No. 18-10545

United States Court of Appeals for the Fifth Circuit

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

Plaintiffs-Appellees Cross-Appellants,

v.

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

Defendants-Appellants Cross-Appellees.

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

BRIEF OF *AMICUS CURIAE*
MEDICAID HEALTH PLANS OF AMERICA IN SUPPORT OF DEFENDANTS-APPELLANTS ON THE REVERSAL OF ORDER ON ACTUARIAL SOUNDNESS REGULATION

Benjamin G. Shatz
Manatt, Phelps & Phillips, LLP
11355 W. Olympic Boulevard
Los Angeles, CA 90064
(310) 312-4000
BShatz@manatt.com

Michael Kolber
Julian Polaris
Manatt, Phelps & Phillips, LLP
7 Times Square
New York, NY 10036

Andrew Zimmitti
Adam Finkelstein
Manatt, Phelps & Phillips, LLP
1050 Connecticut Avenue, Suite 600
Washington, DC 20036

Counsel for *Amicus Curiae*
Medicaid Health Plans of America

CERTIFICATE OF INTERESTED PERSONS

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Defendants-Appellants Cross-Appellees.

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

Plaintiffs-Appellees-Cross-Appellants: The States of Texas, Kansas, Louisiana, Indiana, Wisconsin, and Nebraska

Defendants-Appellants-Cross-Appellees: Charles P. Rettig, Commissioner of Internal Revenue; United States of America; U.S. Department of Health and Human Services; U.S. Internal Revenue Service; Alex M. Azar II, Secretary, U.S. Department of Health and Human Services

Amicus: Medicaid Health Plans of America

Attorneys of Record

For plaintiffs-appellees: Lanora Christine Pettit, Thomas A. Albright, David J. Hacker, Austin Nimocks, Andrew D. Leonie, Michael Christopher Toth, Randall Wilson Miller (Office of the Attorney General, P.O. Box 12548, Austin, TX 78711); Steven Carl Kilpatrick (Wisconsin Dept. of Justice, P.O. Box 7857, Madison, WI 53707)

For defendants-appellees: Jody H. Hunt, Deepthy Kishore, Rohit Dwarka Nath, Sheila Lieber, Julie Straus Harris, Michelle Bennett, Mark B. Stern, Alisa B. Klein, Joshua Revesz (U.S. Dept. of Justice, 950 Pennsylvania Ave NW, Washington, DC 20530); Erin Nealy Cox (U.S. Atty N.D. Texas, 1100 Commerce St., Dallas, TX 75242)

Robert P. Charrow, Kelly M. Cleary, Brian R. Stimson, Janice L. Hoffman, Susan Maxson Lyons (U.S. Dept. of Health & Human Services, 200 Independence Ave SW, Washington, DC 20201)

For amicus: Benjamin G. Shatz, Michael Kolber, Julian Polaris, Andrew Zimmitti (Manatt, Phelps & Phillips, LLP, 355 W. Olympic Blvd, Los Angeles, CA 90064)

Dated: November 27, 2019

Respectfully submitted,
MANATT, PHELPS & PHILLIPS, LLP
By: *s/Benjamin G. Shatz*
Counsel for *Amicus Curiae*
Medicaid Health Plans of America

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STATEMENT OF INTEREST[1]

Amicus curiae Medicaid Health Plans of America ("MHPA") is a nonprofit trade association of managed care organizations ("MCOs") that contract with states to provide medical care for Medicaid beneficiaries. MHPA works on behalf of its 94 member MCOs that serve approximately 23 million Medicaid enrollees in 37 states and the District of Columbia—about a third of all Medicaid beneficiaries in states with managed care delivery systems. Since 1995, MHPA has promoted the interests of the MCO industry through federal advocacy, annual conferences, and educational materials, among other activities. MHPA is dedicated to protecting the financial viability of the Medicaid program to ensure access to needed health care services for America's underserved and vulnerable populations.

