Plaintiff States also provide Medicaid services to a large portion of their respective Medicaid populations, with payments to MCOs totaling a significant amount of each Plaintiff State's budget. *Id.* In addition, MCOs provide the majority of healthcare services to children in the Plaintiff States' CHIP programs. *Id.* ¶ 17. For instance, in Texas, MCOs provide all CHIP services, accounting for about one percent (1%) of Texas's budget in fiscal year 2015. *Id.* The remaining Plaintiff States also utilize MCOs for the majority of their CHIP services.

D. Health Insurance Providers Fee ("HIPF")

In 2010, the United States passed the ACA. *Id.* ¶ 18 (citing Pub. L. 111-148, 124 Stat. 119-1025 (Mar. 23, 2010)). One portion of the ACA imposed the HIPF on all covered health insurance providers for "United States health risks," defined as "the health risk of any individual

who is" a United States citizen, a resident of the United States, or located in the United States. Am. Compl. ¶ 18, ECF No. 19 (citing Pub. L. 111-148, Stat. 865–66); Defs.' Br. Supp. Mot. 4, ECF No. 27 (quoting § 9010(d) of the ACA). The HIPF is imposed as a lump sum on all covered health insurance providers collectively; however, the portion each entity must pay is based on the ratio of the entity's net premiums to all net premiums written for United States health risks. Defs.' Br. Supp. Mot. 5, ECF No. 27 (quoting § 9010(b)(1) of the ACA); *see also* Am. Compl. ¶ 19, ECF No. 19. Congress enacted the HIPF in order to generate revenue from the expected windfall insurers would receive by individuals enrolling in the ACA. Am. Compl. ¶ 18, ECF No. 19.

The HIPF totaled $8 billion in 2014, and is projected to increase to a total of $14.3 billion by 2018. *Id.* ¶ 19. On December 18, 2015, Congress passed, and the President signed into law, a temporary, one-year moratorium on the HIPF for 2017. *Id.* (citing Consolidated Appropriations Act, 2016, Pub. L. No. 114-133, 129 Stat. 2242, 3037–38 (2015)). However, after 2017, the HIPF is scheduled to continue to increase. Am. Compl. ¶ 19, ECF No. 19.

Plaintiffs allege that the ACA does not provide clear notice to states that continuing to receive federal funding for Medicaid and CHIP MCOs is conditioned upon states reimbursing the full of amount of the HIPF assessed against the MCOs. *Id.* ¶ 21. Plaintiffs may avoid the HIPF, however, by contracting with certain nonprofit MCOs. Nonprofit MCOs that receive more than 80% of their gross revenues from government programs serving low-income, elderly, and disabled populations are exempt from paying the HIPF. *Id.* ¶ 22. In addition,

nonprofit MCOs not qualifying for this exclusion can deduct 50% of their premium revenue from the fee calculation. *Id.* Plaintiffs, however, contract with for-profit MCOs. *Id.* They allege that contracting only with exempt MCOs is impossible because of: (1) the relative scarcity of such nonprofit organizations; and (2) that several currently exempt MCOs do not desire to contract with Plaintiffs. *Id.* For example, Texas currently contracts with all nonprofit Medicaid MCOs in Texas who desire to contract with Texas. *Id.* However, the nonprofit MCOs are not able to serve all of the eligible population, requiring Texas to contract with for-profit MCOs, and thus incur substantial liability under the HIPF. *Id.*

E. The Role of the American Academy of Actuaries (the "Academy") in the ACA

Title 42 U.S.C. § 1396b(m) requires that the negotiated capitation rates between states and MCOs be "actuarially sound." *Id.* ¶ 25. To be deemed "actuarially sound" for purposes of Medicaid and CHIP, federal regulations require an actuary's certification that, under the standards established by the Academy, capitation rates are sufficient to cover the insurance providers' expected costs and insurance risks for the coming year. *Id.* ¶ 26.

The Academy is a private, membership-based professional organization. *Id.* ¶ 27. The Academy sets qualification, practice, and professional standards for credentialed actuaries. *Id.* ¶ 28. To set these standards, the Academy created and works with an independent, private organization known as the Actuarial Standards Board ("ASB"). *Id.* ¶ 29. The ASB establishes and improves standards of actuarial practice. *Id.* ¶ 30. These

Actuarial Standards of Practice ("ASOPs") identify what the actuary should consider, document, and disclose when performing an actuarial assignment. *Id.* In March 2015, the ASB adopted ASOP 49, which sets actuarially sound capitation rates for MCO agreements. *Id.* ¶ 31. ASOP 49 requires capitation rates that recover from states the full amount MCOs are taxed. *Id.* ¶ 32. ASOP 49 further requires that, if such taxes are not deductible as expenses for corporate income tax purposes, as is the case for the HIPF, the rate must be adjusted to compensate for additional tax liability. *Id.* ¶ 33.

Generally, if a capitation rate for a managed care agreement does not comply with ASOP 49, an actuary will be unable to certify that the rate is actuarially sound. *Id.* ¶ 34. Without such certification, a managed care agreement will be ineligible for Medicaid and CHIP funds. *Id.* ¶ 35. In conjunction with applicable law and regulations, ASOP 49 requires states to pay MCOs an amount sufficient to cover the HIPF and any additional taxes the MCOs incur from those payments. *Id.* ¶ 36. Therefore, Plaintiff States allege the ACA requires them to pay the HIPF to the for-profit MCOs or lose Medicaid funding for those contracts.

This requirement imposes a significant obligation on the Plaintiff States. For instance, in August 2015, Texas's funded portion of the amount paid to the Medicaid and CHIP MCOs to cover costs associated with the HIPF for the 2013 calendar year was approximately $84,637,710.00. *Id.* ¶ 37. Additionally, Texas has appropriated over $241,000,000.00 in state funds to cover the HIPF for the next biennium. *Id.* The other Plaintiffs have similarly apportioned funds to cover the fee paid to MCOs, which in turn pay the HIPF. *See Id.*

In the next decade, the HIPF is projected to allow the federal government to collect between $13 and $15 billion from the states. *Id.* ¶ 38. Plaintiffs argue that by functionally requiring that the Plaintiff States pay MCOs who in turn pay tax liabilities, the United States has imposed those taxes on the Plaintiff States. *Id.* ¶ 39.

F. Role of HHS

The Centers for Medicare & Medicaid Services ("CMS"), a component of HHS, must approve all of the states' proposed capitation rates. *Id.* ¶ 40. CMS specifically approves the amount of the HIPF, which the Plaintiff States must pay to the MCOs. For example, CMS worked directly with Texas in 2015 to confirm the precise amount Texas owed as a result of the HIPF. *Id.* If capitation rates for any MCO agreement under Medicaid or CHIP are not actuarially sound, then payments pursuant to such plans would be legally ineligible for federal matching funds under Medicaid or CHIP. *Id.* ¶ 41 (citing 42 U.S.C. § 1396b(m)(2)(A)(iii)). By placing in jeopardy a substantial percentage of the Plaintiff States' budgets if the Plaintiff States refuse to help defray the costs of the United States' chosen policy, the ACA, Plaintiffs allege that Defendants have left them no real choice but to acquiesce. *Id.* ¶ 44.

G. Plaintiffs' Claims

Plaintiffs allege the following claims: (1) a declaration under 28 U.S.C. § 2201, the Declaratory Judgment Act ("DJA"), and 5 U.S.C. § 706 of the Administrative Procedure Act ("APA"), that the HIPF violates constitutional standards of clear notice; (2) a declaration under 5 U.S.C. § 706 that the rule implementing the HIPF is arbitrary and capricious; (3) a declaration under

5 U.S.C. § 706 that the rule implementing the HIPF was imposed without observance of necessary procedural requirements; (4) declaratory judgment under 28 U.S.C. § 2201 and 5 U.S.C. § 706 that the HIPF unconstitutionally coerces a sovereign; (5) declaratory judgment under 28 U.S.C. § 2201 and 5 U.S.C. § 706 that the agency action is contrary to constitutional right and in excess of statutory authority; (6) declaratory judgment under 28 U.S.C. § 2201 and 5 U.S.C. § 706 that the HIPF unconstitutionally taxes a sovereign; (7) a claim for refund against the United States under 26 U.S.C. § 7422 for previously paid HIPFs; (8) declaratory judgment under 28 U.S.C. § 2201 and 5 U.S.C. § 706 that the HIPF, as applied to Plaintiff States' Medicaid programs, is insufficiently related to the ACA to be a legitimate exercise of Congress's spending power; (9) injunction against federal officials from collecting the unconstitutional HIPF; and (10) alternatively, declaratory judgment under 28 U.S.C. §§ 2201–2202 and 5 U.S.C. § 706 that, if § 9010(f) of the ACA bars this claim for refund, § 9010(f) is unconstitutional as applied to the Plaintiff States.

II. LEGAL STANDARDS

A. FRCP 12(b)(1) - Subject-Matter Jurisdiction

Rule 12(h)(3) of the Federal Rules of Civil Procedure provides that "if the court determines at any time that it lacks subject-matter jurisdiction, the court must dismiss the action." Fed. R. Civ. P. 12(h)(3); *see Stafford v. Mobil Oil Corp.*, 945 F.2d 803, 805 (5th Cir. 1991) ("Failure adequately to allege the basis for diversity jurisdiction mandates dismissal."). Federal subject-matter jurisdiction is limited; federal courts may entertain only those cases involving a question of federal law or those

where parties are of diverse citizenship. *See* 28 U.S.C. §§ 1331, 1332. Federal courts have original jurisdiction over claims when the complaint states claims arising under federal law. *Id.* § 1331; *Ky. Fried Chicken Corp. v. Diversified Packaging Corp.*, 549 F.2d 368, 392 (5th Cir. 1977). Diversity jurisdiction requires that: (1) the amount in controversy must exceed $75,000; and (2) the citizenship of each plaintiff must be diverse from the citizenship of each defendant. *See* 28 U.S.C. § 1332(a); *see Stafford*, 945 F.2d at 804. "It is well-established that the diversity statute requires 'complete diversity' of citizenship: A district court cannot exercise diversity jurisdiction if one of the plaintiffs shares the same state citizenship as any one of the defendants." *Corfield v. Dall. Glen Hills LP*, 355 F.3d 853, 857 (5th Cir. 2003). The party invoking federal jurisdiction has the burden of establishing it. *Id.*

"Every party that comes before a federal court must establish that it has standing to pursue its claims." *Cibolo Waste, Inc. v. City of San Antonio*, 718 F.3d 469, 473 (5th Cir. 2013); *see also Barrett Comp. Servs., Inc. v. PDA, Inc.*, 884 F.2d 214, 218 (5th Cir. 1989). "The doctrine of standing asks 'whether the litigant is entitled to have the court decide the merits of the dispute or of particular issues.'" *Cibolo Waste*, 718 F.3d at 473 (quoting *Elk Grove Unified Sch. Dist. v. Newdow*, 542 U.S. 1, 11 (2004)).

Standing has both constitutional and prudential components. *See Cibolo Waste*, 718 F.3d at 473 (quoting *Elk Grove*, 542 U.S. at 11) (explaining that standing "contain[s] two strands: Article III standing . . . and prudential standing"). Constitutional standing requires a plaintiff to establish that she has suffered an injury in

fact traceable to the defendant's actions that will be redressed by a favorable ruling. *Lujan v. Defenders of Wildlife*, 504 U.S. 555, 560–61 (1992). The injury-in-fact must be "concrete and particularized" and "actual or imminent," as opposed to "conjectural" or "hypothetical." *Lujan*, 504 U.S. at 560. "Prudential standing requirements exist in addition to 'the immutable requirements of Article III,' . . . as an integral part of 'judicial self-government.'" *ACORN v. Fowler*, 178 F.3d 350, 362 (5th Cir.1999); *see also Id.* "The goal of this self-governance is to determine whether the plaintiff 'is a proper party to invoke judicial resolution of the dispute and the exercise of the court's remedial power.'" *Id.* (quoting *Bender v. Williamsport Area Sch. Dist.*, 475 U.S. 534, 546 n.8 (1986)). The Supreme Court has observed that prudential standing encompasses "at least three broad principles," including "the general prohibition on a litigant's raising another person's legal rights . . . ." *Lexmark Int'l, Inc. v. Static Control Components, Inc.*, 134 S. Ct. 1377, 1386 (2014); *Cibolo Waste*, 718 F.3d at 474 (quoting *Elk Grove*, 542 U.S. at 12); *see also Sprint Commc'ns Co., L.P. v. APCC Servs., Inc.*, 554 U.S. 269, 290 (2008) (discussing cases where third-parties sought "to assert not their own legal rights, but the legal rights of others"); *Vt. Agency of Nat. Res. v. U.S. ex rel. Stevens*, 773 (2000) (noting "the assignee of a claim has standing to assert the injury in fact suffered by the assignor").

B. FRCP 12(b)(6) - Failure to State a Claim

Federal Rule of Civil Procedure 8(a) requires a claim for relief to contain "a short and plain statement of the claim showing that the pleader is entitled to relief." Fed. R. Civ. P. 8(a)(2). Rule 8 does not require detailed factual

allegations, but "it demands more than an unadorned, the-defendant-unlawfully-harmed-me accusation." *Ashcroft v. Iqbal*, 556 U.S. 662, 678 (2009) (quoting *Bell Atl. Corp. v. Twombly*, 550 U.S. 544, 555 (2007)). If a plaintiff fails to satisfy Rule 8(a), the defendant may file a motion to dismiss the plaintiff's claims under Federal Rule of Civil Procedure 12(b)(6) for "failure to state a claim upon which relief may be granted." Fed. R. Civ. P. 12(b)(6).

To defeat a motion to dismiss pursuant to Rule 12(b)(6), a plaintiff must plead "enough facts to state a claim to relief that is plausible on its face." *Twombly*, 550 U.S. at 570. "A claim has facial plausibility when the plaintiff pleads factual content that allows the court to draw the reasonable inference that the defendant is liable for the misconduct alleged." *Iqbal*, 556 U.S. at 663 (citing *Twombly*, 550 U.S. at 556). "The plausibility standard is not akin to a 'probability requirement,' but it asks for more than a sheer possibility that a defendant has acted unlawfully." *Id.* (quoting *Twombly*, 550 U.S. at 556). "Where a complaint pleads facts that are 'merely consistent with' a defendant's liability, it 'stops short of the line between possibility and plausibility of entitlement to relief.'" *Id.* (quoting *Twombly*, 550 U.S. at 557).

In reviewing a Rule 12(b)(6) motion, the Court must accept all well-pleaded facts in the complaint as true and view them in the light most favorable to the plaintiff. *Sonnier v. State Farm Mut. Auto. Ins. Co.*, 509 F.3d 673, 675 (5th Cir. 2007). The Court is not bound to accept legal conclusions as true, and only a complaint that states a plausible claim for relief survives a motion to dismiss. *Iqbal*, 556 U.S. at 678–79. When there are well-pleaded

factual allegations, the Court assumes their veracity and then determines whether they plausibly give rise to an entitlement to relief. *Id.*

"Generally, a court ruling on a 12(b)(6) motion may rely on the complaint, its proper attachments, documents incorporated into the complaint by reference, and matters of which a court may take judicial notice." *Randall D. Wolcott, M.D., P.A. v. Sebelius*, 635 F.3d 757, 763 (5th Cir. 2011) (citations omitted); *see also Tellabs, Inc. v. Makor Issues & Rights, Ltd.*, 551 U.S. 308, 322 (2007). A court may also consider documents that a defendant attaches to a motion to dismiss if they are referred to in the plaintiff's complaint and are central to the plaintiff's claims. *Collins v. Morgan Stanley Dean Witter*, 224 F.3d 496, 498–99 (5th Cir. 2000).

"If it appears that a more carefully drafted pleading might state a claim upon which relief could be granted, the court should give the claimant an opportunity to amend his claim rather than dismiss it." *Kennard v. Indianapolis Life Ins. Co.*, 420 F. Supp. 2d 601, 608–09 (N.D. Tex. 2006) (Fish, C.J.) (citing *Friedlander v. Nims*, 755 F.2d 810, 813 (11th Cir.1985); accord *Taylor v. Dall. Cty. Hosp. Dist.*, 976 F. Supp. 437, 438 (N.D. Tex. 1996) (Fish, J.). Likewise, "leave to amend a pleading should be freely given and should be granted unless there is some justification for refusal." *Kennard*, 420 F. Supp. at 609 (quoting *U.S. ex rel Willard v. Humana Health Plan of Tex.*, 336 F.3d 375, 386 (5th Cir 2003)).

III. ANALYSIS

Defendants move to dismiss all of Plaintiffs' claims under Rules 12(b)(1) and 12(b)(6). Defs.' Br. Supp. Mot. 7, ECF No. 27. The Court addresses each claim in turn, beginning its analysis with subject-matter jurisdiction

under Rule 12(b)(1). In addressing Plaintiffs' subject-matter jurisdiction, the Court first evaluates Plaintiffs' Article III standing.

A. Subject-Matter Jurisdiction Under 12(b)(1)

1. Standing

a. Constitutional Standing

Defendants argue that "[a]t the outset, Plaintiffs face an especially high bar to demonstrate standing in this case," as Plaintiffs "challenge a congressional action whose object is not the States, but for-profit health insurers." Defs.' Br. Supp. Mot. 8, ECF No. 27. Defendants contend that Plaintiffs' alleged injury from the HIPF is not fairly traceable to them, and Plaintiffs have not suffered an injury from the actuarial-soundness requirement. *Id.* at 9–10.

Plaintiffs respond that their "injuries are traceable to the challenged action, and are not attributable to the independent action of a third party not before the Court." Pls.' Resp. 1, ECF No. 29. Plaintiffs also argue that they "have undoubtedly suffered injuries in fact—invasions of their fiscs—that are concrete and particularized." *Id.*

i. Concrete and Particularized Injury

Constitutional standing requires a plaintiff to establish that she has suffered or is immediately in danger of suffering an injury-in-fact traceable to the defendant's actions that will be redressed by a favorable ruling. *Lujan*, 504 U.S. at 560–61; *City of L.A. v. Lyons*, 461 U.S. 95, 102 (1983). The injury-in-fact must be "concrete and particularized" and "actual or imminent," as opposed to "conjectural" or "hypothetical." *Lujan*, 504 U.S. at 560. "When a litigant is vested with a procedural

right, that litigant has standing if there is some possibility that the requested relief will prompt the injury-causing party to reconsider the decision that allegedly harmed the litigant." *Texas v. United States*, 809 F.3d 134, 150–51 (5th Cir. 2015) (quoting *Massachusetts v. EPA*, 549 U.S. 497, 518 (2007)). "[T]he presence of one party with standing is sufficient to satisfy Article III's case-or-controversy requirement." *Texas*, 809 F.3d at 151 (quoting *Rumsfeld v. Forum for Acad. & Institutional Rights, Inc.*, 547 U.S. 47, 52 n.2 (2006)). The party invoking federal jurisdiction bears the burden of establishing standing. *Lujan*, 504 U.S. at 560–61. "Furthermore, because [the Plaintiff States] [are] bringing this action in [their] capacit[ies] as ... sovereign state[s] being pressured to reevaluate state law or incur substantial costs," they are "'entitled to special solicitude in our standing analysis.'" *Texas v. EEOC*, No. 14-10949, 2016 WL 3524242, at *1 (5th Cir. June 27, 2016) (quoting *Massachusetts*, 549 U.S. at 520).

In *Texas v. United States*, the Fifth Circuit held that Texas had standing where it "challenge[d] DHS's affirmative decision to set guidelines for granting lawful presence to a broad class of illegal aliens." *Texas*, 809 F.3d at 152. In evaluating whether Texas asserted a concrete and particularized injury, the court reasoned that the statute "would have a major effect on the states' fiscs, causing millions of dollars of losses in Texas alone, and at least in Texas, the causal chain is especially direct: DAPA would enable beneficiaries to apply for driver's licenses, and many would do so, resulting in Texas's injury." *Id.* Therefore, the court conferred standing even though the relevant statute did not impose a direct duty on the state.

Here, similarly, the Court finds that Plaintiffs have sufficiently pleaded that the HIPF results in a major effect on the Plaintiff States' fiscs, causing millions of dollars of losses in Texas alone. *See* Pls.' Resp. 1, ECF No. 29. Specifically, Plaintiffs allege the ACA imposes the actuarially sound requirement, which requires compliance with ASOP 49, resulting in their payment of the HIPF.[1] Therefore, if Plaintiffs allege that they wish to continue receiving federal Medicaid funding, they must pay the MCOs the full amount of the HIPF that the MCOs, in turn, pay to the federal government. Accordingly, the Court finds that Plaintiffs have pleaded

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[1] Defendants admit that under ASOP 49, "to be actuarially sound, MCO rates must account for any taxes and fees for which MCOs are liable," but argue it also allows actuaries to "exercise their professional judgment to deviate from the guidelines." Defs.' Br. Supp. Mot. 14, ECF No. 27 (internal citations omitted). In a corresponding footnote, Defendants state that HHS offered applicable guidance to actuaries and recently signaled in the Federal Register that the regulatory scheme may change in the future. *See Id.* n. 3. The Court construes Defendants' Motion to Dismiss, which only cites to a Federal Register and HHS Guidance beyond the parties' pleadings, as a facial attack under Rule 12(b)(1). *See Id.* However, the Court notes that at this stage, even if it were construed as a factual attack, Plaintiffs establish jurisdiction, by a preponderance of the evidence, by offering at least one sworn affidavit stating that their payments of the HIPF amount is required. *See infra* Part III (holding that Plaintiffs established Article III standing and subject-matter jurisdiction to all claims except their claims seeking a tax refund); Pls.' App. Supp. Resp. Ex. 3 ("Decl. Rachel Butler"), App. 12, ECF No. 29-1 (stating that Texas "is required to reimburse the MCOs for the HIPF to ensure that the capitations rates paid to the MCOs are actuarially sound as required by [CMS]"). To the extent Defendants contend this is not true, they may submit appropriate evidence on this issue in the next stage of litigation.

a "concrete and particularized injury" by virtue of their having already paid, and their continuing obligation to pay in the future, the full HIPF amounts to MCOs.

ii. Alleged Injury is Fairly Traceable

Defendants argue that the Plaintiff States' "theory of injury relies on the States' choice to engage entities subject to the fee, and it is hornbook law that a plaintiff 'cannot manufacture standing merely by inflicting harm on [itself].'" Defs.' Br. Supp. Mot. 9, ECF No. 27 (quoting *Clapper v. Amnesty Int'l USA*, 133 S.Ct. 1138, 1151 (2013)). Defendants further explain that "[n]o federal law requires the States to contract with MCOs subject to the fee," so "[i]f the States find the HIPF's effect on MCO pricing onerous, they can take their business elsewhere—to fee-for-service providers or qualifying nonprofit MCOs, neither of which is subject to the fee." Defs.' Mot. 9, ECF No. 27.