One of MHPA's top priorities is maintaining the principle of actuarial soundness in rate development. Setting aside the regulatory requirement that a qualified actuary certify, based on professional standards of practice, the capitation rates that states pay to MCOs—which the district court judgment would do—would undermine the effectiveness of the Medicaid statutory requirement for payments to MCOs to be actuarially sound, and would put MCOs at risk for paying

[1] This brief is filed with consent of all parties. No party's counsel authored this brief in whole or in part. No party or party's counsel contributed money that was intended to fund preparing or submitting this brief, and no person other than the *amicus curiae*, its members or its counsel contributed money that was intended to fund preparing or submitting this brief.

the health insurance provider fee ("HIPF") without being compensated by the Plaintiff States for this substantial liability. While the Plaintiff States' adherence to the *statutory* actuarial soundness requirement has resulted in MCOs continuing to be paid the amounts they are owed, if this Court were to affirm the district court, it would create unpredictable and potentially dramatic consequences. The parties stipulated in the district court that, between 2014 and 2016, MCOs paid more than $400 million in HIPF that was reimbursed by just the six Plaintiff States. ROA.4676. While MHPA believes, and the Plaintiffs have conceded, that states remain statutorily obligated to reimburse MCOs for the HIPF,[2] a judgment setting aside key elements of the actuarial soundness regulation would undermine the stability of the Medicaid managed care system, potentially on a national basis.[3]

[2] HIPF payments from states to MCOs may include payment for the HIPF itself, as well as related expenses, such as an additional amount to account for the impact of the HIPF payment on other taxes, fees and assessments the MCO owes. *See* ROA.161-62. These payments are collectively referred to here as payments for the HIPF.

[3] Medicaid managed care is a partnership between states, the federal government, and MCOs. MHPA members work every day with the states to serve Medicaid beneficiaries. MHPA's concern in this case is solely that the rates the states pay MCOs accurately reflect the costs that MCOs are contracted to bear. Therefore, this amicus brief supports the United States solely with respect to the district court's order setting aside the certification portion of the actuarial soundness regulation.

I. Introduction

The district court concluded that the Plaintiff States are indirectly paying the "health insurance providers fee" ("HIPF"), imposed by section 9010 of the Affordable Care Act, via the Plaintiff States' payments to MCOs, and that the Plaintiff States are not required to do so. The district court believes that the Plaintiff States are doing so only because of elements of the federal "actuarial soundness" regulation, and therefore concluded these elements of the regulation are unlawful and set them aside. ROA.3981-83, 4025. However, the Plaintiff States' obligation to reimburse the MCOs actually derives from federal *statutory* law, 42 U.S.C. § 1396b(m)(2)(A)(iii), not merely the "actuarial soundness" *regulation*. Indeed, subsequent to this decision on summary judgment, the Plaintiff States conceded, in this litigation and in parallel litigation they initiated in the same court, that they remain legally obligated to reimburse the plans for any HIPF they pay—*even if the regulation were set aside*. The Plaintiff States' challenges to the validity of the regulation therefore do not represent a justiciable case or controversy and should have been dismissed: their alleged injury (reimbursing MCOs for the HIPF) is not fairly traceable to the allegedly unlawful government action (the regulation), and setting aside the regulation does not redress their injury.

The Plaintiff States' concession that they are statutorily required to reimburse the plans is also fatal to the district court's decision on the

merits that the regulation amounted to an unlawful delegation of rulemaking authority to the nongovernmental Actuarial Standards Board. Because the states are required to reimburse the plans for the HIPF as a matter of federal statutory law, the actuarial soundness regulation could not have delegated this decision to the Actuarial Standards Board, and did not do so.[4]

Even though the federal statute requires the states to reimburse the plans for the HIPF, the Court should be aware of the importance of the actuarial soundness regulation to preserve a well-functioning Medicaid program for states, health plans, healthcare providers and beneficiaries. This brief therefore begins by explaining why the current actuarial soundness regulation (which implements the actuarial soundness requirement set forth in 42 U.S.C. § 1396b(m)(2)(A)(iii)) serves these goals, and then explains why these claims—by the Plaintiff States' own concession—are not justiciable and without merit.

[4] In a separate case pending in district court, *Texas v. United States*, No. 4:18-cv-00779-O (N.D. Tex. filed Sept. 20, 2018), the Plaintiff States contend the Internal Revenue Service has incorrectly calculated HIPF amounts due from covered entities based on their Medicaid and Children's Health Insurance Program (CHIP) capitation payments. Were this Court to conclude in this case that the states are not required to reimburse MCOs for the HIPF, MHPA's position would likely be that the Internal Revenue Service should not calculate HIPF liability based on Medicaid or CHIP capitation rates.

II. The Actuarial Soundness Principle Preserves a Well-Functioning Medicaid Managed Care System for the Benefit of Beneficiaries, Health Plans, Healthcare Providers and the States Themselves

Medicaid is the joint state-federal medical assistance program for low-income individuals, established under title XIX of the Social Security Act, 42 U.S.C. § 1396-1 *et seq*. Section 1932 of the Social Security Act, 42 U.S.C. § 1396u–2, gives states the flexibility to contract with private MCOs to arrange for some or all of beneficiaries' vital medical and long-term care benefits. These MCOs accept a contractually agreed pre-arranged capitation (per beneficiary) payment from the state, and in exchange pay for those beneficiaries' covered health care benefits. *Id*. States contract with MCOs for many reasons including coordinating and managing Medicaid beneficiaries' care, improving quality, beneficiary satisfaction and outcomes, increasing the predictability of the state's costs, and lowering costs in comparison to traditional state-administered "fee-for-service" Medicaid delivery models. ROA.165. *See also* Medicaid & CHIP Payment and Access Comm'n, Managed Care, https://www.macpac.gov/topics/managed-care/ (last accessed 11/24/19).

States are increasingly administering their Medicaid programs through the managed care option, and Medicaid managed care has become the predominant form of benefit administration under title XIX. In 2017, over 55 million individuals, comprising two-thirds of all

Medicaid beneficiaries, received some or all of their benefits through MCOs, rather than directly from state agencies. CMS, MEDICAID MANAGED CARE ENROLLMENT AND PROGRAM CHARACTERISTICS 11 (2017), *available at* https://www.medicaid.gov/medicaid/managed-care/downloads/enrollment/2017-medicaid-managed-care-enrollment-report.pdf.

The Social Security Act requires that when a state pays MCOs on a prepaid capitated basis, or otherwise places a private plan at risk for the costs of those services, the state must pay the plan pursuant to a written contract, "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" in excess of $1 million. § 1903(m)(2)(A)(iii), 42 U.S.C. § 1396b(m)(2)(A)(iii). As a joint state-federal program, a majority of state Medicaid funding is reimbursed from the federal treasury; the particular "federal medical assistance percentage" is set by statutory formulae, and may vary by state and by population served. §§ 1903(a)(1), 1905(b), 42 U.S.C. §§ 1396b(a)(1), 1396d(b). Section 1903(m)(2)(A)(iii) conditions federal financial participation in the state's capitation payment to MCOs on those rates being actuarially sound.

CMS has interpreted this requirement through notice-and-comment rulemaking, and defines actuarially sound rates as those "projected to provide for all reasonable, appropriate, and attainable

costs that are required under the terms of the contract and for the operation of the [MCO] for the time period and the population covered under the terms of the contract," and developed in accordance with CMS requirements. 42 C.F.R. § 438.4(a) (2018). Among these is a requirement that the rates be developed in accordance with "generally accepted actuarial principles and practices," and account for "reasonable, appropriate, and attainable expenses related to [MCO] administration, taxes, licensing and regulatory fees." *Id.* §§ 438.4(b)(1), 438.5(e).[5] The rates, when submitted by the state to CMS for approval, must be certified as meeting the applicable requirements by an actuary "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." *Id.* §§ 438.2, 438.4(b)(6).