Plaintiffs respond that they "do not possess countless viable ways to avoid paying the HIPF," and "the options suggested by Defendants . . . place[] Plaintiff States somewhere between Scylla and Charybdis." Pls.' Resp. 2, ECF No. 29. Plaintiffs argue that on the one hand, "[i]f Plaintiff States were to cease participation in Medicaid as a means of avoiding the HIPF, Plaintiff States would be coercively dispossessed of the policy choice (Medicaid) they believe to be in the best interest of its citizens." *Id.* at 4. Plaintiffs point out that "[a]lternatively, there are not enough non-profit MCOs to ensure adequate access to care for Medicaid clients." *Id.*

In *Texas v. United States*, the Fifth Circuit noted that "[a]lthough Texas could avoid financial loss by requiring applicants to pay the full costs of licenses, it

could not avoid injury altogether," and "the possibility that a plaintiff could avoid injury by incurring other costs does not negate standing." *Texas*, 809 F.3d at 156–57. In contrast, if the plaintiffs "could . . . achieve[] their policy goal in myriad ways," their injury would be deemed self-inflicted. *Id.* at 159 (citing *Pennsylvania v. New Jersey*, 423 U.S. 942 (1975)). However, here, the Plaintiff States assert they "have no meaningful choice between continuing to use [MCOs]—and paying the [HIPF]—or reverting to the former model of paying providers for services," where the latter "is significantly less cost effective and often results in worse participant satisfaction than the [MCO] model." Am. Compl. ¶ 45, ECF No. 19. Thus, from the face of the Amended Complaint, it does not appear that Plaintiffs "manufacture[d] standing" by hand-picking some MCOs above others, since the necessary number of exempt or discounted MCOs does not even exist. *Texas*, 908 F.3d at 159.

In *NFIB v. Sebelius*, the Supreme Court reasoned that "[t]he threatened loss of over 10 percent of a State's overall budget is economic dragooning that leaves the States with no real option but to acquiesce in the Medicaid expansion." *NFIB.v. Sebelius*, 132 S. Ct. 2566, 2605 (2012). Here, Plaintiffs allege they are shouldering tens of millions of dollars, and jeopardizing state programs constituting well above ten percent (10%) of the Plaintiffs States' budgets constitutes similar economic dragooning.[2] *See supra* Section I.A.–B. In this

[2] Defendants aver that "Plaintiffs themselves predict that the HIPF will impact a mere fraction of [one] percent of their budgets." Defs.' Br. Supp.Mot. 23, ECF No. 27. However, the inquiry in *NFIB* turned on the "threat of loss" to a state "adher[ing] to [its] chosen

case, like in *NFIB*, the Amended Complaint pleads "the financial 'inducement' Congress has chosen is much more than relatively mild encouragement. It is a gun to the head." *Id.* at 1604 (internal citations partially omitted); *see also Zelman v. Simmons-Harris*, 536 U.S. 639, 707 (2002) (Souter, dissenting) ("The criterion is one of genuinely free choice on the part of the private individuals who choose, and a Hobson's choice is not a choice, whatever the reason for being Hobsonian."). Accordingly, the Court finds that because of Defendants' requirements, Plaintiffs similarly face a Hobson's choice, as Plaintiffs' Amended Complaint has sufficiently demonstrated that the alleged injury is fairly traceable to Defendants.

iii. Redressability

Neither party squarely addresses whether Plaintiffs' claims would be redressed by a favorable ruling. However, the Court finds that Plaintiffs easily demonstrate that their claims would be redressed if this Court were to provide a favorable ruling. "[T]aking the [Amended] [C]omplaint's allegations as true," Plaintiff States have "alleged [] a sufficient injury in fact," namely, the regulatory scheme that "forces Texas to

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course," rather than the cost of complying with the federal government's demands. As an example, the *NFIB* majority referenced the Court's prior holding in *South Dakota v. Dole*, where the threatened loss of funding for resisting, not the cost of compliance, constituted only half of one percent of the state's budget. *NFIB*, 132 S. Ct. at 2604 (quoting 791 F.2d 628, 630 (1986)). In *NFIB*, however, the Court pointed out that a State that "opts out" of the federal government's demands would lose all of its Medicaid funding, with such a loss of "over 10 percent of a State's overall budget" being "economic dragooning." *NFIB*, 132 S. Ct. at 2604–05.

alter its . . . policies or incur significant costs," and that a favorable ruling would prevent Plaintiffs from incurring such cost in the future. *See Texas*, 2016 WL 3524242, at *5; *see generally* Am. Compl., ECF No. 19 (seeking in part, declaratory and injunctive relief, of which a favorable ruling would prevent the collection of HIPF payments in the future). Based on the foregoing, the Court finds that Plaintiff States have sufficiently alleged constitutional standing.

b. Prudential Standing

The Court also considers *sua sponte* whether Plaintiffs have sufficiently asserted prudential standing. The Supreme Court has "interpreted § 10(a) of the APA to impose a prudential standing requirement in addition to the requirement, imposed by Article III of the Constitution, that a plaintiff has suffered a sufficient injury in fact." *Nat'l Credit Union Admin v. First Nat. Bank & Trust Co.*, 522 U.S. 479, 488 (1998). "For a plaintiff to have prudential standing under the APA, 'the interest sought to be protected by the complainant [must be] arguably within the zone of interests to be protected or regulated by the statute . . . in question." *Id.* (citing *Ass'n of Data Processing Serv. Orgs., Inc. v. Camp*, 397 U.S. 150, 152 (1970)). The Supreme Court has stated that the "zone of interests" test "denies a right of review if the plaintiff's interests are . . . marginally related to or inconsistent with the purposes implicit in the statute." *Clarke v. Secs. Indus. Assn'n*, 479 U.S. 388, 399 (1987). Therefore, the proper inquiry is whether "the interest sought to be protected by the complainant is arguably within the zone of interests to be protected . . . by the statute." *Data Processing*, 397 U.S. at 153.

Section 9010 of the ACA provides that the annual HIPF "fee" or "tax" is on "health insurance providers" only, per the section's title, or "covered entities" under the section's text. *See* Pls.' Resp. 9, ECF No. 29. However, § 9010(c) also provides that a "covered entity" can only be an "entity which provides health insurance for any United States health risk" and expressly includes "any governmental entity." Pub. L. 111-138, 134 Stat. 866.

Here, Plaintiffs seek, at a minimum, a declaration as to the fee or tax they have already paid, and must continue to pay, under ASOP 49 as enforced through the HIPF. Therefore, the Court finds "the States are seeking to protect their own proprietary interests," which they allege has been harmed by financial payments totaling tens of millions of dollars and "will be directly harmed by the [continuing] implementation" of the statutory scheme. *Texas v. United States*, 86 F. Supp.3d 591, 625 (S.D. Tex. 2015). Plaintiffs' claims come within the "zone of interests" to be protected by the relevant healthcare statutory provision at issue in this litigation. The Court finds that Plaintiffs, having already paid to MCOs tens of millions of dollars in order to retain their Medicaid and CHIP funding, readily demonstrate that they meet prudential standing requirements.

2. Subject-Matter Jurisdiction Related to the HIPF

Defendants argue that "[t]he Court lacks jurisdiction to grant any relief related to the HIPF." Defs.' Mot. 11, ECF No. 27 (capitalization omitted). More specifically, Defendants argue that: (1) as to Counts Seven and Ten, "the Court cannot grant states a refund of the HIPF"; (2) as to Counts One through Six and Count Nine, the

Court "lacks authority to bar collection of the HIPF" from MCOs; and (3) as to Counts One through Six, Plaintiffs' challenges to the actuarial-soundness requirements under 42 C.F.R. § 438.6(c)(1)(i)(C) are time-barred. *Id.* at 11–13. The Court addresses each of Defendants' arguments in turn.

a. Counts Seven and Ten: Whether the Court Can Grant States a Refund of the HIPF[3]

In Counts Seven and Ten, Defendants argue that "Plaintiffs lack standing to seek a refund for HIPF fees already paid by MCOs."[4] *Id.* at 11. Defendants admit that 28 U.S.C. § 1346(a)(1) offers a limited waiver of sovereign immunity for any tax "alleged to have been erroneously or illegally assessed or collected," but argue that "Plaintiffs fit within none of these exceptions." *Id.* Defendants contend that "[t]o the extent that third-party challenges are permitted beyond what is expressly listed

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[3] Elsewhere in this Order, the Court clarifies that it need not conclusively decide at this time whether the HIPF is a "fee" or a "tax." *See infra* Section III.A.2.b. However, as to this claim, based on Plaintiffs' pleadings, their claims seeking a tax refund necessarily contemplate the HIPF solely as a tax. *See, e.g.*, Pls.' Resp. 9, ECF No. 29 (citing precedent construing internal-revenue tax provisions and asserting, "The wrongfully taxed may seek a refund. And Plaintiff States may seek a refund of the HIPF though it is initially assessed upon MCOs.").

[4] Count Ten appears to only be a claim for declaratory relief in the event the Court concludes that Plaintiffs may not receive a tax refund under § 9010(f) of the ACA. Am. Compl. 26–27, ECF No. 19. However, Defendants' briefing as to the present Motion construes Count Ten, in part, to assert a claim for a refund. *See, e.g.*, Defs.' Br. Supp. Mot. 11, ECF No. 27 ("The Court cannot grant states a refund of the HIPF (Counts VII and X).") (capitalization omitted). In an abundance of caution, the Court similarly analyzes Count Ten.

in the Code, the Supreme Court has limited such challenges to persons who paid the tax directly to the IRS." *Id.* at 11–12. Defendants argue that because "the HIPF is assessed against and paid by certain insurers, not the States, . . . [the] limited waiver of sovereign immunity therefore does not extend to Plaintiffs" and "Plaintiffs have no constitutional right to challenge a tax they did not pay." *Id.* at 12.

Plaintiffs respond that they "may seek a refund of the HIPF though it is initially assessed upon MCOs," as those "wrongfully taxed may seek a refund." Pls.' Resp. 9, ECF No. 29 (quoting 28 U.S.C. § 1346(a)(1)). Plaintiffs cite *United States v. Williams* for the proposition that the statute "permit[s] 'any civil action' to recover 'any internal-revenue tax alleged to have been erroneously or illegally assessed or collected' or 'in any manner wrongfully collected.'" *Id.* (quoting *United States v. Williams*, 514 U.S. 527, 532 (1995)). Plaintiffs argue that "[t]he commonsense approach adopted in *Williams* supports Plaintiff States here, as they are ultimately paying the HIPF." Pls.' Resp. 10, ECF No. 29 (internal citation omitted).

In *United States v. Williams*, the Supreme Court considered whether a respondent who paid a tax under protest to remove a lien on her property had standing to pursue a refund under 28 U.S.C. § 1346(a)(1), even though the tax she paid was actually assessed against her ex-spouse. 514 U.S. at 529. Section 1346(a) provides in relevant part:

> The district courts shall have original jurisdiction, concurrent with the United States Court of Federal Claims, of:

> (1) 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, or any penalty claimed to have been collected without authority or any sum alleged to have been excessive or in any manner wrongfully collected under the internal revenue laws.

28 U.S.C. § 1346(a). The Supreme Court noted that the language of § 1346(a) "does not say that only the person assessed may sue." *Williams*, 514 U.S. at 531. It reasoned that this broad statutory language "mirrors the broad common-law remedy the statute displaced: actions of assumpsit for money had and received, once brought against the tax collector personally rather than against the United States." *Id.* at 532.

The Supreme Court also examined the meaning of a "taxpayer" under 26 U.S.C. § 6511, under which only a "taxpayer" may sue for a refund. 26 U.S.C. § 6511(a) provides, in relevant part:

> (a) Period of limitation on filing claim
>
> Claim for credit or refund of an overpayment of any tax imposed by this title in respect of which tax the taxpayer is required to file a return shall be filed by the taxpayer within 3 years from the time the return was filed or 2 years from the time the tax was paid, whichever of such periods expires the later, or if no return was filed by the taxpayer, within 2 years from the time the tax was paid.

26 U.S.C. § 6511(a) (emphasis added).

The *Williams* majority observed that the "provision's plain terms provide only a deadline for filing for administrative relief, not a limit on who may file. To read

the term 'taxpayer' as implicitly limiting administrative relief to the party assessed is inconsistent with other provisions of the refund scheme, which expressly contemplate refunds to parties other than the one assessed." *Williams*, 514 U.S. at 534. The Supreme Court reasoned that § 7701(a)(13), which defines "taxpayer," states that "[w]hen used in [the Internal Revenue Code], where not otherwise distinctly expressed or manifestly incompatible with the intent thereof, . . . [t]he term 'taxpayer' means any person *subject to any internal revenue tax*.'" *Id.* (emphasis added). The Supreme Court ultimately held that under the statutory scheme, the respondent was able to seek a refund, as she was "the taxpayer" who filed for a return within the requisite time from which "the tax was paid." *Id.*; *see also* 26 U.S.C. § 6511(a). Therefore, the Supreme Court held that "in authorizing the Secretary to award a credit or refund '[i]n the case of any overpayment,' 26 U.S.C. § 6402(a) describes the recipient not as the 'taxpayer,' but as 'the person who made the overpayment.'" *Id.*

Here, to the extent Plaintiffs plead ASOP 49, as enforced through the actuarially soundness requirement and the HIPF, is a tax pursuant to the statutory text, they were neither directly subject to the HIPF, nor actually paid the relevant tax on behalf of the taxpayer assessed. Rather, Plaintiffs allege that they paid the full amount to the taxpayer against whom the tax was assessed. *See, e.g.*, Am. Compl. ¶ 37, ECF No. 19. Therefore, the Court finds that Defendants' Motion is **GRANTED** as to the statutory claim for refund in Count Seven. Defendants' Motion is **GRANTED in part** as to Count Ten, to the extent that the Plaintiffs seek a refund.

Also under Count Ten, in the alternative, Plaintiffs move the Court to hold that § 9010(f) of the ACA violates the Tenth Amendment for "enabling the federal government to impose an unconstitutional tax on the States while foreclosing the return of such funds." Am. Compl. ¶¶ 78–80. The Court will analyze this argument below. *See infra* Section III.B.2.

b. Whether the Court Has Authority to Bar Collection of the HIPF from MCOs

In Counts One through Six and Count Nine, Plaintiffs seek a declaration under 28 U.S.C. §§ 2201–02 and 5 U.S.C. § 706 that would effectively bar the collection of the HIPF from MCOs. Plaintiffs assert that the HIPF is invalid because the procedures developed to implement the HIPF were improper under the APA. Plaintiffs argue that "whether the HIPF is a 'tax' or 'fee' for purposes of" the DJA, AIA, or APA, "turns upon the language of Congress." Pls.' Resp. 8, ECF No. 29. Plaintiffs argue that "[h]ere, the wording used by Congress in the ACA means that remedies under the DJA and APA apply to Plaintiff States' claims herein." *Id.* Plaintiffs point out that originally, "Congress described the HIPF as an annual 'fee,'" and then "later stated the HIPF shall be treated as an excise tax." *Id.* (citing Pub. L. 111-148, 124 Stat. 865). However, Plaintiffs argue that "even if the HIPF were a 'tax' for purposes of other statutes . . . Plaintiff States still have a remedy because the 'tax' is not textually committed to them." *Id.*

Defendants argue that "[t]o the extent that the States seek to directly restrain the collection of the HIPF from MCOs, this Court plainly lacks jurisdiction to do so" under the Anti-Injunction Act ("AIA") and DJA. Defs.'

Br. Supp. Mot. 13, ECF No. 27. Defendants point out that "[t]he Supreme Court has concluded that the DJA and AIA 'could scarcely be more explicit' in barring suits seeking equitable relief restraining the collection of federal taxes." *Id.* (quoting *Bob Jones Univ. v. Simon*, 416 U.S. 725, 732 n.7 (1974)). Defendants contend that "[t]he AIA . . . bars suits to restrain collection of the HIPF, and the jurisdictional limitations for tax refund suits bar Plaintiffs' request for a tax refund." Defs.' Reply 4, ECF No. 32.

Whether the parties refer to the HIPF as a "fee" or a "tax," it is on: (1) "health insurance providers" under § 9010 of the ACA; or (2) "covered entities," which exclude government entities. Pub. L. 111-148, § 9010(c)(1)–(2). More specifically, to the extent the parties refer to the HIPF as a "fee," neither the DJA's prohibition concerning "federal taxes," nor the AIA's prohibition on parties bringing claims "for the purpose of restraining the assessment or collection of any tax," applies to a "fee." *See* 28 U.S.C. §§ 2201, 7421(a). Conversely, to the extent the parties refer to the HIPF as a "tax" for purposes of seeking a refund, the tax exemptions within the DJA and AIA are inapplicable because the Court has already determined that Plaintiffs are not taxpayers bringing a suit to restrain the assessment or collection of a tax on them. *See supra* Section III.A.2.a. Thus, the Court need not conclusively decide whether the HIPF is a "fee" or a "tax" at this stage in the litigation. To the extent Plaintiffs raise their claims through pleading the HIPF is either a "tax" or a "fee," the Court holds that the Court has subject-matter jurisdiction and that Plaintiffs have stated a claim. *See supra* Part III.A; *see infra* Part III.B. To the extent

Plaintiffs raise their claims through characterizing the HIPF solely as a "tax" to seek a refund, the Court has dismissed those claims as not allowed by the statutory text. *See Id.* Defendants' Motion to Dismiss is **DENIED** as to their argument that the Court lacks subject-matter jurisdiction under the AIA and DJA. The Court will, of course, continually evaluate its subject-matter jurisdiction.

B. Whether Plaintiffs' Amended Complaint States a Claim Under Rule 12(b)(6)

Defendants argue that in addition to subject-matter jurisdiction, Plaintiffs' Amended Complaint fails on the merits as well and should be dismissed in its entirety. Defs.' Br. Supp. Mot. 3–4, ECF No. 27. Specifically, Defendants appear to challenge whether Plaintiffs have claims under Counts One through Eight and Count Ten. *See generally id.* The Court addresses each of Defendants' 12(b)(6) arguments in turn.

1. Counts One Through Five: Whether Plaintiffs' Challenges to the Actuarial-Soundness Requirements Under 42 C.F.R. § 438.6 (c)(1)(i)(C) Are Time-Barred

In Counts One through Five, Plaintiffs challenge 42 C.F.R. § 438.6(c)(1)(i)(C) under the DJA and APA. Defendants argue that "[w]here, as here, no other statute provides a limitations period, a plaintiff has six years to bring a civil action against the United States, and because the regulation went into effect in 2002, the limitations period therefore lapsed in 2008." Defs.' Br. Supp. Mot. 13–14, ECF No. 27. Defendants argue that "[t]he fact that the HIPF was enacted in 2010 makes no

difference" because Plaintiffs "have operated under section 438.6's actuarial-soundness requirements, including the requirement that all managed-care contracts must be certified by an actuary following the practice standards set forth by the Actuarial Standards Board" since 2002. Defs.' Br. Supp. Mot. 14, ECR No. 27.

Plaintiffs respond that ASOP 49, promulgated in March 2015, "was a first of its kind—a post-ACA, targeted ASOP regarding capitation rates in managed care for Medicaid." Pls.' Resp. 11, ECF No. 29. Plaintiffs argue that ASOP 49 uniquely "requires the addition of the HIPF to the capitation rates assessed to Plaintiff States. And until ASOP 49 existed, there was no formula, publication, or notice requiring that the HIPF, in its entirety, must be added as an 'adjustment' to a contracting state's capitation rate." *Id.*

a. Whether the Enactment of ASOP 49, as Enforced Through the HIPF, Constitutes the Accrual of Defendants' Regulation to Begin the Statute of Limitations Period

"[T]he United States, as sovereign, is immune from suit save as it consents to be sued . . . , and the terms of its consent to be sued in any court define that court's jurisdiction to entertain the suit." *United States v. Mitchell*, 445 U.S. 535, 538 (1980) (quoting *United States v. Sherwood*, 312 U.S. 584, 586 (1941)). A waiver of sovereign immunity "cannot be implied but must be unequivocally expressed." *United States v. King*, 395 U.S. 1, 4 (1969). Plaintiffs do not allege that any of the statutes and regulations they attack directly provide their own waiver of sovereign immunity. Thus, Plaintiffs' APA challenge is "governed by the general statute of

limitations provision of 28 U.S.C. § 2401(a), which provides that every civil action against the United States is barred unless brought within six years of accrual." *Dunn-McCampbell Royalty Interest, Inc. v. Nat'l Park Serv.*, 112 F.3d 1283, 1286 (5th Cir. 1997).

Here, the parties do not dispute that the ACA, which includes the HIPF, was passed in 2010, and implements the ASOP, which was announced by the ASB in 2015. *See* Am. Compl. ¶¶ 18, 31, ECF No. 19; *see also* Defs.' Br. Supp. Mot. 4–5, 7, ECF No. 27. In contrast to ASOP 1, announced in 2002, which includes tax rates that "could" factor into an actuary's "sound professional judgment," ASOP 49 mandates that "the actuary should include an adjustment for any taxes, assessments, or fees that the MCOs are required to pay out of the capitation rates" and thereby removes such discretion. *See* Pls.' Resp. 12, ECF No. 29; *see also* Defs.' Br. Supp. Mot. 14 n. 7, ECF No. 27 (emphasis added).

In *Texas v. United States*, the court noted that "[a]s the District of Columbia Circuit observed, in allowing an attack on FCC rules three years after their promulgation" and publication:

> As applied to rules and regulations, the statutory time limit restricting judicial review of [agency] action is applicable only to cut off review directly from the order promulgating a rule. It does not foreclose subsequent examination of a rule where properly brought before this court for review of further [agency] action applying it. For unlike ordinary adjudicatory orders, administrative rules and regulations are capable of continuing application . . . .

749 F.2d 1144, 1146 (5th Cir. 1985) (quoting *Network Project v. FCC*, 511 F.2d 786, 789 n.1 (D.C. Cir. 1975)). In *Texas*, the court noted that the defendants "ha[d] cited no case indicating that such a restrictive standard applies to judicial review of an agency rule when later sought to be applied to a particular situation. Indeed, the cases suggest the opposite, especially when the contention is that the rule lacks statutory authorization." *Texas*, 749 F.2d at 1146 (citing *Nat'l Res. Def. Council*, 666 F.2d at 602; *Ill. Cent. Gulf R.R.*, 720 F.2d 958, 961 (7th Cir. 1983)). The court held that "[w]hen an agency applies a previously adopted rule in a particular case, the [limitations period] does not bar later judicial review of the substantial statutory authority for their enactment or of their applicability to a particular situation." *Texas*, 749 F.2d at 1146 (citing *Nat'l Res. Def. Council*, 666 F.2d at 602).

Therefore, here, like in *Texas*, Plaintiffs properly seek "judicial review of an agency rule when later sought to be applied to a particular situations." *Texas*, 749 F.2d at 1146. Plaintiffs allege Defendants have acted, or applied the ASOP to the HIPF, by requiring the MCO payments be actuarially sound as defined by the Academy. *See generally* Am. Compl., ECF No. 19. Therefore, preventing judicial review would "effectively deny" Plaintiffs "an opportunity to question its validity." *Id.* Accordingly, the Court finds that the application of ASOP 49, beginning in 2015, is sufficiently distinct to begin the statute of limitations period no earlier than the HIPF's promulgation in 2010. Defendants' Motion to Dismiss is **DENIED** as to Plaintiffs' Counts One through Five, to the extent Defendants challenge the timeliness of Plaintiffs' claims.

2. Plaintiffs' Constitutional Claims

a. Plaintiff's Spending Clause Claims

i. Counts Four and Eight: Whether the Actuarial-Soundness Requirement is Coercive

In Counts Four and Eight, Plaintiffs' claims arise under Article I, Section 8 of the United States Constitution, otherwise known as the Spending Clause. Plaintiffs argue that "[a]s applied to the States, the HIPF violates the Spending Clause because its non-payment threatens to withhold Medicaid funds." Pls.' Resp. 15, ECF No. 29. More specifically, Plaintiffs contend that because "Medicaid spending accounts for a substantial percentage of Plaintiff States' total budgets," and the federal government "may deny funds that comprise a substantial percentage of Plaintiff States' budgets if they refuse to pay the HIPF," the ACA results in a proverbial "gun to the head." *Id.* (quoting *NFIB*, 132 S. Ct. at 2604).