The actuarial soundness requirement constitutes the foundation of a secure and stable Medicaid managed care program, protecting beneficiaries, states, providers, and MCOs alike. *See* Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid

[5] The Medicaid managed care regulations were amended and recodified in 2016 and these provisions were added at that time. Medicaid and Children's Health Insurance Program (CHIP) Programs; Medicaid Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27858 (May 6, 2016). There is no indication that the reference to capitation rates being designed to reimburse taxes, regulatory fees, and other operational expenses reflected a new federal policy or anything other than an expression of what professional actuaries have always expected "actuarially sound" rates to include. *See, e.g.*, *id.* at 27572-73, 27576.

Managed Care, CHIP Delivered in Managed Care, and Revisions Related to Third Party Liability, 81 Fed. Reg. 27498, 27564 (May 6, 2016).

Medicaid beneficiaries that enroll in managed care are the first and most important beneficiaries of the actuarial soundness requirement. An actuarially sound MCO capitation rate protects beneficiaries and ensures access to quality care. Once Medicaid beneficiaries select or are assigned to an MCO, the beneficiary must look to the MCO, and not to the state, for payment to providers for covered benefits. 42 C.F.R. § 438.60 (2018). An MCO paid on an actuarially sound basis will have sufficient funds to pay for the covered services to which that beneficiary is entitled, and be able to provide the care coordination, case management, quality improvement and other services on which beneficiaries rely.

Moreover, when MCOs are funded on an actuarially sound basis, MCOs are able to select and build broad networks capable of meeting federally required network adequacy standards, 42 C.F.R. § 438.68, comprised of participating hospitals, physicians and other health professionals that have agreed to treat the MCO's enrollees in exchange for reasonable payments. Absent an actuarially sound rate, a state will not be able to meet its federally mandated requirement to develop and enforce network adequacy standards in its contracts with MCOs to the detriment of Medicaid beneficiaries. In this way, the network adequacy

requirement protects providers, as well, by assuring MCOs can pay them a reasonable rate to treat Medicaid beneficiaries.

The actuarially sound rate standard also protects the states themselves. When MCOs are funded on an actuarially sound basis, state Medicaid agencies have assurances that the MCOs with whom they contract will remain fiscally stable and be able to carry out their duties without disruption. 42 C.F.R. § 438.116. States paying MCOs at an actuarially sound rate need not worry about MCOs facing insolvency in the middle of a contract, leaving the state to untangle the MCO's obligations. The actuarial soundness requirement also establishes an upper bound on payment, and can protect the state from overpaying for services. *See* GAO, MEDICAID MANAGED CARE: CMS'S OVERSIGHT OF STATES' RATE SETTING NEEDS IMPROVEMENT (2005).

MCOs, too, are protected by the actuarially sound rate requirement. In most cases, MCOs do not negotiate their capitation rates with the state. Instead, rates are set by states, and approved by CMS. While MCOs may provide data to states to inform the rate-setting process, the actuarial soundness requirement provides a benchmark against which CMS judges the adequacy of state-proposed rates, and serves as an important procedural protection for MCOs, which have less direct involvement in setting capitation rates they are paid than insurers typically do in setting premium rates.

Without the protection of an actuarially sound rate, MCOs cannot sustainably deliver Medicaid managed care services and meet their contractual obligations. When developing capitation rates, states typically make an allowance for a risk and profit margin of 0.5% to 2%, before income tax. Society of Actuaries, MEDICAID MANAGED CARE ORGANIZATIONS: CONSIDERATIONS FOR CALCULATING MARGIN IN RATE SETTING 5 (2017), *available at* https://www.soa.org/globalassets/assets/Files/Research/medicaid-managed-report.pdf. Reflecting these narrow tolerances, more than one-third of all MCOs reported underwriting losses in 2018 and the average profit before income taxes was just 0.6% across the industry. Milliman, MEDICAID MANAGED CARE FINANCIAL RESULTS FOR 2018, at 4 (2019), *available at* https://assets.milliman.com/ektron/Medicaid_managed_care_financial_results_for_2018.pdf. While the precise financial impact of the HIPF varies from year to year, it represents around two percentage points of revenue across the Medicaid managed care industry.[6] Were the states to stop reimbursing for an expense of this magnitude, it would easily