Defendants argue that "[t]he actuarial-soundness requirement is precisely the type of restriction on the use of federal funds that *NFIB* recognized as valid, as it offers federal funding for managed-care contracts with rates that are actuarially sound and withholds funding for those that are not." *Id.* at 17. Defendants contend that the requirement "in no way coerces Plaintiffs, as the States themselves recognize the reasonableness of actuarial standards" in many of their own separate contracts. *Id.* Defendants conclude that "[b]ecause the actuarial-soundness requirement merely reflects Congress's judgment about which types of managed-care contracts deserve dollars from the federal fisc—a judgment virtually identical to Plaintiff States' own

policies—it falls well within the Spending Clauses's strictures." *Id.*

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. 1, § 8. The Supreme Court has "long recognized that Congress may use this power to grant federal funds to the State, and may condition such a grant upon the States' 'taking certain actions that Congress could not require them to take.'" *NFIB*, 132 S. Ct. at 2601 (quoting *Coll. Savings Bank*, 527 U.S. at 686). "Such measures 'encourage a State to regulate in a particular way, [and] influenc[e] a State's policy choices.'" *NFIB*, 132 S. Ct. at 2601–02 (quoting *New York*, 505 U.S. at 166). "The conditions imposed by Congress ensure that the funds are used by the States to 'provide for the . . . general Welfare' in the manner Congress intended." *NFIB*, 132 S. Ct. at 2602.

"At the same time, [the Supreme Court] ha[s] recognized limits on Congress's power under the Spending Clause to secure state compliance with federal objectives." *Id.* For example, the Supreme Court 'ha[s] repeatedly characterized . . . Spending Clause legislation as 'much in the nature of a contract.'" *Barnes v. Gorman*, 536 U.S. 181, 186 (2002) (quoting *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 17 (1981)). "The legitimacy of Congress's exercise of the spending power 'thus rests on whether the State voluntarily and knowingly accepts the terms of the 'contract.'" *NFIB*, 132 S. Ct. at 2602 (quoting *Pennhurst*, 451 U.S. at 17). "Respecting this limitation is critical to ensuring that Spending Clause legislation does not undermine the status of the States as independent sovereigns in our federal system." *NFIB*, 132 S. Ct. at 2602. Such a system

"rests on what might at first seem a counter-intuitive insight, that 'freedom is enhanced by the creation of two governments, not one.'" *Bond v. United States*, 564 U.S. 211, 220–21 (2011) (quoting *Alden v. Maine*, 527 U.S. 706, 758 (1999)). Therefore, "the Constitution has never been understood to confer upon Congress the ability to require the States to govern according to Congress' instructions." *New York*, 505 U.S. at 162.

The Supreme Court "strike[s] down federal legislation that commandeers a State's legislative or administrative apparatus for federal purposes." *NFIB*, 132 S. Ct. at 2602 (citing *Printz*, 521 U.S. at 933) (striking down federal legislation compelling the action of state law actors, reasoning, "[T]he Constitution protects us from our own best intentions: It divides power among sovereigns and among branches of government precisely so that we may resist the temptation to concentrate power in one location as an expedient solution to the crisis of the day."). "Congress may use its spending power to create incentives for States to act in accordance with federal policies. But when 'pressure turns into compulsion,' the legislation runs contrary to our system of federalism." *NFIB*, 132 S. Ct. at 2602 (quoting *Steward Mach. Co. v. Davis*, 301 U.S. 548, 590 (1937)). "That is true whether Congress directly commands a State to regulate or indirectly coerces a State to adopt a federal regulatory system as its own." *NFIB*, 132 S. Ct. at 2602.

In *NFIB v. Sebelius*, the Supreme Court examined the ACA's expansion of Medicaid, which required states to either dramatically expand Medicaid coverage to all individuals under 133% of the poverty line or lose all federal Medicaid funds. 123 S. Ct. at 2604. The Supreme

Court held that the Medicaid expansion was "in reality a new program," not a "mere alteration of existing Medicaid," and that the Spending Clause did not allow Congress to require that states participate as a condition of participating in the existing Medicaid program. *Id.* at 2605. As Defendants admit, "[t]he [*NFIB*] Court found that the outsized threat of losing all of a state's federal Medicaid matching funds and the dramatic change demanded of the state made the Medicaid expansion unlike any exercise of the Spending Clause the [Supreme] Court had addressed before." Defs.' Br. Supp. Mot. 15, ECF No. 27 (citing *id.* at 2605–06).

Similarly, the Court finds that at this stage in the litigation, Plaintiffs have sufficiently pleaded that "the outsized threat of losing all of a state's federal Medicaid matching funds and the dramatic change demanded of the state" sufficiently made the HIPF's imposition on the Plaintiff States through the actuarially sound requirement "a new program" for states. *See id.*; *see also* Am. Compl. 22, 25–26, ECF No. 19. More specifically, Plaintiffs have sufficiently pleaded that they are effectively forced to pay the HIPF in order to continue their participation in Medicaid, as the number of nonprofit MCOs available to serve its citizens to avoid the HIPF simply does not exist. *See* Am. Compl. ¶ 22, ECF No. 19; *see supra* Section III.A.1.a.ii (finding that Plaintiffs had standing due to the "economic dragooning" of the threatened loss of over 10 percent of each Plaintiff States' budget). Therefore, Defendants' Motion to Dismiss as to Plaintiffs' challenge in Counts Four and Eight that the actuarial-soundness requirement is coercive is **DENIED**.

ii. Whether the HIPF is Sufficiently Related to Medicaid

Defendants argue that the HIPF "does not require the States to participate in any new program, nor does it even impose a condition on the receipt of federal Medicaid funds—a necessary element of a Spending Clause claim." Defs.' Br. Supp. Mot. 16, ECF No. 27. Defendants further contend that "[n]o federal court, to Defendants' knowledge, has ever suggested that the Spending Clause's restrictions on Congress's authority to condition federal funds extend to Congress's taxing power." *Id.* at 16. Defendants further assert that "the States may, depending on the MCOs' historical profits from their Medicaid contracts, be able to use their bargaining power to minimize or eliminate rate increases." *Id.* at 16. Plaintiffs respond that "[b]ecause the actuarial soundness requirement (and ASOP 49) condition Plaintiff States' receipt of federal funds for Medicaid on their payment of the HIPF, that condition must relate to Medicaid to be a legitimate exercise of Congress's spending power." Pls.' Resp. 17, ECF No. 29. However, argue Plaintiffs, because the purpose "of the HIPF is to generate revenue for health insurance subsidies for those that do *not* qualify for Medicaid," the "HIPF is insufficiently related to Medicaid to be a legitimate exercise of Congress's spending power." *Id.*; *see also* Am. Compl. ¶ 18, ECF No. 19 (stating that "the purpose of the fee was to generate revenue from a windfall Congress expected insurers to receive by increasing enrollment" in the ACA).

The Court has already decided it need not conclusively decide whether the HIPF is a "fee" or a "tax" at this juncture, as "either way, Plaintiffs have

established that the Court has subject-matter jurisdiction as to their claims." *See supra* Section III.A.2.b. Therefore, the Court analyzes whether Plaintiffs have stated a Spending Clause claim.

In *Massachusetts v. United States*, the Supreme Court reaffirmed the long-held principle that the "Government may impose appropriate conditions on the use of federal property or privileges and may require that state instrumentalities comply with conditions that are reasonably related to the federal interest in particular national projects or programs." 435 U.S. 444, 461 (1978); *see also Dole*, 483 U.S. at 207 ("[C]onditions on federal grants might be illegitimate if they are unrelated 'to the federal interest in particular national programs or programs") (citing *id.*). In *Dole*, the Supreme Court held that the "condition imposed by Congress [related to minimum legal drinking ages] is directly related to one of the main purposes for which highway funds are expended—safe interstate travel." *Dole,* 483 U.S. at 208.

Here, the Court finds that Plaintiffs have stated a claim that the HIPF is not "directly related," let alone "reasonably related," to the Medicaid program, as the purpose of the HIPF is to generate revenue due to expected enrollment in ACA insurance programs, rather than to generate revenue related to the federal interest in advancing Medicaid services. Pls.' Resp. 17, ECF No. 29; *see also* Am. Compl. ¶ 18, ECF No. 19. Therefore, at this preliminary stage, Defendants' Motion to Dismiss is **DENIED**.

iii. Whether the Medicaid Statute Clearly Notifies States of

Actuarial-Soundness Requirements

In Count One, Plaintiffs claim the HIPF fails the "plain statement rule" by giving them insufficient notice that federal funding for Medicaid is conditioned on the Plaintiffs' required HIPF payments to MCOs. Defendants argue this is untrue because "purchasers of health insurance can be assumed to know that their premiums are affected by costs to the insurance industry." Defs.' Mot. 18, ECF No. 27. Defendants also argue that "Congress never promised the Medicaid program would remain unchanged; to the contrary, it has reserved the right to 'alter, amend, or repeal' the Medicaid program." *Id.* at 18 (quoting 42 U.S.C. § 1304). Defendants add that "presumably the Plaintiffs . . . would not want to enter into contracts with managed-care plans whose rates were not actuarially sound, as that could endanger the quality of care or access to services for Medicaid beneficiaries." *Id.* at 18–19. Defendants conclude that "[t]he suggestion that States could not anticipate changes to the regulatory costs borne by MCOs—participants in a long highly regulated industry—is simply disingenuous. Nor can Plaintiffs claim that they did not know of the HIPF or any of its potential effects since it was enacted." Defs.' Reply 8, ECF No. 32.

Plaintiffs respond that "[n]either the Medicaid Act nor the ACA say that the receipt of federal Medicaid funds for managed care is conditioned on the States paying the HIPF." Pls.' Resp. 18, ECF No. 29. Plaintiffs add that "[m]ore importantly, the payment of the HIPF by Plaintiff States was not part of the ACA and, until ASOP 49 clarified the parameters of actuarial soundness

regarding the HIPF, Plaintiff States did not know that they would incur the full burden of the HIPF." *Id.* Plaintiffs conclude that "[b]ecause Congress did not provide clear notice—and in fact excluded 'governmental entit[ies]' from its coverage—the HIPF is unconstitutional as applied to Plaintiff States." *Id.* at 19.

Under the plain statement rule, "Congress must express clearly its intent to impose conditions on the grant of federal funds so that the States can knowingly decide whether or not to accept those funds." *Pennhurst State Sch. & Hosp. v. Halderman*, 451 U.S. 1, 24 (1981). "[T]hough Congress' power to legislate under the spending power is broad, it does not include surprising participating States with post-acceptance or 'retroactive' conditions." *NFIB*, 132 S. Ct. at 2606 (quoting *id.* at 25). As the Court previously noted, "'legislation enacted pursuant to the spending power is much in the nature of a contract,' and therefore, to be bound by 'federally imposed conditions,' recipients of federal funds must accept them 'voluntarily and knowingly.'" *Arlington Cent. Sch. Dist. Bd. of Educ. v. Murphy*, 548 U.S. 291, 296 (2006) (quoting *Pennhurst*, 451 U.S. at 17). "The crucial inquiry . . . is not whether a State would knowingly undertake that obligation, but whether Congress spoke so clearly that we can fairly say that the State could make an informed choice." *Pennhurst*, 451 U.S. at 25. "Congress may not simply 'conscript state [agencies] into the national bureaucratic army . . . .'" *NFIB*, 132 S. Ct. at 2607 (quoting *FERC v. Mississippi*, 456 U.S. 742, 775 (1982) (O'Connor, J., concurring in judgment in part and dissenting in part)).

The parties do not dispute that "[n]either the Medicaid Act nor the ACA say that the receipt of federal

Medicaid funds for managed care is conditioned on the States paying the HIPF." Pls.' Resp. 18, ECF No. 29; *see also* Defs.' Br. Supp. Mot. 18, ECF No. 27. Defendants point out, though, that Congress has reserved the right, in the Medicaid Act, to "alter, amend, or repeal" the Medicaid program. Defs.' Br. Supp. Mot. 18, ECF No. 27 (quoting 42 U.S.C. § 1304). Plaintiffs respond that "the HIPF was not part of the Medicaid statute, and the Medicaid statute was never amended to address the HIPF." Pls.' Resp. 18, ECF No. 29. Plaintiffs argue that they "'could hardly anticipate that Congress's reservation of the right to alter or amend the Medicaid program included the power to transform it so dramatically' by upsetting the regular workings of Medicaid, for the better part of 50 years, by conditioning the receipt of federal Medicaid funds on the States paying to subsidize federal health insurance programs." *Id.* (quoting *NFIB*, 132 S. Ct. at 2606).

The Court agrees that at this stage of the litigation, Plaintiffs have alleged that Congress has not clearly expressed its intent to condition the grant of federal Medicaid funds on the states paying the HIPF, such that States have had an opportunity to "knowingly decide" whether or not to accept these funds. *Pennhurst*, 451 U.S. at 24. To the extent actuarial soundness requirements or the Medicaid Act's blanket provision that allowing for at-will alterations has existed for some time, the HIPF's pass through requirement materialized with the ASOP 49, as enforced through the HIPF. Plaintiffs have alleged this requirement unlawfully "surpris[ed] participating States with post-acceptance or 'retroactive' conditions." *NFIB*, 132 S. Ct. at 2606.

Therefore, at this stage, Defendants' Motion to Dismiss is **DENIED** as to Count One.

b. Counts Six and Ten: Whether the HIPF Violates the Tenth Amendment or Intergovernmental Tax Immunity Because it Falls Directly on Private Parties

In Count Six, Plaintiffs seek a declaratory judgment under 28 U.S.C. §§ 2201–02 and 5 U.S.C. § 706 that the HIPF unconstitutionally taxes a sovereign. Am. Compl. 23–24, ECF No. 19. In addition, in their alternative argument under Count Ten, Plaintiffs argue that § 9010 violates the Tenth Amendment for "enabling the federal government to impose an unconstitutional tax on the States while foreclosing the return of such funds." *Id.* at 12. The Court considers these claims together, as the parties have in their respective pleadings. *See* Defs.' Br. Supp. Mot. 19, ECF No. 27; *see also* Pls.' Resp. 19, ECF No. 29.

Defendants argue that "Plaintiffs' tax-immunity claim is foreclosed by nearly three-quarters of a century of Supreme Court precedent rejecting the so-called theory of tax immunity." Defs.' Br. Supp. Mot. 19–20, ECF No. 27. Defendants explain that "the HIPF—a nondiscriminatory tax that applies across the board to 'any entity which provides health insurance,' ACA § 9010(c)(1)—is constitutional even if every cent of it is passed on to the States." *Id.* Defendants conclude that "Plaintiffs' intergovernmental tax immunity claim is a non-starter," because their "theory of tax immunity would completely eclipse Congress's power to tax private entities because any tax imposed on private parties risks impacting states' coffers." *Id.*

Plaintiffs argue that "a federal tax which is not discriminatory as to the subject matter may nevertheless so affect the State, merely because it is a State that is being taxed, as to interfere unduly with the State's performance of its sovereign functions of government."[5] *New York v. United States*, 326 U.S. 572, 594–95 (1946) (Stone, C.J., concurring). Plaintiffs allege that "a direct tax on the States is impermissible when it infringes on State sovereignty," and "[s]tates have no immunity from taxation when immunity would 'accomplish a withdrawal from the taxing power of the nation a subject of taxation of a nature which has been traditionally within that power from the beginning.'" Pls.' Resp. 20, ECF No. 29 (quoting *New York*, 326 U.S. at 588). Plaintiffs conclude that "[t]he imposition of the HIPF on Plaintiff States has, in turn, required them to tax their citizens (or make spending cuts to State programs) to pay it, making Plaintiff States bear part of the blame for the costs of the federal program. Allowing Defendants to hijack State treasuries in this manner is no less an affront to State sovereignty than allowing Defendants to commandeer State legislative processes, or State executive officials." *Id.* Plaintiffs also argue that "[n]o federal tax remotely similar to the HIPF has traditionally been imposed on States' Medicaid health plans. . . . And the novelty of the ACA precludes the HIPF from being cogently analogized to any prior tax." *Id.* at 21.

"In *McCulloch v. Maryland*, the Supreme Court held that states are prohibited from directly taxing the

[5] Therefore, Plaintiffs appear to concede that the alleged tax is "nondiscriminatory," rather than "discriminatory." Defendants appear to construe Plaintiffs' pleadings similarly. *See, e.g.*, Defs.' Reply 8, ECF No. 32.

United States government [sic], its activities, and its property. Nor may a state impose a tax whose legal incidence falls upon the United States." *Whitley v. Griffin*, 737 F. Supp. 345, 349 (E.D.N.C. 1990) (citing 17 U.S. 316 (1819) (internal citation omitted)); *see also United States v. Cty. of Fresno*, 429 U.S. 452, 459 (1977). In analyzing this issue, "the court must look beyond the bare face of the taxing statute and consider all relevant circumstances." *Whitley*, 737 F. Supp. at 350 (citing *United States v. City of Detroit*, 355 U.S. 466, 469 (1958)).

In recent decades, "the doctrine of intergovernmental tax immunity started a long path in decline . . . ." *Cotton Petroleum Corp. v. New Mexico*, 490 U.S. 163, 174 (1989) (quoting *Baker*, 485 U.S. 505, 520 (1988)); *see also Cal. State Bd. of Equalization v. Sierra Summit, Inc.*, 490 U.S. 844, 848 (1989) (quoting the same). For instance, in *Baker*, the Supreme Court noted that its prior holdings "completely foreclosed any claim that the nondiscriminatory imposition of costs on private entities that pass them on to State or the Federal Government unconstitutionally burdens state or federal functions." 485 U.S. 505, 521 (1988) (citing *Alabama v. King & Boozer*, 314 U.S. 1, 8–9 (1941)). The Supreme Court stated that such precedent "has 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." *Id.* (citing *Washington v. United States*, 460 U.S. 536, 540 (1983); *United States v. New Mexico*, 455 U.S. 720, 734 (1982); *Cty. of Fresno*, 429 U.S. 452, 460–62 (1977); *City of Detroit*, 355 U.S. 466, 469 (1958)).

The Supreme Court has clarified that "[a] tax is considered to be *directly* on the Federal Government only 'when the levy falls on the United States itself, or on an agency or instrumentality so closely connected to the Government that the two cannot realistically be viewed as separate entities.'" *United States v. Delaware*, 958 F.2d 555, 569 (3d Cir. 1992) (emphasis added) (quoting *Baker*, 485 U.S. at 523). Therefore, "States may not impose taxes directly on the Federal Government, nor may they impose taxes the legal incidence of which falls on the Federal Government." *Memphis Bank & Trust Co. v. Garner*, 459 U.S. 392 (1983) (quoting *Cty. of Fresno*, 429 U.S. at 459). In other words, despite the "decline of the intergovernmental tax immunity doctrine" in recent decades, the doctrine continues to apply to taxes, or the legal incidence of taxes, that fall directly on a government, as such basic "[c]onstitutional principles do not depend upon the rise or fall of particular doctrines." *Baker*, 485 U.S. at 532 (O'Connor, J., concurring). Accordingly, courts, including the Supreme Court, continue to consider whether the doctrine applies in limited factual circumstances. *See, e.g., Jefferson Cty. v. Acker*, 527 U.S. 423, 448–49 (1999) (Breyer, J., concurring in part and dissenting in part) ("If Jefferson County's license fee amounts to a tax imposed directly upon a federal official's performance of his official duties, it runs afoul of the intergovernmental tax immunity doctrine.") (collecting cases).

Notably, "the Supreme Court has held that the *economic* incidence of a tax does not necessarily determine the legal incidence of the tax." *Delaware*, 958 F.2d at 561 (emphasis added) (citing *Washington*, 460 U.S. at 540; *New Mexico*, 455 U.S. at 734). "On the other

hand, the legal incidence does not necessarily fall on the person or entity that the state holds legally responsible for paying the tax." *Id.* (citing *United States v. State Tax Comm'n of Miss.*, 421 U.S. at 607; *First Agric. Nat'l Bank v. State Tax Comm'n*, 392 U.S. 339, 347 (1968)). "[B]oth economic incidence and formal liability are normally relevant in determining legal incidence. Also relevant as a general matter are the intent of the taxing authority, and the rights and obligations involved in the transaction being taxed." *Delaware*, 958 F.2d at 561 (citing *State Tax Comm'n of Miss.*, 421 U.S. at 608; *First Agric. Nat'l Bank*, 392 U.S. at 347; *United States v. City of Leavenworth*, 443 F. Supp. 274, 282 (D. Kan. 1977)).

In *First Agricultural National Bank*, the Supreme Court held it was "indisputable that a sales tax which by its terms must be passed on to the purchaser imposes the legal incidence of the tax on the purchaser." 392 U.S. at 347 (citing *Fed. Land Bank of St. Paul v. Bismarck Lumber Co.*, 314 U.S. 95, 99 (1941)). In *State Tax Commission of Mississippi*, the Supreme Court similarly held that a markup on liquor sales by the State Tax Commission to military bases in Mississippi was effectively a sales tax collected by the seller and remitted to the state, because "where a State requires that its sales tax be passed on to the purchaser and be collected by the vendor from him, this establishes as a matter of law that the legal incidence of the tax falls upon the purchaser." 421 U.S. at 608. The Supreme Court reasoned that this was "plainly the requirement" of the relevant state regulation, which provided that all military facilities' direct orders of alcoholic beverages from distillers "shall bear the usual wholesale markup in price," such that the "price of such alcoholic beverages

shall be paid by such organizations directly to the distiller." *Id.* at 609. The Supreme Court concluded, therefore, that "[t]he Tax Commission clearly intended—indeed, the scheme unavoidably requires—that the out-of-state distillers and suppliers pass on the markup to the military purchasers." *Id.* at 609.

Similarly, in *United States of Delaware*, the Third Circuit Court of Appeals considered whether a Delaware utility tax mandatorily passed on to consumers was unconstitutional as applied to sales of electricity to the Dover Air Force Base in Delaware. 958 F.2d at 562. There, the state Public Service Commission was statutorily "directed, after consultation with such distributors and without a public hearing, to adjust the tariff of such distributor so that the tax is passed through pro rata to the distributor's customers and the distributor's earnings are neither increased nor decreased by such tax." *Id.* (quoting 30 Del. Code Ann. § 5502(c)). The court noted that the state "engage[d] in creative verbal gymnastics to suggest that the pass-through is somehow optional." *Id.* The court reasoned that the "Delaware legislature intended that consumers pay the tax," and therefore the utility tax was unconstitutional as applied to sales to the federal government." *Id.*

Here, similar to *State Tax Commission of Mississippi* and *Delaware*, the Court finds that Plaintiff has sufficiently pleaded at this stage that the legal incidence of the ACA, by enforcing ASOP 49 through the HIPF and actuarially sound requirement, falls on Plaintiff States. Defendants correctly emphasized that the Supreme Court has affirmed that "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." *See* Defs.' Br. Supp. Mot. 19–20, ECF No. 27; *see also Baker*, 485 U.S. at 521 (noting that the Supreme Court previously "foreclosed any claim that the nondiscriminatory imposition of costs on private entities that pass them on to States."). However, the issue here is that Plaintiffs have alleged Congress, not the private MCOs themselves, have mandated that the Plaintiff States pay the full HIPF to the MCOS, which then pay the federal government, such that the full amount of the HIPF is effectively imposed on the Plaintiff States. *State Tax Comm'n of Miss.*, 421 U.S. at 608. Indeed, Plaintiffs allege CMS worked directly with Texas in 2015 to confirm the precise amount Texas owed to the MCOs. *See* Am. Compl. ¶ 40, ECF No. 19. In other words, the statutory "scheme" of the HIPF, through the actuarial soundness requirements, which incorporate the ASOP, "unavoidably requires" that the States pay the MCOs the full amount of the HIPF to be paid to the federal government. *Id.* at 609.