[6] For example, for the 2018 tax year, $14.3 billion in HIPF was paid nationwide, distributed in proportion to applicable net premiums written of covered entities. *See* Affordable Care Act § 9010(b), (e)(1). Approximately $746 billion in applicable net premiums were written by covered entities, Chris Carlson et al., Oliver Wyman, ANALYSIS OF THE IMPACTS OF THE ACA'S TAX ON HEALTH INSURANCE IN YEAR 2020 AND LATER 7 (2018), *available at* https://health.oliverwyman.com/content/dam/oliver-wyman/blog/hls/featured-images/August18/Insurer-Fees-Report-2018.pdf. Thus, Medicaid MCOs, and other covered entities, paid a HIPF of approximately two percent of net premiums written.

erase the industry's slim profit margin, driving down MCO participation in Medicaid managed care.

In response to this persistent unprofitability, MCOs could be forced to shutter operations. This would lead to disruption in services to beneficiaries who are among the most vulnerable populations and interruption in payments to providers, undermining the viability of the state's Medicaid program. and imposing additional costs on taxpayers. But the option to shutter may not be appropriate for local and community-based MCOs, including non-profits, whose corporate charter or mission might oblige them to continue serving their Medicaid populations, even in the face of unfavorable capitation rates. These MCOs, lacking flexibility to exit, would be especially at risk for insolvency or diversion of assets from other community priorities were states to stop paying in a manner that provided for all reasonable costs.

Finally, it is not sufficient that an MCO be paid, in the abstract, at a rate designed to cover reasonably anticipated costs: the CMS regulatory definition of actuarial soundness confirms that actuarial soundness is a meaningful standard that serves these purposes only if a certifying actuary is relying on the professional standards of the actuarial profession. Anticipating future claims and administrative expenses of a health insurer is a difficult proposition for the most experienced actuaries, but is near impossible for laypersons to carry out with any confidence of accuracy. By relying on the standards of

actuaries, a profession with over 100 years of scientific experience in mathematical claims projection, beneficiaries, healthcare providers, states, CMS and the MCOs can all have high confidence that rates developed to be actuarially sound will cover anticipated costs, and keep the Medicaid program functioning smoothly.

III. The Plaintiff States Concede Their Alleged Injury Is Caused By Statute, Not the Regulation, so Their Claims Challenging the Regulation Are Not, and Have Never Been, Justiciable

The district court set aside key elements of the actuarial soundness regulation because it contended that doing so would free the Plaintiff States from an obligation to reimburse MCOs for the HIPF they pay.[7] *See*, *e.g.*, ROA.3982-83. However, the Plaintiff States have now conceded that they are reimbursing the HIPF not because of the actuarial soundness regulation, but because the Plaintiff States' own actuaries have concluded that the Plaintiff States would not satisfy the *statutory* actuarial soundness requirement if they did not reimburse the MCOs for the HIPF. *See*, *e.g.*, ROA.4440, 4462. Thus, the alleged injury of paying the HIPF is not traceable to the challenged regulation at all.

[7] Covered entities under section 9010 of the Affordable Care Act pay the HIPF in proportion to their "net premiums written" for health insurance in the preceding calendar year. The Internal Revenue Service has determined that capitation payments made by states to Medicaid MCOs are included in net premiums written. 26 C.F.R. § 57.2(b)(1)(iv); Health Insurance Providers Fee, 78 Fed. Reg. 71476, 71482 (Nov. 29, 2013) ("Coverage Funded by Targeted Government Programs").

Once the Plaintiff States made that concession, the district court should have dismissed the claims challenging the regulation, on the basis of the Plaintiff States' lack of standing, the mootness of their claims, or the fact that entering judgment on the regulation would amount to an advisory opinion. Because Article III jurisdiction is not waivable and must be considered at each stage of litigation, including on appeal, this Court should reverse the district court and enter judgment for the United States on these claims.

A. The Plaintiff States Have Conceded their Alleged Injury Is Not Traceable to the Actuarial Soundness Regulation

Counts II, III, and V of the First Amended Complaint each challenge the actuarial soundness regulation. ROA.166-69. While the district court granted summary judgment to the Plaintiff States only on Count V, it should have dismissed all three counts for lack of jurisdiction. In granting summary judgment on Count V, the district court set aside the definition of "Actuary" in 42 C.F.R. § 438.2 (2018) and the entirety of 42 C.F.R. § 438.4(b)(6) (2018). ROA.4676. These regulations require that any Medicaid capitation rates paid to MCOs be certified by an actuary who meets qualification standards of the American Academy of Actuaries and who agrees to adhere to Actuarial Standards of Practice established by the Actuarial Standards Board.

However, after prevailing on their motion for summary judgment, the Plaintiff States moved the district court for leave to file a second amended complaint because, in part, the Plaintiff States' own actuaries "have determined, in their professional judgment, that the HIPF must still be added to capitation rates for Medicaid and CHIP contracts to be actuarially sound." ROA.4440. The Plaintiff States elaborated in the proposed second amended complaint they attached to their motion for leave to amend:

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

ROA.4462. Having failed to persuade the district court to permit them to file an untimely second amended complaint, the Plaintiff States filed a new action in the same court in which they again conceded that, notwithstanding the invalidation of the actuarial soundness regulation, their own actuaries had concluded that the actuarial soundness statute requires the Plaintiff States to reimburse the MCOs for the HIPF. *Texas v. United States*, No. 4:18-cv-00779-O, Complaint, Doc. No. 1, at 7

(Sept. 20, 2018); *id.*, Memo. in Supp. of Temp. Rest. Ord. and Prelim. Inj., Doc. No. 8, at 4-5 (Sept. 21, 2018). It is undisputed in the record that even if the regulatory actuarial certification requirement were set aside, actuaries applying the *statutory* actuarial soundness requirement would nonetheless conclude that the Plaintiff States must reimburse MCOs for the HIPF the MCOs pay.[8]

B. If the Court Considers the Question De Novo, It Should Conclude the Statute Requires Reimbursement of the HIPF

While the Court should credit the Plaintiff States' factual concession, were the Court to consider *de novo* whether the actuarial soundness statute requires states to reimburse MCOs for the HIPF, it should conclude that the statute does do so. As the district court itself noted, actuarial soundness requires that the capitation rates paid to MCOs be "economically sustainable according to principles of actuarial science." ROA.4012. The plain meaning of the term "actuarially sound" at the time of the statute's adoption in the Omnibus Budget Reconciliation Act of 1981, Pub. L. No. 97-35, § 2178(a)(2)(D), 95 Stat. 357, 814 (1981) (codified at Social Security Act § 1903(m)(2)(A)(iii)), is unambiguous. As applied to financial transactions, "sound" means

[8] There is no basis to conclude that the Plaintiff States' concession is limited to the 2018 HIPF. The same principles and same facts will recur in any year in which the MCOs are liable for the HIPF. Congress suspended the collection of the HIPF for 2019. *See* Pub. L. No. 115-120, § 4003, 132 Stat. 28, 38 (2018).

"safe and secure financially," and "actuarial" means "calculated by actuaries"—persons whose "work is to calculate statistically risks, premiums, etc. for insurance." WEBSTER'S NEW WORLD DICT. (2d College ed. 1986).