Also here, as in *Delaware*, Defendants appear to "engage[] in creative verbal gymnastics to suggest that the pass-through is somehow optional" as to the Plaintiff States. *See Delaware*, 958 F.2d at 562; *see also* Defs.' Br. Supp. Mot. 16, ECF No. 27 (hypothesizing that "the States may, depending on the MCOs' historical profits from their Medicaid contracts, be able to use their bargaining power to minimize or eliminate rate increases" but not HIPF payments). However, based on Plaintiffs' pleadings, ASOP 49's mandate on Plaintiff States, as required by the actuarially soundness requirement and the HIPF, plainly "cannot be read . . .

as discretionary," and this argument seems to concede states must pay the HIPF but can achieve savings elsewhere.[6] *Delaware*, 958 F.2d at 562; *see also* Pls.' Resp. 1, ECF No. 29 ("Here, the HIPF passes through Plaintiff States' Medicaid [MCOs] to Plaintiff States because of the requirements of an agency regulation (42 C.F.R. § 438.6) and [ASOP 49] . . . ."). Whether Plaintiffs could hypothetically contract differently to minimize rate increases in the future is irrelevant to determining the constitutionality of the HIPF itself. *See Baker*, 485 U.S. at 518 ("Congress cannot employ unconstitutional means to reach a constitutional end.").

Accordingly, the Court finds that Plaintiffs have pleaded a violation of the intergovernmental tax immunity doctrine, and Count Six is accordingly **DENIED**. To the extent Plaintiffs similarly plead that the alleged direct tax imposed through § 9010(f) of the ACA violates the Tenth Amendment, the Court finds for the same reasons that § 9010 may not be constitutionally applied to deny a refund. Accordingly, Plaintiffs' alternative argument under Count Ten is also **DENIED**.

c. Count Five: Whether the Actuarial-Soundness Requirement is an Unconstitutional Delegation of Legislative Power

In Count Five, Plaintiffs seek, in part, a declaratory judgment under 28 U.S.C. §§ 2201–02 and 5 U.S.C. § 706

[6] The difference between (1) ASOP 1's statement that actuarially soundness "could" factor into an actuary's judgment, and (2) ASOP 49's statement that it "should" factor into an actuary's judgment and ASOP 49's impact on the legal incidence, will be considered in the evidentiary stage of the litigation.

that Plaintiff States being forced to pay the HIPF is an unconstitutional delegation of Congress's legislative power to a private entity in contravention of Article 1, Section 1 of the United States Constitution. Am. Compl. 22–23, ECF No. 19. Defendants contend that "[t]he Supreme Court's decision in *Currin v. Wallace*, 306 U.S. 1 (1939), controls this case." Defs.' Br. Supp. Mot. 21, ECF No. 27. There, "the [Supreme] Court considered a delegation challenge to the Tobacco Inspection Act, which permitted the Secretary of Agriculture to act only subject to certification by two-thirds of tobacco growers voting at a prescribed referendum." *Id.* (internal citations omitted). Defendants argue that in *Currin*, "the Court noted that '[t]he Constitution has never been regarded as denying to the Congress the necessary resources of flexibility and practicality, which will enable it to perform its function in laying down policies and establishing standards.'" *Id.* Defendants note that "[f]urthermore, the Supreme Court has applied the delegation doctrine only where Congress has delegated authority to interested private parties," as the doctrine "is animated by the fear that industry groups might 'regulate the affairs of an unwilling minority.'" *Id.* (quoting *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936)). Defendants note that "[t]he ASB has no financial interest in the outcome of capitation-rate negotiations." Defs.' Br. Supp. Mot. 21–22, ECF No. 27.

Plaintiffs respond that its "improper delegation claim is best understood against the backdrop of the separation of powers." Pls.' Resp. 22, ECF No. 29. Plaintiffs aver that "Congress cannot delegate power to make the law or change the law," and "[w]hile not every historic or future application of 42 C.F.R. § 438.6

contravenes the statutory text, it works here, especially in light of ASOP 49, to rewrite the statute and impose the HIPF on a non-'covered entity'—the States." *Id.* Here, Plaintiffs assert the Academy has rewritten the ACA by ensuring the Plaintiff States pay the HIPF when Congress expressly excluded the Plaintiff States from having to pay it. Pub. L. 111-148, § 9010(c)(1)–(2). Plaintiffs also argue that "it is significant that the unconstitutional delegation here is to a private entity," because "[f]ederal lawmakers cannot delegate regulatory authority to a private entity. To do so would be 'legislative delegation in its most obnoxious form.'" *Id.* (citing *Ass'n of Am. R.R.s. v. Dep't of Transp.*, 721 F.3d 666, 670 (D.C. Cir. 2013), *rev'd on other grounds*, 1235 S. Ct. 1225 (2015)). Plaintiffs also argue that *Currin* is "questionable precedent" and moreover, in that case, "Congress did not delegate to a private entity the authority to craft or define the regulations." *Id.* at 23 (quoting *Ass'n of Am. R.R.s*, 135 S. Ct. at 1254 (Thomas, J., concurring)). Plaintiffs conclude that "Congress delegated to ASB—a single, private, membership-based organization—the authority to define what is 'actuarially sound' for purposes of Medicaid and craft the standards for determining whether States' Medicaid programs comply with federal law." *Id.*

In *Association of American Railroads*, the railroad association sued the Department of Transportation, among other agencies, challenging a statute requiring the Federal Railroad Administration and federally chartered Amtrak to jointly develop standards to evaluate Amtrak's performance. *See generally id.* The Supreme Court held that Amtrak was a governmental entity rather than an autonomous private entity for

purposes of determining the relevant standards because Congress mandates certain aspects of its day to day operations, the Secretary of Transportation holds all of Amtrak's preferred stock and most of its common stock, the political branches exercise "substantial, statutorily mandated supervision over Amtrak's priorities and operations," and "[a] majority of its Board is appointed by the President and confirmed by the Senate and is understood by the Executive to be removable by the President at will." *Id.* at 1231–33. The Supreme Court summarized that "Amtrak was created by the Government, is controlled by the government, and operates for the government's benefit." *Id.* at 1232.

In his concurrence, in which he "entirely agree[d] . . . that Amtrak is 'a federal actor or instrumentality'" for constitutional purposes, Justice Alito noted that "the formal reason why the Court does not enforce the nondelegation doctrine with more vigilance is that the other branches of government have vested powers of their own that can be used in ways that resemble lawmaking." *Id.* at 1237 (citing *Arlington v. FCC*, 133 S. Ct. 1863, 1873 (2013)). Justice Alito noted that "[w]hen it comes to private entities, however, there is not even a fig leaf of constitutional justification" because private entities are vested with neither legislative nor executive powers. *Id.* at 1237. "By any measure, handing off regulatory power to a private entity is 'legislative delegation in its most obnoxious form.'" *Id.* at 1238 (quoting *Carter*, 298 U.S. at 311).

In their Amended Complaint, Plaintiffs allege that "[t]o be deemed 'actuarially sound' for purposes of Medicaid or CHIP, federal regulations require an actuary's certification that, under the standards

established by the [Academy], capitation rates are sufficient to cover the insurance providers' expected costs and insurance risks for the coming year." Am. Compl. ¶ 26, ECF No. 19 (citing 42 C.F.R. § 438.6). Plaintiffs point out that "[t]he American Academy of Actuaries is a private, membership-based professional organization." *Id.* ¶ 27. Furthermore, "[t]o set practice standards for actuaries, the American Academy of Actuaries has created and works with an independent, private organization known as the [ASB]." *Id.* ¶ 29. Plaintiffs assert that "[i]n March 2015, the ASB adopted ASOP 49, which "requires capitation rates to recover from States the amount of all taxes managed care organizations are required to pay." *Id.* ¶ 31. Plaintiffs allege that "[w]ithout such certification of an actuary, a managed care organization agreement will not be eligible for participation in Medicaid and CHIP." *Id.* ¶ 35.

Under the principles established in *American Association of Railroads*, the Court finds that Plaintiffs have sufficiently stated a claim that Congress delegated rulemaking authority to an independent, private organization, in direct contravention of Article I, Section 1 of the United States Constitution. Defendants' Motion is **DENIED** as to Count Five as to Plaintiffs' constitutional claim. Plaintiffs also bring a statutory claim under Count Five, which the Court will address below. *See infra* Section III.B.3.a.

3. Plaintiffs' Statutory Claims

a. Counts Two and Three: Whether HHS's Decision to Rely on ASOP 49 was Subject to Notice-and-Comment Rulemaking and Was Not Arbitrary or Capricious

In Count Two, Plaintiffs seek declaratory relief under 5 U.S.C. § 706 that "the delegation by [HHS] . . . of ultimate decision-making authority to the [ASB] on whether States must pay their Medicaid and CHIP [MCOs] the [HIPF] is arbitrary and capricious and not otherwise in accordance with law." Am. Compl. ¶ 52, ECF No. 19. In Count Three, Plaintiffs allege that HHS "failed to properly engage in notice-and-comment rulemaking by delegating final authority and discretion to the [ASB] without observance of procedure required by law," with the HIPF imposed upon the States functioning as a "rule" under the APA. *Id.* ¶¶ 55, 57.

i. Count Three: Whether HHS's Decision to Rely on ASOP 49 Was Subject to Notice-and-Comment Rulemaking

In Count Three, Plaintiffs allege that HHS "failed to properly engage in notice-and-comment rulemaking by delegating final authority and discretion to the Actuarial Standards Board without observance of procedure required by law." *Id.* ¶ 57. Defendants point out that HHS's decision "to refer to the ASOP, 42 C.F.R. § 438(c)(i)(C), *did* go through notice-and-comment rulemaking." Defs.' Br. Supp. Mot. 23, ECF No. 27. Defendants argue that "[t]o the extent Plaintiffs are trying to challenge the ASB's decision, those are not

'rules' that require notice-and-comment procedures because they are not 'agency statement[s].' " *Id.* at 23–24 (quoting 5 U.S.C. § 551(4)).

In *Perez v. Mortgage Bankers Association*, the Supreme Court outlined the three-step procedure that 5 U.S.C. § 533 of the APA prescribes for notice and comment rulemaking. "First, the agency must issue a 'general notice of proposed rule making,' ordinarily by publication in the Federal Register." *Id.* at 1203 (quoting 5 U.S.C. § 533(b)). "Second, if 'notice [is] required,' the agency must 'give interested persons an opportunity to participate in the rule making through submission on written data, views, or arguments.' " *Perez*, 135 S. Ct. at 1203 (quoting 5 U.S.C. 5 U.S.C. § 533(c)). At that stage, "[a]n agency must consider and respond to significant comments received during the period for public comment." *Perez*, 135 S. Ct. at 1203 (citing *Citizens to Preserve Overton Park, Inc. v. Volpe*, 401 U.S. 402, 416 (1971); *Thompson v. Clark*, 741 F.2d 401, 408 (D.C. Cir. 1984)). "Third, when the agency promulgates the final rule, it must include in the rule's test 'a concise general statement of [its] basis and purpose.'" *Perez*, 135 S. Ct. at 1203 (quoting 5 U.S.C. 5 U.S.C. § 533 (c)).

Here, however, Plaintiffs appear to be challenging HHS's continued delegation to the ASB in light of the ASOP's impact on the HIPF. "When an agency has given its regulation a definitive interpretation, and later significantly revises that interpretation, the agency has in effect amended its rule, something it may not accomplish without notice and comment." *Shell Offshore Inc. v. Babbitt*, 238 F.3d 622, 629 (5th Cir. 2001) (quoting *Alaska Prof'l Hunters Ass'n v. FAA*, 177 F.3d 1030, 1084 (D.C. Cir. 1999)). In other words, "the APA requires an

agency to provide an opportunity for notice and comment before substantially altering a well established regulatory interpretation." *Shell Offshore Inc.*, 238 F.3d at 629.

The Court has already found that Plaintiffs have sufficiently stated that ASOP 49, as enforced through the actuarial soundness requirement and the HIPF, results in a substantial alteration of the HIPF's text. *See supra, e.g.*, Section III.A.1.a.i; III.B.2.a.i. Therefore, the Court finds that Plaintiffs sufficiently alleged, at this stage, that HHS has significantly revised its interpretation of the HIPF, as it integrates the ASOP 49, without providing the requisite notice-and-comment period. Therefore, Defendants' Motion to Dismiss Count Three is **DENIED**.

ii. Counts Two and Five: Whether Implementation of the HIPF is Entitled to Chevron Deference, and Whether HHS's Decision to Rely on ASOP 49 Was Arbitrary and Capricious

In Count Two, Plaintiffs seek declaratory relief under 5 U.S.C. § 706 that "the delegation by [HHS] . . . of ultimate decision-making authority to the [ASB] on whether States must pay their Medicaid and CHIP [MCOs] the [HIPF] is arbitrary and capricious and not otherwise in accordance with law." Am. Compl. ¶ 52, ECF No. 19. Defendants argue that to the extent "Plaintiffs also allege that requiring that managed care rates comply with the ASOP was arbitrary and capricious," their claim "fails because Plaintiffs offer no more than a 'conclusory statement' that this decision was

arbitrary and capricious.'" Defs.' Br. Supp. Mot. 24, ECF No. 27 (citing *Iqbal*, 556 U.S. at 678).

Plaintiffs argue that "Defendants' decision to run the consequences of the HIPF, an unprecedented multi-billion dollar tax, through a pre-ACA rule promulgated in 2002, instead of addressing it separately, is arbitrary and capricious."[7] Pls.' Resp. 24–25, ECF No. 29. Plaintiffs further allege that "while Defendants may prefer to employ a one-size-fits-all 'actuarial soundness' rule to all Medicaid plans, that preference cannot override the multiple legal and constitutional problems with the result." *Id.* at 25. Plaintiffs conclude that "this is especially so where the operational result of Defendants' status quo work, as it does here, to alter the text of Congress by shifting the full liability for the HIPF from MCOs to Plaintiff States." *Id.* (emphasis added). Plaintiff States conclude that they should not be "required to anticipate that a pre-ACA regulation (42 C.F.R. § 438.6), coupled with a post-ACA ASOP, would effectively shift the HIPF burden to the States—something different from what Congress expressly said." *Id.* at 18.

The parties dispute whether *Chevron* applies, and for purposes of resolving this Motion, the Court assumes its does. *See, e.g.*, Defs.' Br. Supp. Mot. 22, ECF No. 27; Pl.'s Resp. 25, ECF No. 29; *see also Chevron U.S.A. v. Nat. Res. Def. Council*, 467 U.S. 837 (1984). To determine

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[7] Plaintiffs do not appear to plead in this claim that the HIPF is conclusively a "tax." While generally referring to their DJA and APA claims elsewhere, Plaintiffs state, "That the HIPF should be *treated* as an excise tax for administrative purposes doesn't change the fact that it is a fee." Pls.' Resp. 8, ECF No. 29. As the Court has already stated, the Court need not decide at this early stage where the HIPF is a "fee" or a "tax." *See supra* Section III.A.2.b.

whether agency action was arbitrary or capricious, a court must consider "whether the decision was based on a consideration of the relevant factors and whether there has been a clear error of judgment." *Tex. Comm. on Nat. Res. v. Wan Winkle*, 197 F. Supp. 2d 586, 596 (N.D. Tex. 2002) (Means, J.) (citing *Sierra Club v. Dombeck*, 161 F. Supp. 2d 1052, 1064 (D. Ariz. 2001); *Marsh v. Or. Nat. Res. Council*, 490 U.S. 360, 378 (1989)). "The burden of proving that an agency decision was arbitrary or capricious generally rests with the party seeking to overturn the agency decision." *Tex. Comm.*, 197 F. Supp. 2d at 596. "'If the decision reached by the agency 'represents a reasonable accommodation of conflicting policies that were committed to the agency's care by statute, we should not disturb it unless it appears that the accommodation is not one that Congress would have sanctioned.'" *Id.* (quoting *Chevron*, 467 U.S. at 844; *United States v. Shimer*, 367 U.S. 374, 383 (1961)). "In applying this standard, courts generally look at 'whether the decision was based on a consideration of relevant factors, whether there has been a clear error of judgment and whether there is a rational basis for the conclusions approved by the administrative body.'" *Tex. Comm.*, 197 F. Supp. at 596 (citing *Mobil Oil v. Dep't of Energy*, 610 F.2d 796 (Em. App. 1979).

Here, by asserting that HHS has "alter[ed] the text of Congress by shifting the full liability for the HIPF from MCOs to Plaintiff States," the Court finds that Plaintiffs have sufficiently alleged at this stage that HHS has acted arbitrarily or capriciously, such that the decision to rely on ASOP 49 in enforcing the HIPF may not be an "accommodation . . . that Congress would have sanctioned" or a "reasonable" decision by the Secretary

of HHS. *Tex. Comm.*, 197 F. Supp. at 596; *Chevron*, 467 U.S. at 844. Accordingly, Defendants' Motion to Dismiss is **DENIED** as to Count Two. Because the Court finds that at this preliminary stage, that if *Chevron* were to apply, that Plaintiffs have stated a claim, the Court need not analyze at this stage whether implementation of the HIPF is subject to *Chevron* deference. Therefore, the Court **DEFERS** ruling on Count Five as to Plaintiff's statutory claim until trial. *See* Fed. R. Civ. P. 12(i).

IV. CONCLUSION

Based on the foregoing, Defendants' Motion to Dismiss Plaintiffs' Amended Complaint (ECF No. 26) is **GRANTED in part and DENIED in part**. In summary, Defendants' Motion is: (1) **DENIED** as to Count One; (2) **DENIED** as to Count Two; (3) **DENIED** as to Count Three; (4) **DENIED** as to Count Four; (5) **DEFERRED in part and DENIED in part** as to Count Five; (6) **DENIED** as to Count Six; (7) **GRANTED** as to Count Seven; (8) **DENIED** as to Count Eight; (9) **DENIED** as to Count Nine; and (10) **GRANTED in part and DENIED in part** as to Count Ten.

SO ORDERED on this **4th day of August, 2016**.

/s/ Reed O'Connor
Reed O'Connor
UNITED STATES DISTRICT JUDGE

APPENDIX D

UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 18-10545

STATE OF TEXAS; STATE OF KANSAS; STATE OF LOUISIANA; STATE OF INDIANA; STATE OF WISCONSIN; STATE OF NEBRASKA,

Plaintiffs – Appellees/Cross-Appellants,

versus

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; XAVIER BECERRA, SECRETARY, U.S. DEPARTMENT OF HEALTH AND HUMAN SERVICES,

Defendants – Appellants/Cross-Appellees.

Appeal from the United States District Court
for the Northern District of Texas
USDC No. 7:15-CV-151

ON PETITION FOR REHEARING EN BANC
(Opinion: Revised February 12, 2021, 5 CIR., 987 F.3D 518)

Before BARKSDALE, HAYNES, and WILLETT, *Circuit Judges*.[1]

PER CURIAM:

The court having been polled at the request of one of its members, and a majority of the judges who are in regular active service and not disqualified not having voted in favor (Fed. R. App. P. 35 and 5th Circ. R. 35), the petition for rehearing en banc is DENIED.

In the en banc poll, five judges voted in favor of rehearing (Judges Jones, Smith, Elrod, Ho, and Duncan), and eleven judges voted against rehearing (Chief Judge Owen, and Judges Stewart, Dennis, Southwick, Haynes, Graves, Higginson, Costa, Willett, Engelhardt, and Wilson).

[1] Judge Oldham did not participate in the consideration of the rehearing en banc.

JAMES C. HO, *Circuit Judge*, joined by JONES, SMITH, ELROD, and DUNCAN, *Circuit Judges*, dissenting from denial of rehearing en banc:

For those who believe in the text and original understanding of the Constitution, the panel decision is troubling for at least two different reasons.

First, the Constitution vests lawmaking power in the most politically accountable branch of our government—the Congress of the United States. Yet the panel blesses the placement of lawmaking power in purely private hands, wholly unaccountable to the people. That devalues the right to vote and desecrates the entire premise of our constitutional democracy—that our laws are supposed to be written by members of Congress elected by the American people, not by private interests pursuing unknown private agendas.

Second, judges swear an oath to uphold the Constitution, consistent of course with a judicial system based on precedent. That should mean that we decide every case faithful to the text and original understanding of the Constitution, to the maximum extent permitted by a faithful reading of binding precedent. Dutiful application of this standard is vital to respecting and restoring our nation's founding principles. But rather than apply this standard, the panel instead extends precedent unnecessarily, in a strained effort to uphold the uniquely unlawful delegation challenged here.

The Constitution vests "[a]ll legislative Powers herein granted" in Congress. U.S. CONST. art. I, § 1. And it makes clear that "any Bill . . . shall not be a Law" unless it has complied with the bicameralism and presentment requirements of Article I. U.S. CONST. art.

I, § 7, cl. 2. These provisions do not permit Congress to delegate its lawmaking powers elsewhere, any more than they permit the President to delegate the power to sign legislation. *See, e.g., Gundy v. United States*, 139 S. Ct. 2116, 2121 (2019) (plurality opinion by Kagan, J.) ("The nondelegation doctrine bars Congress from transferring its legislative power to another branch of Government."). *See also, e.g., Electronic Presentment and Return of Bills*, 35 Op. O.L.C. 51, 62 (2011) ("[T]he President . . . could not delegate his constitutional signing responsibility."); *Whether the President May Sign a Bill by Directing That His Signature Be Affixed to It*, 29 Op. O.L.C. 97, 124 (2005) (same).

This prohibition on delegation might seem inconvenient and inefficient to those who wish to maximize government's coercive power. But the purpose of the nondelegation doctrine is not to serve Congress, but to preserve liberty. *See, e.g., Dep't of Transp. v. Ass'n of Am. R.Rs.*, 575 U.S. 43, 61 (2015) (Alito, J., concurring) ("The principle that Congress cannot delegate away its vested powers exists to protect liberty.").

"'[B]icameralism and presentment make lawmaking difficult by design.'" *Id.* (quoting John F. Manning, *Lawmaking Made Easy*, 10 GREEN BAG 2D 191, 202 (2007)). This "deliberative process was viewed by the Framers as a valuable feature, . . . not something to be lamented and evaded." *Id.* Indeed, "the framers went to great lengths to make lawmaking difficult," for "[a]n 'excess of law-making' was, in their words, one of 'the diseases to which our governments are most liable.'" *Gundy*, 139 S. Ct. at 2134 (Gorsuch, J., dissenting) (quoting THE FEDERALIST NO. 62 (James Madison)).

The processes for new legislation may be "arduous," "but to the framers these were bulwarks of liberty." *Id.*

The modern administrative state illustrates what happens when we ignore the Constitution: Congress "pass[es] problems to the executive branch" and then engages in "finger-pointing" for any problems that might result. *Id.* at 2135. The bureaucracy triumphs—while democracy suffers.

That's why our Founders deliberately designed the legislative power to be exercised "only by elected representatives in a public process"—so that "the lines of accountability would be clear" and "[t]he sovereign people would know, without ambiguity, whom to hold accountable." *Id.* at 2134. In short: When it comes to lawmaking, the buck stops with Congress.

Admittedly, the nondelegation doctrine has been more honored in the breach than in the observance. "[S]ince 1935, the Court has uniformly rejected nondelegation arguments and has upheld provisions that authorized agencies to adopt important rules pursuant to extraordinarily capacious standards." *Id.* at 2130–31 (Alito, J., concurring).

So when the panel upheld the unlawful delegation of legislative power challenged in this case, it no doubt assumed it could invoke precedents reflecting the general dormancy and underenforcement of the nondelegation doctrine, and call it a day.

But fidelity to the Constitution requires much more than this. Critical features of the delegation challenged here make it categorically different from—and unsupportable under—current precedent.

To begin with, this case involves a delegation of lawmaking power, not to another governmental entity,

but to private bodies wholly unaccountable to the citizenry. In addition, the delegation was effectuated not by Congress, but at the whim of an agency—and without Congressional blessing of any kind. There is no precedent that permits this kind of "double delegation" from Congress to public bureaucrats to private parties—no case cited by the panel or the parties, and no case that I have independently uncovered.

To the contrary, the Supreme Court has made clear that delegation to "private persons" is "legislative delegation in its *most obnoxious form*." *Carter v. Carter Coal Co.*, 298 U.S. 238, 311 (1936) (emphasis added). "[F]or it is not even delegation to an official or an official body." *Id.* Delegation of legislative power to private entities is "unknown to our law" and "utterly inconsistent with the constitutional prerogatives and duties of Congress." *A.L.A. Schechter Poultry Corp. v. United States*, 295 U.S. 495, 537 (1935).

After all, "[w]hen it comes to [delegating to] private entities, . . . there is not even a fig leaf of constitutional justification." *Ass'n of Am. R.Rs.*, 575 U.S. at 62 (Alito, J., concurring). "Private entities are not vested with 'legislative Powers.' Nor are they vested with the 'executive Power,' which belongs to the President." *Id.* (citations omitted). Indeed, "[e]ven the United States accepts that Congress 'cannot delegate regulatory authority to a private entity.'" *Id.* at 61.

At bottom, the regulation challenged here is uniquely offensive to the Constitution—and unsupported by precedent—for three reasons: (1) It subdelegates substantive lawmaking power, rather than some minor factual determination or ministerial task; (2) the subdelegation is authorized by an administrative agency,

rather than by Congress; and (3) the agency is subdelegating power to a private entity, rather than to another governmental entity that is at least minimally accountable to the public in some way.

Not a single one of the precedents cited by the panel involves this toxic combination of constitutional abnormalities. Not one of them prevents us from enforcing the Constitution and the democratically accountable government for which it stands.

I dissent from the denial of rehearing en banc. The right to vote means nothing if we abandon our constitutional commitments and allow the real work of lawmaking to be exercised by private interests colluding with agency bureaucrats, rather than by elected officials accountable to the American voter.[1]

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[1] *See*, *e.g.*, PHILIP HAMBURGER, IS ADMINISTRATIVE LAW UNLAWFUL? 369 (2014) ("[T]he expansion of the electorate has been accompanied by the growth of administrative law . . . . One of the extraordinary achievements of American life over the past two centuries has been to make the theory of consensual government a reality. Yet when consensual government became a reality, the administrative state undermined that reality by shifting lawmaking away from people and their representatives . . . . [W]hether in 1870, 1920, or 1965 . . . each time, after representative government became more open to the people, legislative power increasingly has been sequestered to a part of government that is largely closed to them."); *id.* at 374–75 ("[A]lthough [members of the knowledge class] mostly supported expanded suffrage, they also supported the removal of legislative power to administrative agencies staffed by persons who shared their outlook. The development of administrative power thus . . . must be recognized as a sociological problem—indeed, a profoundly disturbing shift of power. As soon as the people secured the power to vote, a new class cordoned off for themselves a sort of legislative power that they could exercise without representation.").

I.

The Medicaid program provides financial assistance to low-income individuals so that they may obtain medical care. "States have two options for providing care to Medicaid beneficiaries: a 'fee-for-service' model and a managed-care model." *Texas v. Rettig*, 987 F.3d 518, 524 (5th Cir. 2021). "Under the . . . managed-care model, the state pays a third-party health insurer ('managed-care organization' or 'MCO') a monthly premium (the 'capitation rate') for each Medicaid beneficiary the MCO covers, and the MCO provides care to the beneficiary." *Id.*

In order for states to be reimbursed for these expenditures, MCO capitation rates must be "actuarially sound." 42 U.S.C. § 1396b(m)(2)(A)(iii), (xiii). In 2002, the Department of Health and Human Services (HHS) promulgated the "Certification Rule" to further delineate what it means for an MCO capitation rate to be "actuarially sound":

> (i) *Actuarially sound* capitation rates means capitation rates that—
>
> > (A) Have been developed in accordance with generally accepted actuarial principles and practices;
> >
> > (B) Are appropriate for the populations to be covered, and the services to be furnished under the contract; *and*
> >
> > (C) *Have been certified*, as meeting the requirements of this paragraph (c), *by actuaries who* meet the qualification standards established by the American Academy of Actuaries and *follow the practice*

> *standards established by the Actuarial Standards Board.*

42 C.F.R. § 438.6(c)(1)(i)(A)–(C) (2002) (emphases added).[2]

The Actuarial Standards Board is not a governmental entity accountable to the American people. It is a private organization that sets practice standards for private actuaries certified by the private American Academy of Actuaries (AAA). Yet the Certification Rule empowers the Board to determine the regulatory standard for whether a capitation rate is "actuarially sound," by allowing the Board to dictate the "practice standards" that an actuary must follow in so certifying the rate. *Id.* And other private entities—AAA-qualified private actuaries—determine whether a particular capitation rate meets the Board's private standards. *Id.*

One such privately promulgated "practice standard" is the requirement that capitation rates "certified in accordance with 42 CFR 438.6(c)" "provide for all reasonable, appropriate, and attainable costs," "includ[ing] . . . government-mandated assessments, fees, and taxes." *Rettig*, 987 F.3d at 525–26. It is the issuance of this practice standard in 2015 that gives rise to the instant case. *Id.* With the issuance of this private rule, the Plaintiff States suddenly had a new legal

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[2] The Certification Rule has since been recodified into multiple provisions. 42 C.F.R. § 438.4 now states that "[t]o be approved by [the Centers for Medicare and Medicaid Services], capitation rates must . . . [b]e certified by an actuary as meeting the applicable requirements," while § 438.2 defines "[a]ctuary" as "an individual who meets the qualification standards established by the American Academy of Actuaries . . . and follows the practice standards established by the Actuarial Standards Board."

obligation to account for (and thus pay) a new "Provider Fee"—a "cost" (specifically, a "government-mandated . . . tax[]") incurred by certain MCOs. *See id.* at 528–29.

In October 2015, the State of Texas filed suit, joined by Indiana, Kansas, Louisiana, Nebraska, and Wisconsin, challenging the validity of both the Provider Fee itself and the Certification Rule that enabled a private entity to impose the Provider Fee. They sought various injunctive and declaratory remedies to relieve them from the burden of paying the Fee. Most relevant here, Plaintiffs claimed that the Certification Rule violates the nondelegation doctrine. The district court agreed. *Texas v. United States*, 300 F. Supp. 3d 810, 820 (N.D. Tex. 2018).

A panel of this court reversed. First, the panel held that there is no subdelegation at all because "[c]ertification by a qualified actuary who applies the Board's standards is reasonably connected to ensuring actuarially sound rates," and the private parties "have institutional expertise in actuarial principles and practices." *Rettig*, 987 F.3d at 531. Second, the panel held that "even assuming arguendo that HHS subdelegated authority to private entities, such subdelegations were not unlawful" because HHS (the panel claimed) "reviewed and accepted" the Board's standards and retained "the ultimate authority to approve a state's contract," "superintend[ing]" the approval process "in every respect." *Id.* at 532–33.

II.

As discussed, the Constitution vests legislative power in Congress and does not permit delegation of that power—especially not to private parties. *Ante*, at 1–4. The panel responds by invoking various precedents. But

at the very most, current precedent allows only Congress itself to involve private parties in the rulemaking process. *See Currin v. Wallace*, 306 U.S. 1, 15–16 (1939) allowing Congress to condition agency action on private approval); *Sunshine Anthracite Coal Co. v. Adkins*, 310 U.S. 381, 388 (1940) (allowing Congress to permit private parties to propose prices and regulations for agency approval).

There is good reason to limit these precedents to only those delegations authorized by Congress itself. Congress has express constitutional authority to legislate. U.S. CONST. art. I, § 1. And it is directly accountable to the American people. Neither is true of administrative agencies. As our sister circuit once observed, "when an agency delegates power to outside parties, lines of accountability may blur, undermining an important democratic check on government decision-making . . . . In short, subdelegation to outside entities aggravates the risk of policy drift inherent in any principal-agent relationship." *U.S. Telecom Ass'n v. FCC*, 359 F.3d 554, 565–66 (D.C. Cir. 2004). "Agencies may play the sorcerer's apprentice but not the sorcerer himself." *Alexander v. Sandoval*, 532 U.S. 275, 291 (2001).

The Certification Rule plainly violates the private nondelegation doctrine. First, it delegates to a private entity the power to determine what constitutes an "actuarially sound" capitation rate. But Congress gave HHS no authority to turn this decision over to a private entity such as the Board. Moreover, there is no agency review of the Board's established "practice standards." If HHS disagrees with the Board's standards regarding capitation rates, its only recourse is to amend or repeal

the rule delegating power to the Board in the first place. HHS has thus semi-permanently subjugated its regulatory power to that of the Board.

Second, there is no agency review of capitation rates unless and until they are approved by the private actuaries. The rule itself indicates that the Centers for Medicare and Medicaid Services (CMS) will not review an MCO contract before these actuaries confirm the capitation rates' actuarial soundness. *See* 42 C.F.R. § 438.6(c)(1)(i)(C) (2002) ("Actuarially sound capitation rates . . . *[h]ave been certified* . . . by actuaries who . . . follow the practice standards established by the . . . Board.") (emphasis added). And the record confirms that CMS does not in fact review an MCO contract unless and until private parties have blessed the capitation rates. See Declaration of Christopher J. Truffer at 10 ("*[T]he state actuary must certify the rates* . . . . *Next*, a state sends a contract . . . to the appropriate . . . Office . . . , and the CMS actuarial review process *begins*. *After* ensuring that the documentation . . . contains the rate certification, . . . the [office] forwards the contract package to the Center for Medicaid and CHIP Services.") (emphases added)).

So before CMS even *begins* to exercise its own judgment and determine whether a rate meets the standards promulgated by the Board, private actuaries may apply the Board's private standards and determine that a capitation rate is *not* actuarially sound. In such cases, the agency's review process ends before it ever begins.

Under the Certification Rule, then, HHS neither sets the regulatory standard nor exercises final authority over the application of that standard. Private actors

wield "final reviewing authority." *Rettig*, 987 F.3d at 532–33. They act as veto-gates that categorically preclude agency review—whether it's review of the "actuarially sound" standard itself, the determination that a capitation rate complies with that standard, or both. The Constitution forbids such delegations of government power to private entities.

III.

The panel offers two arguments for why the Constitution permits the Certification Rule. Neither is persuasive.

A.

First, the panel denies that there is any subdelegation at all. It cites the D.C. Circuit's decision in *Telecom* for the proposition that "an agency does not improperly subdelegate its authority when it 'reasonabl[y] condition[s]' federal approval on an outside party's determination of some issue," because "such conditions only amount to legitimate requests for input." *Rettig*, 987 F.3d at 531.

But the panel misreads *Telecom*. For starters, that case *rejected* an agency's unauthorized subdelegation of legal determinations. 359 F.3d at 567–68. And it had nothing at all to do with an agency delegating its substantive rulemaking power.

What's more, *Telecom* makes clear that any "subdelegation[] to outside parties [is] assumed to be improper absent an affirmative showing of congressional authorization." *Id.* at 565. *See also id.* at 566 ("A general delegation of decision-making authority to a federal administrative agency does not, i the ordinary course of

things, include the power to subdelegate that authority beyond federal subordinates.").

In other words, under *Telecom*, at most only Congress may involve private parties in agency decision-making—an agency does not get to make that decision itself.

To be sure, the panel notes that, under *Telecom*, "specific types of legitimate outside party input into agency decision-making processes" do not amount to "subdelegation[s] of decision-making authority"—such as "establishing a reasonable condition for granting federal approval." *Id.* But *Telecom* limited this principle to *governmental* conditions—determinations by "state, local, or tribal government[s]." *Id.* at 567. It endorsed no such principle with respect to private parties.[3]

And it's clear why. In the cases cited in *Telecom*, the "reasonable connection between the outside entity's decision and the federal agency's determination" was patently obvious and justified—there was simply no reason for the agency to approve a federal permit if the state (in the case of *United States v. Matherson*, 367 F. Supp. 779 (E.D.N.Y. 1973)) or tribal entity (in the case of *Southern Pacific Transportation Co. v. Watt*, 700 F.2d 550 (9th Cir. 1983)) was going to prevent the petitioner from engaging in the regulated activity anyway. So the

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[3] The panel claims that, under *Telecom*, it does not matter whether an agency is conditioning its approval on that of a government entity or a private party. *Rettig*, 987 F.3d at 531 n.10. But *Telecom* equated governmental and private entities only to say that an unauthorized subdelegation to either is invalid: "[F]ederal agency officials . . . may not subdelegate to outside entities—*private or sovereign—absent affirmative evidence of authority to do s*o." 359 F.3d at 566 (emphasis added). And it is undisputed that Congress gave HHS no such authority here.

agencies weren't subordinating their authority to outside entities—they were refusing to waste agency resources on futile approvals. *See Matherson*, 367 F. Supp. at 782 ("[I]t is apparent that a vehicular permit from the National Seashore is of little value without the corresponding vehicular permit from the appropriate local municipality .... [A]n individual holding only a National Seashore vehicular permit would be prohibited from traversing state land and thereby be precluded from ever reaching the National Seashore by motor vehicle. The promulgation of [the regulation] has foreclosed the possibility of such an anomaly ever existing."); *Southern Pacific*, 700 F.2d at 556 ("The regulation at issue is not an abdication of the Secretary's power to administer the 1899 Act but rather an effort by the Secretary to incorporate into the decision-making process the wishes of a body with independent authority over the affected lands.").

The situation here could not be more different. The private Board and private actuaries would have no say at all in the approval of capitation rates or MCO contracts but for HHS's decision to hand them its rulemaking and review powers in the first place.

So the Certification Rule is plainly unconstitutional under *Telecom*. "Congress has not delegated to [HHS] the authority to subdelegate [the actuarial soundness requirement] to outside parties." 359 F.3d at 566. And "[i]n contrast to [*Matherson and Southern Pacific*], where an agency with broad permitting authority ... adopted an obviously relevant local [government] concern as an element of its decision process," HHS has not only "delegated to another [private] actor almost the entire determination of whether a specific statutory

requirement . . . has been satisfied," *id.* at 567—it has even granted a private party the power to *define* the statutory requirement in the first place.[4]

B.

Second, the panel argues that, if there is a subdelegation here, it's permissible under Supreme Court and circuit precedent. But all the panel's authorities are inapposite.

The panel first invokes *Adkins*. *Rettig*, 987 F.3d at 532. But as noted, in *Adkins* it was Congress itself, not the agency, that enlisted the assistance of private parties in rulemaking. As our sister circuit has noted, "*Adkins* . . . affirmed a modest principle: *Congress* may formalize the role of private parties in proposing regulations." *Ass'n of Am. R.Rs. v. U.S. Dep't of Transp.*, 721 F.3d 666, 671 (D.C. Cir. 2013), *rev'd on other grounds by Ass'n of Am. RRs.*, 575 U.S. 43 (emphasis added). *See also Telecom*, 359 F.3d at 565 ("[S]ubdelegations to outside

[4] The panel also invokes *Louisiana Forestry Association v. Secretary of United States Department of Labor*, 745 F.3d 653 (3rd Cir. 2014). Rettig, 987 F.3d at 531 & n.10. But the statute in that case specifically granted the Department of Homeland Security (DHS) the authority to "determine[]" an alien's status "after consultation with appropriate agencies of the Government." *La. Forestry Ass'n*, 745 F.3d at 660. So of course DHS's decision to seek the "advice" of the Department of Labor in the form of a labor certification was not an unconstitutional subdelegation. It was one agency *acting pursuant to congressional authorization* to enlist the help of another agency in making a legal determination. There is no serious way to analogize the scheme in that case to the Certification Rule. Here, there is no statutory language granting HHS authority to give the *private* Board (or anyone else) *rulemaking power* to *craft* the legal standard.

parties are assumed to be improper absent an affirmative showing of congressional authorization.").

As explained, it is one thing to bless a Congressional decision to involve private parties in the rulemaking process. It is quite another to allow an agency—already acting pursuant to delegated power—to *re*-delegate that power out to a private entity. *See, e.g., Gundy*, 139 S. Ct. at 2123 (plurality opinion by Kagan, J.) ("Accompanying [Article I, section 1's] assignment of power to Congress is a bar on its further delegation. Congress, this Court explained early on, may not transfer to another branch 'powers which are strictly and exclusively legislative.'") (quoting *Wayman v. Southard*, 23 U.S. 1, 42–43 (1825)); *Kisor v. Wilkie*, 139 S. Ct. 2400, 2416 (2019) ("Congress has delegated rulemaking power, and all that typically goes with it, to the agency alone.").

Moreover, the private parties in *Adkins* truly "function[ed] subordinately to the Commission," 310 U.S. at 399—serving as merely "an aid" that "*propose[d]*" minimum prices and regulations. *Id.* at 388 (emphasis added). The agency exercised "pervasive surveillance and authority," including the power to "approve[], disapprove[], or modif[y]" the industry proposals. *Id.* It was therefore the agency, and "not the [private actors]," that set the regulations. *Id.* at 399. Ultimately, "*Adkins* . . . affirmed a modest principle: Congress may formalize the role of private parties in proposing regulations *so long as that role is merely 'as an aid'* to a government agency that retains the discretion to 'approve[], disapprove[], or modif[y]' them." *Ass'n of Am. R.Rs.*, 721 F.3d at 671 (emphasis added).

Here, by contrast, HHS has delegated to the Board the power to *define* actuarial soundness. And that power

is reviewable only in the sense that the agency can amend or repeal the Certification Rule altogether. So absent new rulemaking, the Board's practice standards and the actuaries' certifications can prevent a state's capitation rate and associated MCO contract from ever reaching CMS for review. In short, while the instant scheme arguably allows HHS to "approve[]" private standards and actuarial certifications, it emphatically does not leave HHS free to "disapprove[] or modif[y]" them. *Id.*

The panel also cites *Sierra Club v. Lynn*, 502 F.2d 43 (5th Cir. 1974). But *Sierra Club* did not decide whether an agency was unconstitutionally re-delegating its delegated rulemaking powers. Rather, it questioned whether an agency was "abdicat[ing] its statutory duties [under the National Environmental Policy Act] by reflexively rubber stamping a[n impact] statement prepared by others." *Id.* at 59.

At most, then, *Sierra Club* tells us how much "fact-finding" an agency can delegate. *See Telecom*, 359 F.3d at 567 ("[T]here is some authority for the view that a federal agency may use an outside entity, such as a state agency or a private contractor, to provide the agency with factual information."). There, we allowed a private developer to assist an agency in compiling studies that were conditions precedent to federal approval. *See Sierra Club* at 47, 59. So a private party was *assisting* the agency in determining the *facts* underlying the agency's decision to exercise government power. That is a far cry from allowing private parties to both define and apply a legal standard, and to do so without congressional authorization or agency review.

In any event, the panel cites *Sierra Club* for the proposition that there is no impermissible subdelegation where an agency "retains final reviewing authority," and "independently perform[s] its reviewing, analytical and judgmental functions." *Rettig*, 987 F.3d at 532. But again, HHS doesn't review the Board's practice standards, or the capitation rates rejected by private actuaries. So even if *Sierra Club* could justify an unauthorized subdelegation of substantive rulemaking power, its standard hasn't been met.

The panel's reliance on *Louisiana Public Service Commission v. FERC*, 761 F.3d 540 (5th Cir. 2014), is unavailing for the same reason. No matter how many times the panel claims otherwise, HHS has never "reviewed and accepted" the Board's practice standards or the actuaries' rejected capitation rates—let alone "continue[d] to exercise oversight" over those actions. *Id.* at 552. It just made a one-time decision to hand the private parties a blank check.

In the end, then, the only "final reviewing authority" HHS retains is the ability to issue a new rule.

Incredibly, the panel is fine with this: "[A]ny state dissatisfied with the Board's practice standards can petition HHS for 'amendment[] or repeal' of the . . . Rule's requirement that the Board's practice standards be followed." *Rettig*, 987 F.3d at 532 n.13 (quoting 5 U.S.C. § 553(e)). But by that logic, *any* agency subdelegation of rulemaking power is permissible. After all, any agency can always claw back its delegated power by issuing a new rule. *See Fund for Animals v. Kempthorne*, 538 F.3d 124, 133 (2nd Cir. 2008) ("If all it reserves for itself is 'the extreme remedy of totally terminating the [delegation agreement],' an agency

abdicates its 'final reviewing authority.'") (alteration in original) (citation omitted). But that would render the nondelegation doctrine a dead letter. We might as well say that Congress can never violate the nondelegation doctrine, because the American people can always petition Congress to pass a new law and claw back its lawmaking power from an agency.[5]

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[5] According to the panel, holding the Certification Rule unconstitutional would also "jeopardize over a thousand regulations promulgated by federal agencies." *Rettig*, 987 F.3d at 532 n.11. But this collapses the distinction between the completely legitimate practice of codifying preexisting private standards and the novel, unconstitutional practice of handing private parties a blank check to fill (and amend) at their leisure.

As the panel notes, it is a "common and accepted practice" for agencies to incorporate by reference standards established by private organizations. *See id.* at 531–32 (citing A*m. Soc'y for Testing & Materials v. Public.Resource.Org, Inc.*, 896 F.3d 437, 442 (D.C. Cir. 2018)). But this just tells us what HHS could have done in this case—not that what HHS *did* was okay. In *American Society*, the agencies exercised their rulemaking power to approve fixed, preexisting private standards. The standards were not automatically updated by the unilateral action of those outside entities. *See, e.g.*, 896 F.3d at 443 (describing a statute requiring the Secretary of Energy to decide whether to adopt revisions to incorporated materials); *id.* at 447 ("[W]e need not determine what happens when a regulation or statute *is revised to incorporate newer versions* of a particular standard.") (emphasis added); *id.* at 450 (explaining that the 2011 National Electrical Code had been incorporated into a power source regulation, "but not the 2014 edition"). *See also* Office of Mgmt. & Budget, Exec. Office of the President, *OMB Circular A-119: Federal Participation in the Development and Use of Voluntary Consensus Standards and in Conformity Assessment Activities* 4 (2016) (requiring agencies "to ensure[] . . . that regulations incorporating standards by reference are updated on a timely basis").

To say that HHS can empower the Board to write whatever standards it chooses because it "could achieve *exactly the same*

IV.

As judges, we have sworn an oath to uphold the Constitution. So if we are forced to choose between upholding the Constitution and extending precedent in direct conflict with the Constitution, the choice should be clear: "[O]ur duty [is] to apply the Constitution—not extend precedent." *NLRB v. Int'l Ass'n of Bridge, Structural, Ornamental, & Reinforcing Iron Workers, Local 229, AFL-CI*O, 974 F.3d 1106, 1116 (9th Cir. 2020) (Bumatay, J., dissenting from denial of rehearing en banc). "[F]idelity to original meaning counsels against further extension of [] suspect precedents." *Hester v. United States*, 139 S. Ct. 509, 509 (2019) (Alito, J., concurring in the denial of certiorari).