An "actuarially sound" amount is one that is projected to be safe and secure financially as calculated by actuaries using statistical methods. Congress has used the term "actuarially sound" to describe, for example, the need to statistically balance the premiums with expected payments of benefits for Medicare Supplementary Medical Insurance (Medicare Part B): "The actuarial soundness" of this system depends "upon the 'short-term' premium rates being adequate to meet, on an accrual basis, the benefit payments and administrative expenses over the period for which they are established (including the accumulation and maintenance of a contingency fund)." S. REP. 90-744 (1967), *reprinted in* 1967 U.S.C.C.A.N. 2834, 2960.

Whether actuarial soundness is defined as the financial stability of an insurance product as defined by actuaries, or in a more general sense of balancing income and expenses, the statute requires the states reimburse MCOs for the HIPF they pay. No party disputes that actuarial principles, as reflected in both ASOP 49 and the conclusions of the Plaintiff States' own actuaries, require that the states reimburse the MCOs for this substantial cost associated with these contracts, lest the MCOs' expenses and income fall out of balance, leading to the

financial collapse of Medicaid MCOs and substantial disruption to state Medicaid programs where managed care is now the primary mode of health care delivery.

As discussed *supra* Part II, MCO liability for the HIPF represents approximately two percent of revenue to the MCO industry, which can have expected profit margins as low as 0.5% of revenue. No definition of actuarial soundness can permit states to fail to reimburse an expense of this magnitude, which would persistently threaten the financial solvency of MCOs.

C. Because the Statute Requires the Plaintiff States to Reimburse the HIPF, their Claims Challenging the Regulation are Not Justiciable

The Plaintiff States' claims that elements of the actuarial soundness regulation are unlawful does not constitute a justiciable case or controversy under Article III of the Constitution because the actuarial soundness statute already *requires* the Plaintiff States to reimburse MCOs for the HIPF. The Plaintiff States therefore lack standing to bring such claims, which are also moot, and tantamount to asking the court to render an improper advisory opinion.

Because federal courts "lack[] the power to render advisory opinions," *U.S. Nat'l Bank of Ore. v. Indep. Ins. Agents of Am., Inc.*, 508 U.S. 439, 446 (1993), they may not exercise jurisdiction over a civil case unless the plaintiff establishes standing to sue by showing a concrete

injury that is both "fairly traceable" to the defendant's "challenged action" and likely to be "redressed by a favorable decision," *Lujan v. Defs. of Wildlife*, 504 U.S. 555, 561–61 (1992) (internal quotation marks and alterations omitted); *see* U.S. Const. art. III, § 2, cl. 1. "No matter how vehemently the parties continue to dispute the lawfulness of the conduct that precipitated the lawsuit, the case is moot if the dispute 'is no longer embedded in any actual controversy about the plaintiffs' particular legal rights." *Yarls v. Bunton*, 905 F.3d 905, 909 (5th Cir. 2018). A challenge to Article III standing may be raised at any time in litigation, including for the first time on appeal. *Kontrick v. Ryan*, 540 U.S. 443, 455 (2004).

In this case, the Plaintiff States' alleged injury of being required to reimburse MCOs for the HIPF is not now—nor ever has been—fairly traceable to the challenged regulation: "[T]here must be a causal connection between the injury and the conduct complained of—the injury has to be 'fairly … trace[able] to the challenged action of the defendant, and not … th[e] result [of] the independent action of some third party not before the court.' *Simon v. Eastern Ky. Welfare Rights Organization*, 426 U.S. 26, 41-42 (1976)." *Lujan*, 504 U.S. at 560.

Here, the Plaintiff States' obligation to reimburse the MCOs is mandated by Congress's decision to impose a statutory actuarial soundness requirement, 42 U.S.C. § 1396b(m)(2)(A)(iii), as acknowledged by the Plaintiff States' own actuaries who have counseled

that the capitation rates paid to MCOs must include reimbursement for the HIPF. Consequently, the Plaintiff States lack Article III standing due to the lack of a justiciable controversy. Moreover, the Plaintiff States' claims have been mooted by their own determination that they are required to pay the HIPF even assuming the regulation were invalid. Proceeding otherwise would effectively cause the Court to render an improper advisory opinion.