The Supreme Court has repeatedly applied this principle when confronted with the choice between fidelity to the Constitution and an otherwise logical extension of its own precedent. *See, e.g.*, *Seila Law LLC v. CFPB*, 140 S. Ct. 2183, 2201 (2020) ("The question . . . is whether to extend those precedents to the 'new situation' before us, namely an independent agency led by a single Director and vested with significant executive power. We decline to do so. Such an agency has no basis in history and no place in our constitutional structure.") (citation omitted); *id.* at 2211 ("A decade ago, we declined to extend Congress's authority to limit the President's removal power to a new situation, never before confronted by the Court. We do the same today.") (referring to *Free Enter. Fund v. Pub. Co. Accounting*

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result by promulgating regulations . . . adopt[ing] the . . . Board's standards," *Rettig*, 987 F.3d at 532, is to say that process doesn't matter. But when it comes to the Constitution and the separation of powers, the ends do not justify the means. *Ante*, at 2.

Oversight Bd., 561 U.S. 477 (2010)); *Hernandez v. Mesa*, 140 S. Ct. 735, 749 (2020) ("In sum, this case features multiple factors that counsel hesitation about extending Bivens, but they can all be condensed to one concern—respect for the separation of powers.").

We should do the same. "As inferior court judges, we are bound by Supreme Court precedent. Yet[] . . . judges also have a 'duty to interpret the Constitution in light of its text, structure, and original understanding.'" *Edmo v. Corizon, Inc.*, 949 F.3d 489, 506 (9th Cir. 2020) (Bumatay, J., dissenting from denial of rehearing en banc) (quoting *NLRB v. Noel Canning*, 573 U.S. 513, 573 (2014) (Scalia, J., concurring)). "While we must faithfully follow [Supreme Court] precedent . . . , '[w]e should resolve questions about the scope of those precedents in light of and in the direction of the constitutional text and constitutional history.'" *Id.* (quoting *Free Enter. Fund v. Public Co. Accounting Oversight Bd.*, 537 F.3d 667, 698 (D.C. Cir. 2008) (Kavanaugh, J., dissenting), *aff'd in part, rev'd in part and remanded*, 561 U.S. 477 (2010)). *See also, e.g., Alvarez v. City of Brownsville*, 904 F.3d 382, 401 (5th Cir. 2018) (en banc) (Ho, J., concurring) (noting that an important purpose of rehearing en banc is "to better align our precedents with the text and original understanding of the Constitution" "where the Supreme Court has not yet ruled").

* * *

Our Founders fought a war to defend the principle of "no taxation without representation." And that is precisely the principle Plaintiffs seek to vindicate today. The federal government forces them to pay nearly half a billion dollars—not by an act of their elected

representatives in Congress, but by private entities acting in collusion with unelected public bureaucrats.

The Constitution forbids this result. And no precedent requires it. I respectfully dissent from the denial of rehearing en banc.

APPENDIX E

Relevant Provisions of the United States Constitution

Article I, Section 1 provides:

> All legislative Powers herein granted shall be vested in a Congress of the United States, which shall consist of a Senate and House of Representatives.

Article I, Section 8 provides, in relevant part:

> The Congress shall have Power To lay and collect Taxes, Duties, Imposts and Excises, to pay the Debts and provide for the common Defence and general Welfare of the United States; . . . .

Article I, Section 9 provides, in relevant part:

> No Capitation, or other direct, Tax shall be laid, unless in Proportion to the Census or Enumeration herein before directed to be taken.

Article II, Section 1 provides, in relevant part:

> The executive Power shall be vested in a President of the United States of America.

Article III, Section 1 provides, in relevant part:

> The judicial Power of the United States, shall be vested in one supreme Court, and in such inferior Courts as the Congress may from time to time ordain and establish.

The Fifth Amendment provides, in relevant part:

> No person shall . . . be deprived of life, liberty, or property, without due process of law . . . .

APPENDIX F

5 U.S.C. § 702. Right of review

A person suffering legal wrong because of agency action, or adversely affected or aggrieved by agency action within the meaning of a relevant statute, is entitled to judicial review thereof. An action in a court of the United States seeking relief other than money damages and stating a claim that an agency or an officer or employee thereof acted or failed to act in an official capacity or under color of legal authority shall not be dismissed nor relief therein be denied on the ground that it is against the United States or that the United States is an indispensable party. The United States may be named as a defendant in any such action, and a judgment or decree may be entered against the United States: Provided, That any mandatory or injunctive decree shall specify the Federal officer or officers (by name or by title), and their successors in office, personally responsible for compliance. Nothing herein (1) affects other limitations on judicial review or the power or duty of the court to dismiss any action or deny relief on any other appropriate legal or equitable ground; or (2) confers authority to grant relief if any other statute that grants consent to suit expressly or impliedly forbids the relief which is sought.

28 U.S.C. § 1902. Time for commencing action against United States

(a) Except as provided by chapter 71 of title 41, 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. The action of any person under legal disability or beyond the seas at the

time the claim accrues may be commenced within three years after the disability ceases.

(b) A tort claim against the United States shall be forever barred unless it is presented in writing to the appropriate Federal agency within two years after such claim accrues or unless action is begun within six months after the date of mailing, by certified or registered mail, of notice of final denial of the claim by the agency to which it was presented.

Health Care and Education Reconciliation Act of 2010, Pub. L. No. 111-152, § 1406, 124 Stat. 1029, 1066

(a) IN GENERAL.—Section 9010 of the Patient Protection and Affordable Care Act, as amended by section 10905 of such Act, is amended— . . .

(3) in subsection (c)—

(A) by inserting "during the calendar year in which the fee under this section is due" in paragraph (1) after "risk";

(B) in paragraph (2), by striking subparagraphs (C), (D), and (E) and inserting the following new subparagraphs:

"(C) any entity—

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

"(ii) no part of the net earnings of which inures to the benefit of any private shareholder or individual, no substantial part of the activities of which is carrying on propaganda, or otherwise attempting, to influence legislation (except as

otherwise provided in section 501(h) of the Internal Revenue Code of 1986), and which does not participate in, or intervene in (including the publishing or distributing of statements), any political campaign on behalf of (or in opposition to) any candidate for public office, and

"(iii) more than 80 percent of the gross revenues of which is received from government programs that target low-income, elderly, or disabled populations under titles XVIII, XIX, and XXI of the Social Security Act, and

"(D) any entity which is described in section 501(c)(9) of such Code and which is established by an entity (other than by an employer or employers) for purposes of providing health care benefits.";

(C) in paragraph (3)(A), by striking "subparagraph (C)(i)(I), (D)(i)(I), or (E)(i)" and inserting "subparagraph (C) or (D)"; and

(D) by adding at the end the following new paragraph:

"(4) JOINT AND SEVERAL LIABILITY.—If more than one person is liable for payment of the fee under subsection (a) with respect to a single covered entity by reason of the application of

paragraph (3), all such persons shall be jointly and severally liable for payment of such fee."

Patient Protection and Affordable Care Act, Pub. L. No. 111-148, 1224 Stat. 119 (2010)

§ 2501(c) PRESCRIPTION DRUG REBATES

(c) EXTENSION OF PRESCRIPTION DRUG DISCOUNTS TO ENROLLEES OF MEDICAID MANAGED CARE ORGANIZATIONS.—

(1) IN GENERAL.—Section 1903(m)(2)(A) of such Act (42 U.S.C. 1396b(m)(2)(A)) is amended— . . .

(C) by adding at the end the following:

"(xiii) such contract provides that (I) covered outpatient drugs dispensed to individuals eligible for medical assistance who are enrolled with the entity shall be subject to the same rebate required by the agreement entered into under section 1927 as the State is subject to and that the State shall collect such rebates from manufacturers, (II) capitation rates paid to the entity shall be based on actual cost experience related to rebates and subject to the Federal regulations requiring actuarially sound rates, and (III) the entity shall report to the State, on such timely and periodic basis as specified by the Secretary in order to include in the information submitted by the State

to a manufacturer and the Secretary under section 1927(b)(2)(A), information on the total number of units of each dosage form and strength and package size by National Drug Code of each covered outpatient drug dispensed to individuals eligible for medical assistance who are enrolled with the entity and for which the entity is responsible for coverage of such drug under this subsection (other than covered outpatient drugs that under subsection (j)(1) of section 1927 are not subject to the requirements of that section) and such other data as the Secretary determines necessary to carry out this subsection.".

§ 9010. IMPOSITION OF ANNUAL FEE ON HEALTH INSURANCE PROVIDERS

(a) IMPOSITION OF FEE.—

(1) IN GENERAL.—Each covered entity engaged in the business of providing health insurance shall pay to the Secretary not later than the annual payment date of each calendar year beginning after 2009 a fee in an amount determined under subsection (b).

(2) ANNUAL PAYMENT DATE.—For purposes of this section, the term "annual payment date" means with respect to any calendar year the date determined by the Secretary, but in no event later than September 30 of such calendar year.

(b) DETERMINATION OF FEE AMOUNT.—

(1) IN GENERAL.—With respect to each covered entity, the fee under this section for any calendar year shall be equal to an amount that bears the same ratio to $6,700,000,000 as—

(A) the sum of—

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

(ii) 200 percent of the covered entity's third party administration agreement fees that are taken into account during the preceding calendar year, bears to

(B) the sum of—

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

(ii) 200 percent of the aggregate third party administration agreement fees of all covered entities that are taken into account during such preceding calendar year.

(2) AMOUNTS TAKEN INTO ACCOUNT.—For purposes of paragraph (1)—

(A) NET PREMIUMS WRITTEN.—The net premiums written with respect to

health insurance for any United States health risk that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's net premiums written during the calendar year that are:	**The percentage of net premiums written that are taken into account is:**
Not more than $25,000,000	0 percent
More than $25,000,000 but not more than $50,000,000	50 percent
More than $50,000,000	100 percent.

(B) THIRD PARTY ADMINISTRATION AGREEMENT FEES.—The third party administration agreement fees that are taken into account during any calendar year with respect to any covered entity shall be determined in accordance with the following table:

With respect to a covered entity's third party administration agreement fees during the calendar year that are:	**The percentage of third party administration agreement fees that are taken into account is:**
Not more than $5,000,000	0 percent
More than $5,000,000 but not more than $10,000,000	50 percent
More than $10,000,000	100 percent.

(3) SECRETARIAL DETERMINATION.—The Secretary shall calculate the amount of each covered entity's fee for any calendar year under paragraph (1). In calculating such amount, the Secretary shall determine such covered entity's net premiums written with respect to any United States health risk and third party administration agreement fees on the basis of reports submitted by the covered entity under subsection (g) and through the use of any other source of information available to the Secretary.

(c) COVERED ENTITY.—

(1) IN GENERAL.—For purposes of this section, the term "covered entity" means any entity which provides health insurance for any United States health risk.

(2) EXCLUSION.—Such term does not include—

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

(B) any governmental entity (except to the extent such an entity provides health insurance coverage through the community health insurance option under section 1323).

(3) CONTROLLED GROUPS.—

(A) IN GENERAL.—For purposes of this subsection, all persons treated as a single employer under subsection (a) or (b) of section 52 of the Internal Revenue Code of 1986 or subsection (m) or (o) of section 414

of such Code shall be treated as a single covered entity (or employer for purposes of paragraph (2)).

(B) INCLUSION OF FOREIGN CORPORATIONS.—For purposes of subparagraph (A), in applying subsections (a) and (b) of section 52 of such Code to this section, section 1563 of such Code shall be applied without regard to subsection (b)(2)(C) thereof.

42 U.S.C. § 1396B. Payment to States

. . .

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

. . .

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

(iii) such services are provided for the benefit of individuals eligible for benefits

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

APPENDIX G

42 C.F.R. § 438.6 (2002) Contract requirements.

(c) Payments under risk contracts—

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

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

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

. . .

(C) Have been certified, as meeting the requirements of this paragraph (c), by actuaries who meet the qualification standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board.

APPENDIX H

ASB (Logo)

ACTUARIAL STANDARDS BOARD

Actuarial Standard of Practice No. 49

Medicaid Managed Care Capitation Rate Development and Certification

Developed by the Medicaid Rate Setting and Certification Task Force of the Health Committee of the Actuarial Standards Board

Adopted by the Actuarial Standards Board March 2015

Doc. No. 179

T A B L EO FC O N T E N T S

APPENDIXES

March 2015

TO: Members of Actuarial Organizations Governed by the Standards of Practice of the Actuarial Standards Board and Other Persons Interested in Medicaid Managed Care Capitation Rates and their Certification

FROM: Actuarial Standards Board (ASB)

SUBJ: Actuarial Standard of Practice (ASOP) No. 49

This document contains the final version of ASOP No. 49, *Medicaid Managed Care Capitation Rate Development and Certification*.

Background

This ASOP was developed to establish guidance for actuaries preparing, reviewing, or giving advice on capitation rates for Medicaid programs, including those certified in accordance with 42 CFR 438.6(c). Since the federal regulations took effect, actuaries have used various methods to prepare the capitation rates. This ASOP incorporates the appropriate aspects of these methods to establish guidance and considerations in the rate development process.

Exposure Draft

In December 2013, the ASB approved the exposure draft with a comment deadline of May 15, 2014. Twenty-six comment letters were received and considered in making changes that are reflected in this final ASOP. For a summary of issues contained in these comment letters, please see appendix 2.

The significant changes made to the final standard in response to the comment letters are as follows:

1. Section 1.2 was edited to clarify situations when this ASOP applies.
2. Language was added to section 3.1 to require the actuary to have knowledge of and understand the requirements of 42 CFR 438.6(c).
3. Section 3.2.2 was modified to add a reference to ASOP No. 12, Risk Classification, and to clarify that capitation rates may vary by Medicaid eligibility groups.
4. In section 3.2.12(a)(1) was changed from "should" to "may."

The ASB voted in March 2015 to adopt this standard.

Task Force on Medicaid Rate Setting and Certification

Robert M. Damler, Chairperson

Sabrina Gibson	Martin E. Staehlin
Michael E. Nordstrom	Kathleen A. Tottle
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Actuarial Standards Board

Patricia E. Matson, Chairperson

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Maryellen J. Coggins	Frank Todisco
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The Actuarial Standards Board (ASB) sets standards for appropriate actuarial practice in the United States through the development and promulgation of Actuarial Standards of Practice (ASOPs).These ASOPs describe the procedures an actuary should follow when performing actuarial services and identify what the actuary should disclose when communicating the results of those services.

ACTUARIAL STANDARD OF PRACTICE NO. 49

MEDICAID MANAGEDCARE CAPITATION RATE DEVELOPMENT AND CERTIFICATION

STANDARD OF PRACTICE

Section 1. Purpose, Scope, Cross References, and Effective Date

1.1 Purpose—This actuarial standard of practice (ASOP) provides guidance to actuaries when performing professional services related to Medicaid (Title XIX) and Children's Health Insurance Program (CHIP or Title XXI) managed care **capitation rates**, including a certification on behalf of a state to meet the requirements of 42 CFR 438.6(c).

1.2 Scope—This standard applies to actuaries performing professional services related to Medicaid managed care **capitation rates** including, but not limited to, the following:

a. certification on behalf of a state to meet the requirements of 42 CFR 438.6(c);
b. capitation rate bid or rate acceptance; and
c. department of insurance capitation rate filing.

This standard also applies to actuaries performing professional services related to managed care **capitation rates** for CHIP. Throughout this standard the term "Medicaid" also refers to CHIP.

If the actuary departs from the guidance set forth in this standard in order to comply with applicable law (statutes, regulations, and other legally binding authority) or for any other reason

the actuary deems appropriate, the actuary should refer to section 4.

1.3 Cross References—When this standard refers to the provisions of other documents, the reference includes the referenced documents as they may be amended or restated in the future, and any successor to them, by whatever name called. If any amended or restated document differs materially from the originally referenced document, the actuary should consider the guidance in this standard to the extent it is applicable and appropriate.

1.4 Effective Date—This standard is effective for actuarial communications issued on or after August 1, 2015.

Section 2. Definitions

The terms below are defined for use in this actuarial standard of practice.

2.1 Actuarially Sound/Actuarial Soundness—Medicaid **capitation rates are "actuarially sound"** if, for business for which the certification is being prepared and for the period covered by the certification, projected **capitation rates** and other revenue sources provide for all reasonable, appropriate, and attainable costs. For purposes of this definition, other revenue sources include, but are not limited to, expected reinsurance and governmental stop-loss cash flows, governmental **risk adjustment** cash flows, and investment income. For purposes of this definition, 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.

2.2 Base Data—The historical data set used by the actuary to develop the **capitation rates**. The data may be from Medicaid fee-for-service data, **MCO** data, or from a comparable population data source.

2.3 Capitation Rate—A monthly fee paid for each member assigned or each event (for example, maternity delivery) regardless of the number or actual cost of services provided under a system of reimbursement for MCOs. Capitation rates can vary by member based on demographics, location, covered services, or other characteristics. Capitation rates can be structured so that an MCOs is fully at risk, or so that an **MCO** shares the risk with other parties.

2.4 Disproportionate Share Hospital (DSH) Payments—Additional amounts paid to hospitals that serve a disproportionally large number of Medicaid or uninsured patients. These payments may be subject to a hospital-specific limit. An annual allotment to each state limits federal financial participation in these payments. These payments are subject to requirements set forth in Section 1923(i) of the Social Security Act.

2.5 Encounter Data—Information about an interaction between a provider of health care services and a member that is documented through the submission of a claim to an **MCO**, and

shared between the **MCO** and the state Medicaid agency.

2.6 Enhanced or Additional Benefits—Benefits offered by MCOs to their Medicaid members that are above and beyond the benefits offered by the state Medicaid plan. Common examples are adult dental services, non-emergency transportation, and adult vision services.

2.7 Federally Qualified Health Center (FQHC)—An organization that (1) receives grants under Section 330 of the Public Health Service Act; (2) does not receive a grant under the Section 330 of the Public Health Service Act, but otherwise meets all requirements to receive such a grant; or (3) is an outpatient health clinic associated with tribal or Urban Indian Health Organizations (UIHO). The organization must have also applied for recognition, and been approved as a federally qualified health center for Medicare and Medicaid, as described in Sections 1861(aa)(3) and 1905(l)(2) of the Social Security Act. Payments to these organizations are subject to requirements set forth in Section 1902(bb) of the Social Security Act.

2.8 Intergovernmental Transfer (IGT)—A transfer of public funds between governmental entities (for example, county government to state government or state university hospital to state Medicaid agency).

2.9 Managed Care Organization (MCO)—The entity contracting with the state Medicaid agency to

provide health care services for selected subsets of the Medicaid population.

2.10 Medical Education Payments—Payments for graduate medical education as part of the rate structure for inpatient hospital payments or as supplemental payments under 42 CFR 447.272. These payments may include direct graduate medical education (GME) or indirect medical education (IME) costs. These payments may be included as part of Medicaid managed care **capitation rates** or may be made directly to providers for managed care enrollees.

2.11 Minimum Medical Loss Ratio—A provision that requires the **MCO** to use no less than a stated portion of its earned premium for defined medical or care management expenditures.

2.12 Performance Incentive—A payment mechanism under which an **MCO** may receive funds in addition to the **capitation rates** for meeting targets specified in the contract between the state and the **MCO**.

2.13 Performance Withhold—An amount included in the **capitation rates** that is paid if the **MCO** meets certain state requirements that may be related to quality or operational metrics. The amount may be withheld or paid up front with the monthly capitation rate.

2.14 Rating Period—The time period for which managed care Medicaid **capitation rates** are being developed.

2.15 Risk Adjustment—The process by which relative risk factors are assigned to individuals or groups

based on expected resource use and by which those factors are taken into consideration and applied.

2.16 Rural Health Clinic (RHC)—A clinic that meets certain requirements for providing primary care services in specific areas, as outlined in the Public Health Service Act and defined in Section 1905(l)(1) of the Social Security Act. Medicaid payment rates to RHCs may be specified in applicable law.

2.17 State Plan Services—The benefits provided to Medicaid beneficiaries who are eligible under a qualifying category of Medicaid assistance in a state.

Section 3. Analysis of Issues and Recommended Practices

3.1 Overview—An actuary may be developing, certifying, or reviewing Medicaid Managed Care **capitation rates** on behalf of a state Medicaid agency or an **MCO**. When certifying whether **capitation rates** meet the requirements of 42 CFR 438.6(c) or reviewing such a certification, the actuary must-have knowledge and understanding of those requirements.

Title 42 CFR 438.6(c) requires that **capitation rates** paid by the state to the MCOs be certified as actuarially sound. The soundness opinion applies to all contracted **capitation rates**. However, the actuary is not certifying that the underlying assumptions supporting the certification are appropriate for an individual **MCO**.

An actuary providing actuarial services for a contracting **MCO** may be required to develop and submit **capitation rates** to the state Medicaid agency for a rating period. While the federal regulation 42 CFR 438.6(c) does not extend to an **MCO** actuary, the **MCO** actuary may be required under the terms of a proposal or contract to submit an actuarial opinion for the **capitation rates** that may or may not indicate compliance with 42 CFR 438.6(c).

3.2 Medicaid Managed Care Capitation Rate Development Process and Considerations—The actuary should address the following when developing **capitation rates**.

3.2.1 Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)—The capitation rate certification may apply to a single point estimate capitation rate or a range of **capitation rates**. If a range of **capitation rates** is prepared, the contracted rates with an **MCO** may be at either end of the range or a point within the range. The **capitation rates** may vary by **MCO**.

3.2.2 Structure of the Medicaid Managed Care Capitation Rates—**Capitation rates** are usually separately developed and paid in individual capitation rate cells based on characteristics that cause costs to differ materially. Examples of these characteristics include age, gender, qualifying event (for example, maternity delivery), geographic region, Medicaid eligibility group, eligibility for Medicare benefits, diagnosis or **risk adjustment** factors, and **MCO** differences. In

determining the rating structure, the actuary should consider how well the structure aligns capitation revenue and **MCO** risk as well as the complexity of the rating structure. A certification of the **capitation rates** under 42 CFR 438.6(c) applies to each of the individual **capitation rate** cells. For further guidance, see ASOP No. 12, *Risk Classification*.

3.2.3 Rebasing and Updating of Rates—When developing **capitation rates** for subsequent **rating periods**, the actuary should either rebase the rates or update existing rates. Rebasing of rates generally refers to using **base data** from a more recent time period to develop **capitation rates** along with updating assumptions used to develop the rates. Updating of rates involves adjusting existing rates to reflect the impacts of any program, benefit, population, trend, or other changes between the **rating period** of the existing rates and the **rating period** of the updated rates.

The actuary should consider the following in making the determination whether to rebase rates or update existing rates: availability of updated data, likely materiality of rebasing, changes in the underlying population, quality of data since the last rebasing, and time elapsed since the last rebasing.

3.2.4 Base Data—The actuary should use **base data** (for example, population, benefits, provider market dynamics, geography) that is appropriate for the program for which **capitation rates** are

being developed. The **base data** may span more than one year.

The actuary should use **base data** sources for utilization or unit cost that are relevant to the given Medicaid population and appropriate for the given use. Program-specific historical experience from the following sources are examples of **MCO** data that may meet these criteria:

a. financial reports;
b. summary **encounter data** reports;
c. **encounter data** with payment information;
d. **encounter data** without payment information;
e. sub-capitation payment information; and
f. provider settlement payment reports.

If the managed care program is new or if previously carved-out services are to be included in the rates, the actuary may need to use alternative data sources. Such alternative data sources typically include fee-for-service experience and experience from other states, although other sources may be appropriate. That experience may be available in several forms, including the following:

1. financial reports;
2. summary claims data reports;
3. raw claims data with payment information; and
4. state-specific provider settlement payment reports.