Finally, the district court's order that the Internal Revenue Service disgorge funds to the Plaintiff States does not render their claims justiciable. Even assuming *arguendo* that disgorgement could be seen as somehow remedying an allegedly unlawful regulation, the fact remains that the regulation itself did not cause the Plaintiff States' alleged injury. *See Allen v. Wright*, 468 U.S. 737, 753 n.19 (1984) (traceability "examines the causal connection between the assertedly unlawful conduct and the alleged injury" whereas redressability "examines the causal connection between the alleged injury and the judicial relief requested . . . . [I]t is important to keep the inquiries separate . . . . Even if the relief respondents request might have a substantial effect on [remedying the alleged injury], whatever [injuries exist] might not be traceable to . . . violations of law").[9]

[9] Apart from claims that challenge the certification portion of the actuarial soundness regulation, MHPA takes no position on whether the Plaintiff States have other justiciable claims that could entitle them to disgorgement. *See Allen*, 468 U.S. at 752 ("[T]he standing inquiry requires careful judicial

IV. No Unlawful Delegation to the Actuarial Standards Board Occurred Because Statute, Not the Board's Decision, Requires States to Reimburse MCOs for the HIPF

The Court should not consider whether elements of the actuarial soundness regulation are unlawful because it lacks jurisdiction to do so, *see supra* Part III. To the extent the Court does consider this question, presented in Count V of the First Amended Complaint, MHPA agrees with the United States' argument on this point.[10]

MHPA especially notes that, whatever the merits of Plaintiff States' nondelegation argument as a general matter, no delegation has occurred in this case because neither Congress nor a federal agency has delegated to the Actuarial Standards Board the decision of whether or not the states are required to build federal taxes, including the HIPF, into capitation rates. The statute, 42 U.S.C. § 1396b(m)(2)(A)(iii), requires that capitation rates be actuarially sound. The Plaintiff States concede that the statute, notwithstanding any action by the Actuarial Standards Board, requires states to reimburse MCOs for the HIPF. There has been no unlawful delegation to the Actuarial Standards

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examination of a complaint's allegations to ascertain whether the particular plaintiff is entitled to an adjudication of the *particular claims* asserted" (emphasis added)).

[10] Should the Court reach the merits of Counts II or III of the First Amended Complaint, MHPA concurs in the district court's judgment, and underlying rationale, to grant summary judgment to the Defendants on these counts, also challenging the certification portion of the actuarial soundness regulation. ROA.4014-15.

Board, because the statute already requires states to reimburse MCOs for the HIPF.

V. Conclusion

The district court should be reversed in part and judgment should be granted to the United States with respect to Counts II, III, and V of the First Amended Complaint.

Dated: November 27, 2019

Respectfully submitted,
MANATT, PHELPS & PHILLIPS, LLP
By: *s/Benjamin G. Shatz*
Counsel for *Amicus Curiae*
Medicaid Health Plans of America

CERTIFICATE OF COMPLIANCE

This brief complies with the type-volume limitation of Fed. R. App. P. 32(a)(7)(B) because this brief contains **4,756** words (within the 6,500 words allowed), excluding parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii).

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the typestyle requirements of Fed. R. App. P. 32(a)(6) because this brief has been prepared in a 14-point proportionally spaced Century Schoolbook typeface using Microsoft Word 2010.

Dated: November 27, 2019

Respectfully submitted,
MANATT, PHELPS & PHILLIPS, LLP
By: *s/Benjamin G. Shatz*

CERTIFICATE OF SERVICE

I hereby certify that I electronically filed the foregoing document with the Clerk of the Court for the United States Court of Appeals for the Fifth Circuit by using the appellate CM/ECF system. I certify that all participants in the case are registered CM/ECF users and that service will be accomplished by the appellate CM/ECF system.

Dated: November 27, 2019

Respectfully submitted,
MANATT, PHELPS & PHILLIPS, LLP
By: *s/Benjamin G. Shatz*

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