If the covered population is new, the actuary should identify data sources for similar populations and make appropriate adjustments.

3.2.5 Covered Services—When developing **capitation rates** under 42 CFR 438.6(c), the actuary should reflect covered services for Medicaid beneficiaries, as defined in the contract between the state and the **MCOs**, which may include cost effective services provided in lieu of **state plan services**.

When developing capitation rates for other purposes, the actuary should reflect the cost of all services, including **enhanced or additional benefits**, provided to Medicaid beneficiaries.

3.2.6 Special Payments—Payments in addition to the Medicaid fees may be made by states directly or through the MCOs to providers of Medicaid services. These payments are usually made to hospitals, but other provider types may also qualify for such payments. These payments are sometimes reciprocation for the provider paying a special tax or assessment fee.

The actuary should identify any special payments to providers (for example, supplemental payments or bonuses) and include these payments in development of the **capitation rates** in a manner that reflects the payment policy for these special payments in the **rating period**.

3.2.7 Base Data Period Adjustments—The actuary should consider **base data** period adjustments of the following three types:

a. Retroactive Period Adjustments—The retroactive period adjustments reflect changes that occurred during the **base data**

period to standardize the data over the **base data** period.

b. Interim Period Adjustments—The interim period adjustments reflect changes that occurred between the **base data** period and the **rating period**.

c. Prospective Period Adjustments—The prospective period adjustments reflect changes that will occur in the **rating period**.

3.2.8 Other Base Data Adjustments—The actuary should consider other **base data** adjustments, which may include the following:

a. Missing Data Adjustment—Circumstances that may cause data to be missing include, but are not limited to, the following:

1. certain claims are not processed through the same system as the **base data**;
2. Medicaid fee-for-service data may not include all services or expenses to be covered by the **capitation rate**; or
3. Medicaid **encounter data** may not reflect services that are subcapitated and not reported through the **encounter data** system.

b. Incomplete Data Adjustment—The incomplete data adjustment reflects claims that were in course of settlement, claims that were incurred but not reported, or amounts that are due for reinsurance or claim settlements.

c. Population Adjustment—The population adjustment modifies the **base data** to reflect differences between the population underlying the base period and the population expected to be covered during the **rating period**.

d. Funding or Service Carve-Out Adjustments—The funding or service carve-outs are not the financial responsibility of the **MCO**. Funding carveouts may include graduate **medical education payments, disproportionate share hospital payments**, or provider taxes. Service carve-outs reflect services that will not be covered by the **capitation rate**.

e. Retroactive Eligibility Adjustments—Medicaid beneficiaries are often provided retroactive eligibility coverage for a period prior to submitting an application for Medicaid coverage. The retroactive eligibility adjustment reflects the exclusion of periods of retroactive eligibility, if any, that are not the responsibility of the **MCO**.

f. Program, Benefit, or Policy Adjustments—The program, benefit, or policy adjustments reflect differences in benefit or service delivery requirements between the base period and the **rating period** that impact the financial risk assumed by the **MCO**.

g. Data Smoothing Adjustments—The data smoothing adjustments address anomalies or distortions in the **base data**, such as large claims or limited enrolment.

3.2.9 Claim Cost Trends—The actuary should include appropriate adjustments for trend and may consider a number of elements in establishing trends in utilization, unit costs, or in total. Medicaid utilization trend rates may be particularly affected by changes in demographics and benefit levels, and by policy or program changes. Medicaid unit cost trends may be particularly affected by changes in state-mandated reimbursement schedules (if applicable), Medicaid fee-for-service fee schedules, and provider contracting performed by the **MCOs**. The trend assumption should not include adjustments captured elsewhere in the capitation rate development.

3.2.10 Managed Care Adjustments—The actuary may apply managed care adjustments based on the assumption that the program will move from the level of managed care underlying the **base data** to a different level of managed care during the rating period. The adjustments may be to utilization, unit cost, or both, and the impact of the adjustments may be either an increase or a decrease to the **base data**. If managed care adjustments are included, the changes reflected in the adjustments should be attainable in the rating period, in the actuary's professional judgment.

The actuary should consider the following when reviewing the need for and developing the managed care adjustments:

a. state contractual and operational requirements, and relevant laws and regulations;
b. current characteristics of the provider markets; and
c. the maturity level of the managed Medicaid program.

3.2.11 Non-Claim Based Medical Expenditures—The actuary should consider Medicaid-specific payments that are not included in the **base data** or that are included in the **base data** but for which the historical costs do not represent future costs. The actuary should determine whether these amounts will be an expense to the **MCOs**, and if so, how the amounts should be reflected. These types of payments include, but are not limited to, the following:

a. **disproportionate share hospital payments**;
b. **federally qualified health centers** or **rural health clinics** supplemental settlement payments;
c. **medical education payments**;
d. **intergovernmental transfers**; and
e. pharmacy rebates anticipated to be collected by the **MCO**.

3.2.12 Non-Medical Expenses—The actuary should include amounts for appropriate nonmedical expenses in the development of the **capitation rates**. The non-medical expenses may vary by **MCO**.

a. Administration—The actuary should include a provision for administrative expenses appropriate for the Medicaid managed care business in the state.

1. Determination of Administrative Expenses—In determining administrative expenses, the actuary may take into account relevant characteristics and functions of the **MCOs** and the Medicaid program, such as the following:
   i. overall size of the **MCO** across all lines of business;
   ii. age and length of time participating in Medicaid;
   iii. organizational structure; and
   iv. demographic mix of enrollees.

2. Types of Administrative Expenses—Appropriate types of administrative expenses include, but are not limited to, the following:
   i. marketing;
   ii. claims-processing;
   iii. medical management costs including those required to achieve savings from fee-for-service or prior periods assumed in the medical cost targets; and
   iv. general corporate overhead.

b. Underwriting Gain—The actuary should include a provision for underwriting gain, which is typically

expressed as a percentage of the premium rate, to provide for the cost of capital and a margin for risk or contingency. The underwriting gain provision provides compensation for the risks assumed by the **MCO**. These risks may include insurance, investment, inflation, and regulatory risks, as well as risks associated with social, economic, and legal environments. The actuary should consider the effect of any risk sharing arrangements discussed in section 3.2.14, and **performance withholds** and incentives discussed in section 3.2.15.

The methods used to develop the underwriting gain provision of the **capitation rate** should be appropriate to the level of capital required and the type and level of risk borne by the **MCO**. The actuary may reflect investment income in establishing the underwriting gain component of the **capitation rate**, although an explicit adjustment is not required. Elements of investment income that the actuary may reflect include investment income from insurance operations and investment income on capital and underlying cash flow patterns.

An actuary working on behalf of an **MCO** may determine that a negative underwriting gain is appropriate for

that plan's circumstances. In this case, the negative underwriting gain should be disclosed in the actuarial communication.

c. Income Taxes—The actuary should consider the effect of expected income taxes on the underwriting gains and investment income retained by the **MCO**.

d. Taxes, Assessments, and Fees—The actuary should include an adjustment for any taxes, assessments, or fees that the MCOs are required to payout of the **capitation rates**. If the tax, assessment, or fee is not deductible as an expense for corporate tax purposes, the actuary should apply an adjustment to reflect the costs of the tax. Taxes, assessments, and fees may differ among the MCOs in the program. The actuary preparing a certification under 42 CFR 438.6(c) should consider the need to adjust **capitation rates** for each **MCO** to reflect each **MCO**'s expected expenses for these items.

3.2.13 Risk Adjustment—An actuary working on behalf of the state should determine whether to adjust capitation payments to different **MCOs** by using a **risk adjustment** methodology. Considerations in making this determination include program enrollment procedures that may affect differences in

risk across **MCOs** or among the populations used to develop the rates and to which the rates will be applied, data availability and quality, timing, and other practical considerations including cost. ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*, provides further guidance. Risk-adjusted rates that may be developed from **actuarially sound** base rates and application of an appropriate risk adjustment method are considered **actuarially sound**, even if the resulting rates fall outside of the unadjusted rate ranges or vary from the single point rates.

The actuary, whether working on behalf of the state or an **MCO**, should understand and consider the potential impact of the **risk adjustment** methodology being used, if any, on the **capitation rate**.

3.2.14 Reinsurance, Risk Corridors, and Other Risk Sharing Arrangements—The actuary should consider the effect of any risk sharing arrangements between the **MCO** and the state Medicaid agency or the federal government.

The actuary should consider how payments related to risk sharing arrangements have been reported in the base period data, how these payments are to be estimated in the future, and how these payments will be reflected in the **capitation rates**.

3.2.15 Performance Withholds and Incentives—The actuary should consider how the

existence of the withholds and incentives will affect the plan costs, including claims and administration costs. The **capitation rates** should reflect the value of the portion of the withholds for targets that the **MCOs** can reasonably achieve.

The **capitation rates** should not reflect the value of incentives. The actuary should also consider any limitations to the amount of incentive payments or withholds specified in legislative regulations or guidance.

3.2.16 Minimum Medical Loss Ratios—The actuary should consider governmental and contractual **minimum medical loss ratio** requirements as well as the sharing of gains or losses. Such provisions may affect the underwriting gain provision component of the **capitation rates**.

3.2.17 State Initiatives—In setting capitation rates, the actuary should only include the impact of state initiatives that are supported by corresponding cost saving policies including, but not limited to, program changes or reimbursement changes.

3.2.18 Inaccurate or Incomplete Information Identified after Opinion or Rate Certification—If the actuary determines after the opinion or certification was issued that he or she used inaccurate or incomplete information, the actuary should notify the principal if, in the actuary's professional judgment, the new information is material to the **actuarial soundness** of the rates and is

not inherent in the assumptions already included in the rates.

3.3 Qualified Opinion on Actuarial Soundness—The actuary should provide a qualified opinion if, in the actuary's judgment, the rates are not **actuarially sound**. Further, the opinion should be qualified if a negative underwriting gain is determined to be appropriate for a specific plan's circumstance by an actuary working on behalf of an **MCO**.

3.4 Documentation—The actuary should document the methods, assumptions, procedures, and sources of the data used. The documentation should be in a form such that another actuary qualified in the same field could assess the reasonableness of the work. The actuary should consider documentation to address the Centers for Medicare & Medicaid Services' regulations specific to Medicaid managed care **capitation rate** development and certification. For further guidance, see ASOP No. 23, *Data Quality*; ASOP No. 25, *Credibility Procedures*; and ASOP No. 41, *Actuarial Communications*.

Section 4. Communications and Disclosures

4.1 Communications—When issuing actuarial communications under this standard, the actuary should refer to ASOP No. 41.

4.2 Disclosures—The actuary should include the following, as applicable, in an actuarial communication:

a. as required by 42 CFR 438.6(c), a statement that **capitation rates** provided with a rate certification are considered "**actuarially sound**," according to the following criteria:
   1. the **capitation rates** "have been developed in accordance with generally accepted actuarial principles and practices";
   2. the **capitation rates** "are appropriate for the populations to be covered, and the services to be furnished under the contract"; and
   3. the **capitation rates** "have been certified, as meeting the requirements of this paragraph [42 CFR 438.6(c)], by actuaries who meet the Qualification Standards established by the American Academy of Actuaries and follow the practice standards established by the Actuarial Standards Board."

b. the definition of "**actuarial soundness**";

c. disclosure of any items causing the opinion to be qualified such as the use of a negative underwriting gain by an actuary working on behalf of a Medicaid **MCO**;

d. the disclosure in ASOP No. 41, section 4.2, if any material assumption or method

was prescribed by applicable law (statutes, regulations, and other legally binding authority);

e. the disclosure in ASOP No. 41, section 4.3., if the actuary states reliance on other sources and thereby disclaims responsibility for any material assumption or method selected by a party other than the actuary; and

f. the disclosure in ASOP No. 41, section 4.4, if, in the actuary's professional judgment, the actuary has otherwise deviated materially from the guidance of this ASOP.

Appendix 1

Background and Current Practices

Note: This appendix is provided for informational purposes only and is not part of the standard of practice.

Background

Medicaid is a program that pays for health care services for certain low-income persons in the United States and its Territories, as authorized by Title XIX of the Social Security Act. The federal and state governments cooperatively administer Medicaid. The Centers for Medicare & Medicaid Services (CMS) is the agency charged with administering Medicaid on behalf of the federal government. The federal government establishes certain requirements for Medicaid, and the states administer their own programs. The federal government and the states share the responsibility for funding Medicaid.

Medicaid programs were originally fee-for-service (FFS) programs in which the state paid the providers directly. In the 1980s, some states began to contract with managed care organizations (MCOs) to provide health care services for selected subsets of the Medicaid population. In some cases, states may need to obtain a CMS waiver in order to waive certain Medicaid regulations and contract with MCOs. In many states, the state or its contractor develops capitation rates that are offered to the MCOs, rather than the MCOs proposing rates to the state. Under this arrangement, typically the MCOs may accept the rates or decline to participate in the program, though some negotiation may be possible.

Beginning in August 2003, the capitation rates paid by the state to the MCOs must be certified as actuarially sound under 42 CFR 438.6(c). The actuary performing the rate certification process may be an employee of the state Medicaid agency or contracted as a consulting actuary. Normally, the certifying actuary will not have as specific knowledge of each MCO's operations and experience as an actuary working on behalf of the MCO. The soundness certification applies to all contracted capitation rates. However, the actuary is not certifying that the capitation rates are appropriate for an individual MCO.

Since the federal regulations took effect, actuaries have used various methods to prepare the capitation rates. This ASOP has been developed to incorporate the appropriate aspects of these methods to establish guidance and considerations in the rate development process.

Current Practices

The current Medicaid capitation rate setting and certification methodology varies state by state, but actuaries across the country use many of the considerations outlined in the ASOP. Actuaries rely on the August 2005 practice note and traditional health care actuarial principles in the development of the actuarially sound capitation rates.

In many states, the capitation rates are developed independently by the state Medicaid agency and the certifying actuary. The capitation rates are often offered to the contracting MCO without negotiation, but the contracting MCOs and their actuaries may have the

ability to review the capitation rate development and provide comment. Further, a state Medicaid agency may negotiate rates with each MCO based on a rate range or allow a competitive bid. Due to the unique nature of these contracting arrangements, the certifying actuary has a greater responsibility in the determination of the capitation rates (either the point estimates or capitation rate ranges), since the certifying actuary is not directly affiliated with the contracted MCO.

Actuaries rely on data and information provided by the state Medicaid agency, the contracted MCOs, and other publicly available information. Actuaries may publish a data book that outlines the baseline data, adjustments to the baseline data, actuarial assumptions, and the development of capitation rates. Public meetings may be held where the capitation rate development process is presented to the contracted MCOs. Following the public meetings, the MCOs may provide questions to the state Medicaid agency and the certifying actuary regarding the capitation rate development process and assumptions. The certifying actuary reviews the comments and adjusts the capitation rates, if appropriate.

The state Medicaid agency presents the actuarial rate certification and related documentation to CMS for review and approval. CMS may submit questions to the state Medicaid agency and the certifying actuary regarding the capitation rate development and the related contract with the MCOs. The certifying actuary will often provide written responses to CMS.

Additional Resources

The following resources may assist in furthering actuaries' understanding of the capitation rate development process.

- American Academy of Actuaries, Health Council Practice Note, Actuarial Certification of Rates for Medicaid Managed Care Programs, August 2005, http://actuary.org/content/actuarial-certification-rates-medicaid-managed-care-programs
- Centers for Medicare and Medicaid Services, Medicaid website, http://medicaid.gov/
- Medicaid and CHIP Payment and Access Commission (MACPAC), http://www.macpac.gov/
- CMS Medicaid Managed Care Rate Setting Guidance, 2015 http://www.medicaid.gov/medicaid-chip-program-information/by-topics/deliverysystems/managed-care/downloads/2015-medicaid-manged-care-rate-guidance.pdf
- Federal Register / Vol. 67, No. 115 / Friday, June 14, 2002 / Rules and Regulations, page 41097, Sec. 438.6 Contract Requirements (c) Payments under risk contracts, http://www.cms.gov/Regulations-and-Guidance/Regulations-and-Policies/QuarterlyProviderUpdates/downloads/cms2104f.pdf

Appendix 2

Comments on The Exposure Draft and Responses

The exposure draft of proposed ASOP, *Medicaid Managed Care Capitation Rate Development and Certification*, was issued in December 2013 with a comment deadline of May 15, 2014. Twenty-six comment letters were received, some of which were submitted on behalf of multiple commentators, such as by firms or committees. For purposes of this appendix, the term "commentator" may refer to more than one person associated with a particular comment letter. The Medicaid Task Force and the Health Committee of the Actuarial Standards Board carefully considered all comments received, and the Health Committee and ASB reviewed (and modified, where appropriate) the changes proposed by the Task Force.

Summarized below are the significant issues and questions contained in the comment letters and the responses.

The term "reviewers" in appendix 2 includes the Task Force, Health Committee, and the ASB. Also, unless otherwise noted, the section numbers and titles used in appendix 2 refer to those in the exposure draft.

TRANSMITTAL MEMORANDUM QUESTIONS
Question 1: This ASOP has been prepared to apply both to actuaries developing actuarial statements of opinion for a Medicaid MCO and to actuaries developing rate certifications under 42 CFR

438.6(c). Is this appropriate? Or, should the ASOP be limited to actuaries developing rate certifications under 42 CFR 438.6(c)?	
Comment	Several commentators indicated support for both limiting the ASOP to 42 CFR 438.6(c) rate certifications and for applying it to all Medicaid rate setting actuarial opinions; however, the majority of the responses supported having the ASOP apply to all Medicaid rate development statements of actuarial opinion.
Response	The reviewers believe that the ASOP provides appropriate guidance and covers appropriate situations involving Medicaid capitation rate development, Medicaid certifications, and Medicaid statements of actuarial opinion.
Question 2: As written, this ASOP applies to Children's Health Insurance Program (CHIP) managed care capitation rate development. Is this appropriate?	

Comment	Several commentators supported having the ASOP apply to CHIP capitation rate development and certification. Additionally, comments were received indicating that the ASOP should also apply to the Medicaid expansion programs.
Response	The reviewers retained language indicating applicability of the ASOP to CHIP capitation rate development and certification. The reviewers reviewed the ASOP language to make sure it applies to the appropriate healthcare programs funded under Title XIX (Medicaid) and Title XXI (CHIP).
Question 3: Is the definition of "actuarially sound/actuarial soundness" in section 2.1 clear?	
Comment	The comments received suggested that the following terms in the "actuarially sound/actuarial sound"

	definition be separately defined: "revenue in aggregate"; marginally or fully-loaded administrative expenses; reinsurance cash flows; underwriting gain; investment income; and taxes.
Response	The reviewers made no change to the definition of "actuarial soundness." The reviewers modified the definition of "underwriting gain" in section 3.2.11(b).The reviewers determined the other suggested definitions were not needed but in some cases the guidance in the standard was clarified.
Comment	Commentators suggested that the terms "generally accepted actuarial practices" and "certified by an actuary who meets the qualification standard" should be included in the definition of "actuarial soundness."

Response	The reviewers believe that the definition of "actuarial soundness" is appropriate for this standard and does not need to include these additional terms.
Comment	Several commentators suggested that the word "attainable" is insufficiently described.
Response	The reviewers determined that further description of the word "attainable" would be overly prescriptive and made no change.
Question 4: Is section 3.2.16, Inaccurate or Incomplete Information Identified after Opinion or Rate Certification, which discusses the actions required of the certifying actuary if the underlying data is identified to be inaccurate or incomplete, clear and appropriate?	
Comment	Commentators suggested that additional information should be provided regarding who the actuary should notify if the actuary determines that the capitation rates should be changed due to inaccurate or incomplete

	data, to include CMS or MCOs.
Response	The reviewers disagree and believe that the requirement to provide notice to the principal is sufficient and, therefore, made no change.
Comment	Commentators suggested providing clear guidelines on a process for reporting inaccuracies and including the new or corrected information in the rate development, and increasing transparency when this situation arises and the rates are corrected.
Response	The reviewers disagree that the ASOP should specify such a process and, therefore, made no change.
Comment	Commentators suggested providing MCOs with a process for sending information to the actuary about errors in the data.

Response	ASOPs provide guidance for actuaries, not organizations. The reviewers disagree that the ASOP should specify such a process and, therefore, made no change.
Comment	Two commentators were concerned that the term "incomplete" would be misinterpreted to mean that the actuary would need to change the rates due to prospective assumptions not equaling actual assumptions.
Response	The reviewers believe that the ASOP appropriately differentiates between incomplete data and prospective assumptions and, therefore, made no change.
Comment	Two commentators did not understand the timing around making a correction given the words "If prior to issuance . . . in the section.

Response	The reviewers revised this section to address this comment.
Question 5: Does the ASOP restrict practice inappropriately?	
Comment	Most commentators stated that the ASOP does not restrict practice inappropriately. Two commentators thought it restricted practice if it applies to actuaries that develop rates outside of 42 CFR 438.6(c). One commentator felt that the guidelines around development of the administrative components of the rates were too prescriptive.
Response	The reviewers made some revisions to the guidance to address the comments expressing concern regarding inappropriate restriction of practice.
Question 6: Does this ASOP provide sufficient guidance for actuaries practicing in these areas?	
Comment	Several commentators indicated that the ASOP

	provided sufficient guidance and some that indicated the ASOP did not provide sufficient guidance. Where commentators indicated the ASOP did not provide sufficient guidance, some provided general recommendations while others provided more specific recommendations.
Response	While some commentators indicated that the ASOP did not provide sufficient guidance, in most cases they provided specific comments on where they believed additional guidance was necessary. The reviewers have addressed those comments in the relevant sections.
Question 7: Does this ASOP provide sufficient guidance to actuaries in identifying and addressing potential inconsistencies in the expectations of actuaries working for Medicaid MCOs and those actuaries working for State Medicaid Agencies?	

Comment	Commentators were divided in their response to this question. Several commentators believed that the ASOP did provide sufficient guidance on this topic. Several other commentators believed that the ASOP should provide additional guidance, either generally or in specific sections. Several other commentators believed that the ASOP did not provide sufficient guidance, but that the ASOP should be limited to actuaries working for state Medicaid agencies and thus did not need to provide additional guidance.
Response	The reviewers determined that the ASOP should apply to both actuaries working for Medicaid MCOs and actuaries working for state Medicaid agencies. The reviewers made

	clarifications and modifications in relevant sections in response to the comments received.
Comment	Several commentators felt that the ASOP could go further in addressing these differences. One commentator asked if there could be an illustration of circumstances when the MCO actuary is not certifying compliance with 42 CFR 438.6(c) and is not bound by the ASOP; and sought clarification of whether or not the MCO actuary needed to comply with the ASOP when completing a certification. Another commentator suggested further guidance on issues for actuaries working for state Medicaid agencies.
Response	The reviewers note the MCO actuary would be required to comply with the ASOP regardless of whether or not the

	actuary is completing a certification related to the 42 CFR 438.6(c). The reviewers modified the scope section by adding examples of situations to which the ASOP applies.
SECTION 1. PURPOSE, SCOPE, CROSS REFERENCES, AND EFFECTIVE DATE	
Section 1.1, Purpose	
Comment	Several commentators questioned the applicability of the ASOP to various populations including: the Aged, Blind and Disabled - SSI population, ACA Medicaid expansion populations, and Medicare-Medicaid dual integration populations.
Response	The reviewers reviewed the ASOP language to make sure it applies to the appropriate healthcare programs funded under Title XIX (Medicaid) and Title XXI (CHIP) and made no change.
SECTION 2. DEFINITIONS	

Section 2.3, Capitation Rate	
Comment	One commentator mentioned the particular situation in Minnesota where risk is shared with providers. The suggestion was made to add a phrase to the end of the definition "or with providers."
Response	The reviewers agree and modified the definition.
Section 2.8, Intergovernmental Transfers (IGTs)	
Comment	One commentator recommended that the ASOP define medical and non-medical IGTs and to consider whether or not the actuary should be required to report certain IGTs separately if they increase the federal government or state share of Medicaid costs.
Response	The reviewers believe this type of reporting is beyond the scope of the standard and made no change.
Section 2.10, Medical Education Payments	

Comment	One commentator suggested noting that medical education payments may be made directly from the state to the providers.
Response	The reviewers believe that the definition addresses this situation and made no change.
Comment	One commentator suggested expanding this section to discuss all supplemental payments and not just medical education payments.
Response	The reviewers note that section 3.2.6, Special Payments, was modified to include supplemental payments as one example of special payments. The reviewers believe the revised section appropriately covers special payments, including supplemental payments.
Section 2.15, Risk Adjustment	
Comment	One commentator wanted the definition of "risk

	adjustment" expanded to include capitation rate structural elements used such as maternity delivery case rate payments.
Response	The reviewers believe this is addressed in section 3.2.2, Structure of the Medicaid Managed Care Capitation Rates, as amended, and made no change to section 2.15.
Section 2.17, State Plan Services	
Comment	Several commentators requested clarification on definitions related to "state plan services," "covered services," and "in-lieu-of services."
Response	The reviewers modified section 3.2.5, Covered Services, to provide additional clarity.
SECTION 3. ANALYSIS OF ISSUES AND RECOMMENDED PRACTICES	
Section 3.1, Overview	
Comment	Several commentators recommended that language be added stating that the rates

	[under 42 CFR 438.6 (c)] should be appropriate for each individual MCO, with one commentator stating that such appropriateness should be achieved using risk adjustment.
Response	The reviewers note that certification of capitation rates under 42 CFR 438.6 (c) for individual MCOs is allowed under this standard but do not believe it should be required by the standard. Therefore, no change was made.
Comment	One commentator recommended that the ASOP clarify that the actuary may, in some circumstances, be certifying different rates by MCO.
Response	The reviewers agree and believe the standard makes clear this is permitted and made no change.

Comment	One commentator recommended that the ASOP explicitly prohibit actuaries from considering state budgetary limitations when setting rates.
Response	The reviewers have added additional guidance related to state initiatives in section 3.2.17.
Section 3.2.1, Form of the Capitation Rates (Single Rate or Capitation Rate Ranges)	
Comment	Several commentators recommended that the ASOP state or reinforce that the assumptions used to develop rates at each end of the rate range should be attainable and consider the interdependence of various assumptions and not just represent an aggregation of the best or worst case scenarios for each rating variable.
Response	The reviewers believe that the definition of actuarial soundness

	addresses this issue and made no change.
Comment	One commentator recommended that the rate range width should be required to be disclosed.
Response	The reviewers believe that requiring such a disclosure is beyond the scope of this ASOP and made no change.
Comment	One commentator recommended defining the midpoint of the rate range as the best estimate, and several commentators recommended that further requirements be added to inform the principal (state or MCO) of the effect of the choice of the rate within the rate range.
Response	The reviewers believe such a change would not be appropriate and made no change.
Comment	One commentator recommended that the

	ASOP clarify that maternity case rate payments and other event based payments are covered by this ASOP.
Response	The reviewers agree and have updated section 3.2.2, Structure of the Medicaid Managed Care Capitation Rates, to also include event based payments.
Comment	One commentator recommended clarifications around assumptions specific to geographic areas and that administrative expenses may be higher on the low end of the rate range than on the high end of the rate range.
Response	The reviewers believe that the definition of actuarial soundness addresses this issue and made no change.
Section 3.2.2, Structure of the Medicaid Managed Care Rates	

Comment	Several commentators recommended that section 3.2.2 clarify that event based (i.e., case rate) payments are also capitation rates.
Response	The reviewers agree that adding event based payments to this section would be helpful and updated the language.
Comment	One commentator recommended that section 3.2.2 reference ASOP No. 12, Risk *Classification*.
Response	The reviewers agree that such reference would be helpful and added it.
Comment	One commentator recommended that the list of examples should include Medicaid eligibility groups.
Response	The reviewers agree and added "Medicaid eligibility groups" to the list of examples.
Comment	One commentator recommended that "MCO differences" be excluded

	from the list of examples because it implied that MCOs with inefficient cost structures would be rewarded.
Response	The reviewers note that the listing only provides examples of characteristics that may affect the rating structure. Therefore, no change was made.
Comment	One commentator stated clarification should be provided that not all assumptions need to be developed at the rate cell level, including the standard practice of administrative loads being applied uniformly across rate cells.
Response	The reviewers do not believe that further clarification needs to be provided and made no change.
Comment	Several commentators believed that the ASOP would require separate administrative loads be

	developed for each rate cell and recommended not requiring this.
Response	The reviewers believe that the ASOP allows the actuary to use his or her judgment about whether or not a single administrative load, margin, or cost of capital assumption is appropriate for all rate cells. Therefore, no change was made.
Comment	One commentator suggested including a definition regarding a "competitive procurement."
Response	The reviewers disagree that this definition needs to be included in the ASOP and made no change.
Comment	One commentator requested the inclusion of a definition of "covered services."
Response	The reviewers believe section 3.2.5, Covered

	Services, provided appropriate guidance and did not add a definition. However, some clarifications were made to section 3.2.5.
Comment	One commentator requested clarification of the terms "should" or "should consider."
Response	The reviewers note these terms are discussed in ASOP No. 1, *Introductory Actuarial Standard of Practice*, and made no change.
Comment	One commentator stated that language regarding non-state plan services is not appropriate since it is a regulatory issue and not an actuarial requirement.
Response	The reviewers believe that the ASOP provides appropriate guidance regarding the treatment of enhanced or additional benefits in the rate certification process and made no change.

Comment	One commentator stated that data quality issues should be further addressed in the ASOP.
Response	The reviewers believe this ASOP, in conjunction with ASOP No. 23, *Data Quality*, appropriately addresses data quality and made no change.
Comment	One commentator stated the need for the ASOP to address the impact on third party vendors or providers that may be receiving a sub-capitation payment from the health plan to the provider.
Response	The reviewers believe that financial impacts to third-party vendors are outside the scope of this standard and made no change.
Section 3.2.3, Rebasing and Updating of Rates	
Comment	One commentator suggested that the practice of using interim financial results to develop an experience adjustment was

	essentially rebasing and this practice should be addressed in section 3.2.3.
Response	The reviewers believe that the existing language appropriately addresses such situations, even though it does not specifically describe this practice. Therefore, no change was made.
Comment	One commentator suggested that competitive procurements were a form of rebasing and this should be addressed in the rebasing section.
Response	The reviewers did not feel that a discussion of competitive procurements was warranted in this section and made no change.
Comment	Several commentators recommended that the ASOP require actuaries to consider the adequacy of the rates in total or by

	rate cell in deciding whether to rebase.
Response	The reviewers note that rate adequacy is addressed in other areas of the ASOP and, therefore, made no change.
Comment	One commentator recommended that program and benefit changes be a required consideration in rebasing rates.
Response	The reviewers believe this is dependent on specific facts and circumstances, and therefore made no change.
Comment	One commentator recommended that capitation rate development, including the rebasing of rates, should occur and be distributed to interested parties well in advance of the effective date of rates.
Response	The reviewers believe this recommendation is outside the scope of the ASOP and made no

	change.
Section 3.2.5, Covered Services	
Comment	One commentator thought that "in lieu of services" should be defined or clarified given that policy and regulatory considerations impact the appropriateness of including these services in the rate development. Another commentator thought that the word "may" should be changed to "should" in the sentence "Non-state plan services may be included in the capitation rate if the service is provided in lieu of a state plan service." Another commentator thought that this section should clarify that costs incurred for the use of innovative, non-traditional programs that obviate the need for or reduce medical costs and improve patient care should be included as covered services.

Response	The reviewers note section 3.2.5 was divided into two sections in the final ASOP (section 3.2.5, Covered Services, and new section 3.2.6, Special Payments). The reviewers believe the updated sections are clear and appropriate.
Comment	One commentator noted that the sentence "In determining covered services, the actuary should include state plan services that form the basis for the claims experience used to develop the rates" was difficult to read.
Response	The reviewers modified section 3.2.5 and believe the guidance on determining covered services is clear.
Comment	One commentator indicated that the use of the word "consistently" in the sentence "The actuary should also identify any special payments to providers

	(for example, supplemental payments or bonuses) and make sure that these payments are handled consistently between the base data and the capitation rates" should be modified to reflect that there are situations where there is a change in practice between the base period and rating period.
Response	The reviewers agree and revised this sentence, which is now included in new section 3.2.6, Special Payments.
Comment	One commentator noted that the phrase "enhanced or additional services" should be "enhanced or additional benefits" to be consistent with the definitions.
Response	The reviewers agree and revised the word "services" to "benefits" in this phrase.

Comment	One commentator noted that if a definition for "covered services" is added to the definitions there may be no need to include the words "unless provided for by a waiver" at the end of the section.
Response	The reviewers modified section 3.2.5 and believe the guidance on determining covered services is now clear.
Comment	One commentator asked for further clarification of state plan, non-state plan and in-lieu-of benefits.
Response	The reviewers modified section 3.2.5 and believe the guidance regarding covered services is now clear.
Comment	One commentator asked that the ASOP include a definition regarding "critical access hospitals."
Response	The reviewers disagree that this definition needs to be included in the

	ASOP and made no change.
Section 3.2.7, Other Base Data Adjustments	
Comment	One commentator recommended adding two additional paragraphs related to "area factor adjustments" and "affiliated provider organizations."
Response	The reviewers disagree that these items should be included in this section. The reviewers believe sections 3.2.2, Structure of the Medicaid Managed Care Capitation Rates; section 3.2.4, Base Data; and section 3.2.9, Claim Cost Trends, adequately address this issue, and therefore made no change.
Comment	One commentator thought that this section should include a section on a base data adjustment for potential increased access in the managed care program versus what was available

	in a fee-for-service program.
Response	The reviewers disagree and believe section 3.2.9 adequately addresses this issue. Therefore, no change was made.
Comment	Two commentators thought that this section did not address adjustments needed for missing or incomplete encounter data.
Response	The reviewers disagree. The examples in the section 3.2.7(a) are not all-inclusive. Therefore, no change was made.
Comment	One commentator proposed expanding section 3.2.7(a)(1) to read "certain claims or a portion of provider payments are not processed through the same system as the base data;" in order to include consideration for bulk retrospective provider payments such as "pay for performance"

	incentives that may not be attributable to particular claims.
Response	The reviewers believe this issue does not warrant a specific example and made no change.
Comment	One commentator thought that the sentence "The actuary should consider other base data adjustments, which may include the following:" should be changed to "The actuary should consider other base data adjustments, which should include the following to reflect all applicable costs incurred during the base data period:"
Response	The reviewers believe the language as written is clear and made no change.
Comment	One commentator recommended that section 3.2.7(f) explicitly mention changes in medical practice,

	including newly approved drugs and devices, as a situation in which base data and capitation rates may need to be adjusted.
Response	The reviewers believe this issue does not warrant a specific example and made no change.
Comment	One commentator recommended that the ASOP be revised to provide that actuaries should disclose to MCOs the methodology, assumptions, and data that serve as the basis for adjustments to base year data. The commentator also recommended that language be added to section 3.2.7 stating that actuaries should avoid using Fee for Service (FFS) data as the basis for the base data adjustments if the FFS data is more than one year removed from the rating year.

Response	The reviewers believe that section 4 of this ASOP and other applicable ASOPs (including ASOP No. 41, *Actuarial Communications*) provide appropriate guidance regarding disclosures. The reviewers disagree with adding specific instructions around what data may or may not be used to develop base year data adjustments. ASOP No. 23 provides the actuary with guidance for data selection. Therefore, no change was made.
Section 3.2.8, Claim Cost Trends	
Comment	One commentator suggested that a list of items for developing claim cost trends should be added to this section.
Response	The reviewers believe the level of detail in this section is sufficient and made no change.
Comment	One commentator thought that the actuary

	should be directed in this section to disclose the basis of trend estimates such as the source, applicability, claims experience, time periods, trend surveys, etc.
Response	The reviewers disagree and believe that section 4 of this ASOP and other applicable ASOPs (including ASOP No. 41) provide appropriate guidance regarding disclosures. Therefore, no change was made.
Comment	One commentator thought that the wording "Trends should be exclusive of other adjustments" indicated that a blending of the utilization component of trend with the adjustment in section 3.2.9, Managed Care Adjustments, was prohibited; yet they felt that if historic managed care data was used to develop the trends, it would be an unnecessary

	exercise to separate historical utilization trend and managed care savings components.
Response	The reviewers revised the sentence for clarity and believe no further guidance is necessary.
Comment	Two commentators recommended that this section be amended to add a requirement that actuaries should reflect new technological and pharmaceutical advancements in the trend assumptions.
Response	The reviewers believe the level of detail in this section is sufficient and made no change.
Comment	One commentator requested a specific section on network re-pricing and stated this section should specify that the fee schedule used to re-price claims be attainable to the MCOs.

Response	The reviewers believe that this issue is covered by the definition of "actuarial soundness." Therefore, no change was made.
Section 3.2.9, Managed Care Adjustments	
Comment	One commentator thought that the ASOP should clarify that managed care savings should be documented by category of service and should clarify that the level of managed care adjustments should not be linking to non-medical loads in the rate development.
Response	The reviewers disagree that this wording should be added and made no change.
Comment	One commentator suggested that the ASOP clarify that managed care impacts must be considered in aggregate and not in isolation (for example, reduction in ER utilization may be accompanied by higher

	primary care utilization, possibly with higher per unit costs in both settings, as delivery of care is managed towards the appropriate setting.).
Response	The reviewers disagree that this wording should be added and made no change.
Comment	Several commentators felt that the words . . . adjustments should be attainable in the rating period . . . were not sufficient guidance to recognize the various items that can impact the timing of attaining managed care savings and suggested additional wording be added to the ASOP that clarifies the limitations that can cause managed care adjustments to be obtained during the rating period.
Response	The reviewers believe this issue is covered by the definition of actuarial

	soundness. "Therefore, no change was made.
Comment	One commentator thought that the wording "state contractual and operational requirements, and relevant laws and regulations" allowed actuaries to add managed care adjustments due to state budget limitations.
Response	The reviewers added a new section 3.2.17, State Initiatives, to clarify the guidance.
Comment	One commentator thought that section 3.2.9(b) should be revised to "current characteristics and desired changes in those characteristics of the. . . . "
Response	The reviewers believe the language is clear and, therefore, made no change.
Comment	Several commentators recommended that wording should be added to this section indicating

	that base data adjustments need to be done in a transparent and data-driven manner.
Response	The reviewers believe that transparency and use of underlying data are appropriately covered in this standard as well as ASOP Nos. 23 and 41 and, therefore, made no change.
Comment	One commentator recommended adding language that the actuary should make sure that managed care savings are not double counted with trend assumptions.
Response	The reviewers note this is addressed in new section 3.2.9, Claim Cost Trends. Therefore, no change was made.
Comment	One commentator thought that this section did not distinguish between changes from base year data that are likely to be achievable when a new Medicaid

	managed care program is implemented and managed care efficiencies have not previously been implemented and the nature and scope of changes that can be expected when a program is well-established and the baseline data already reflect the impact of Medicaid health plan performance.
Response	The reviewers note this is addressed in section 3.2.9(c) and made no change.
Section 3.2.11, Non-Medical Expenses	
Comment	One commenter suggested that the ASOP recommend a correlation between underwriting gain and the level of risk or uncertainty.
Response	The reviewers agree and have added clarifying language to section 3.2.11(b).
Comment	One commentator suggested that medical management costs should

	be considered medical expenses and not administrative costs.
Response	The reviewers note the ASOP only lists medical management as a possible administrative expense. Therefore, no change was made.
Comment	One commentator expressed concern that the ASOP requires developing distinct rates for each MCO based on administrative expenditures and profit or non-profit status.
Response	The reviewers note that new section 3.2.12, Non-Medical Expenses, states non-medical expenses may vary by MCO and, therefore, made no change.
Comment	One commenter expressed concern over requiring the consideration of cost of capital and stated that it should be left to the actuary to consider.

Response	The reviewers believe the updated ASOP includes appropriate consideration of cost of capital in section 2.1, Actuarially Sound/Actuarial Soundness and new section 3.2.12 (b), Underwriting Gain.
Comment	One commentator expressed concern about establishing different non-medical expenses by rate cell.
Response	The reviewers modified the language to remove "for each rate cell" to avoid implying that the non-medical expenses were required to vary by rate cell.
Section 3.2.11(a), Administration	
Comment	One commenter recommended clarifying what is an appropriate administrative load for Medicaid managed care and what are acceptable data sources or information to use.

Response	The reviewers believe that such clarification is not appropriate in this ASOP and therefore made no change
Section 3.2.11(a)(1), Determination of Administrative Expenses	
Comment	One commentator suggested additional requirements for the actuary in determining the administrative payments to affiliated organizations to make sure they are reasonable and appropriate.
Response	The reviewers believe section 3.2.11 and the definition of "actuarial soundness" appropriately address this concern and made no change.
Comment	One commenter recommended deleting section 3.2.11(a)(1) on administrative expenses and stated that it would limit states' ability to place limits on administrative costs.
Response	

	The reviewers modified the language from "should" to "may" and also made other changes to this section to clarify guidance.
Comment	One commentator suggested that several of the considerations for administrative expenditures under 3.2.11(a)(1) should not be required and instead be made permissible.
Response	The reviewers modified the language from "should" to "may" and also made other changes to this section to clarify guidance.
Comment	One commentator suggested that the complexity of providing services for certain populations (such as aged or disabled enrollees) should be required as a consideration of administrative expenditures.

Response	The reviewers note that the list is not meant to be all inclusive. The reviewers believe the ASOP provides appropriate guidance and made no change.
Section 3.2.11(a)(2), Types of Administrative Expenses	
Comment	One commentator suggested adding contract provisions as a type of administrative expenditure.
Response	The reviewers believe the ASOP provides appropriate guidance and made no change.
Section 3.2.11(a)(2)(i), Types of Administrative Expenses	
Comment	One commentator suggested deleting the phrase regarding "competitive environment."
Response	The reviewers agree and made the change.
Section 3.2.11(a)(2)(iv), Types of Administrative Expenses	
Comment	One commentator suggested defining "general corporate overhead."

Response	The reviewers disagree and made no change.
Section 3.2.11(b), Underwriting Gain	
Comment	Several commentators recommended "cost of capital" be defined and explained how this related to margins for risk or underwriting gain.
Response	The reviewers believe the ASOP provides appropriate guidance and made no change.
Comment	One commentator recommended that the actuary must consider investment income when determining the underwriting gain.
Response	The reviewers believe the use of the word "may" is appropriate for the ASOP and made no change.
Comment	One commentator recommended addressing the importance of allowing negative underwriting gain

	margins in rate development.
Response	The reviewers believe the ASOP adequately addresses negative underwriting gain and, therefore, made no change.
Comment	Several commentators suggested that the effects of risk sharing arrangements, performance withholds, and minimum medical loss ratios should be addressed in determining the underwriting gain assumption.
Response	The reviewers added language to clarify the guidance.
Comment	One commentator recommended that the margin for the underwriting gain should be explicit in the capitation rate.
Response	The reviewers believe the ASOP provides appropriate guidance and made no change.

Comment	One commentator asked for guidance on how an appropriate underwriting gain provision was determined and for requirements about disclosing negative underwriting gain provisions.
Response	The reviewers believe it is beyond the scope of the ASOP to specify how the underwriting gain provision should be determined or deemed appropriate. The reviewers note that section 4 of the ASOP provides guidance for actuarial communications and disclosures, including specific mention of disclosure of negative underwriting gains. Therefore, no change was made.
Comment	One commentator recommended that the ASOP address new Medicaid managed care populations in regard to the underwriting gain provision.

Response	The reviewers disagree that additional guidance is needed and made no change.
Comment	One commentator asked whether payment delays should also be considered in the standard.
Response	The reviewers note that "cash flow patterns" are addressed in section 3.2.11(b). Therefore, no change was made.
Section 3.2.11(c), Income Taxes	
Comment	One commentator recommended that section 3.2.11(c) be revised so that actuaries may consider income taxes, but would not be required to do so.
Response	The reviewers believe this is an appropriate consideration in setting Medicaid managed care capitation rates and made no change.
Comment	One commenter recommended deleting section 3.2.11(c) and

	making section 3.2.11(d) permissive at the state's discretion.
Response	The reviewers disagree and made no change.
Section 3.2.11(d), Taxes, Assessments, and Fees	
Comment	One commentator expressed concern that section 3.2.11(d) was too specific relative to the rest of the ASOP and that the actuary would be required to make several explicit forecasts that the actuary may not be able to do.
Response	The reviewers believe this section does not place an unreasonable requirement on the actuary and made no change.
Section 3.2.12, Risk Adjustment	
Comment	Several commentators recommended that the risk adjustment section refer to section 3.2.7 or include discussion of data quality and appropriateness for risk adjustment.

Response	The reviewers believe that additional guidance is not necessary since ASOP No. 23 applies and is referenced in section 3.4, Documentation, and ASOP No. 45, *The Use of Health Status Based Risk Adjustment Methodologies*, is referenced in section 3.2.12, Risk Adjustment. Therefore, no change was made.
Section 3.2.14, Performance Withholds/Incentives	
Comment	Several commentators suggested the actuary should document any differences between the ASOP and CMS requirements.
Response	The reviewers note that section 4 of this ASOP provides guidance in this area.
Comment	Several commentators felt the language regarding including withhold amounts that are reasonably achievable was overly prescriptive while

	others felt the language did not provide enough guidance.
Response	The reviewers believe the language is appropriate and made no change.
Comment	One commentator recommended that data related to the characteristics of the covered population be considered when actuaries evaluate the effect that performance withholds and incentives could have on plan costs. The commentator also stated there should be clear expectations communicated to the MCO up front regarding targets and improvement goals before the rate period begins.
Response	The reviewers did not believe adding this consideration or required communication was necessary or appropriate. Therefore, no change was made.

Section 3.2.15, Minimum Medical Loss Ratios	
Comment	One commentator felt a statement should be added recognizing that minimum medical loss ratio provisions increase the level of risk borne by the MCO that the actuary should consider when determining the underwriting gain provision of the capitation rates.
Response	The reviewers note this is adequately addressed in this section and made no change.
Section 3.3, Qualified Opinion on Actuarial Soundness	
Comment	A commentator felt that an entire actuarial opinion should not be qualified when a negative underwriting gain is utilized.
Response	The reviewers note a qualified opinion is meant to highlight special circumstances with respect to actuarial soundness within the rate

	certification. Section 3.2.12(b), Underwriting Gain, requires the disclosure of a negative underwriting gain assumption. The reviewers changed the language from "for example" to "further". However, no other change was made.
Section 3.4, Documentation	
Comment	One commentator requested that the actuary be required to test capitation structures for appropriateness using emerging experience.
Response	The reviewers believe the ASOP provides appropriate guidance and made no change.
Comment	The reviewers note the distribution of the actuary's work product and documentation is governed by ASOP No. 41 and other related ASOPs. Therefore, no
Response	change was made.
Comment	One commentator asked what CMS regulations

	actuaries should consider in their documentation.
Response	The reviewers believe that listing all specific regulations the actuary should consider is outside the scope of this ASOP and made no change.