IN THE UNITED STATES COURT OF FEDERAL CLAIMS

DOUG OMMEN, *in his capacity as Liquidator of CoOportunity Health, Inc.*, and DAN WATKINS, *in his capacity as Special Deputy Liquidator of CoOportunity Health, Inc.*,	)	**No. 17-957 C**
Plaintiffs,	)	
v.	)	
THE UNITED STATES OF AMERICA,	)	
Defendant.	)	

FIRST AMENDED COMPLAINT

As a part of the Affordable Care Act ("ACA"), the federal government[1] funded a start-up insurance company called CoOportunity Health, Inc. ("CoOportunity"). CoOportunity operated in Nebraska and Iowa for just over one year, during which its enrollment and claims costs soared. On December 16, 2014, the Iowa Insurance Commissioner put the company in supervision. On December 23, 2014, the company was put in rehabilitation. Effective February 28, 2015, the Iowa court overseeing the company's rehabilitation declared it insolvent and issued an order of liquidation pursuant to the Iowa Insurers Liquidation Act. Since then, the Government has refused to pay CoOportunity funds owed, including $157 million under just one ACA program. It also wrongfully held and set off over $15 million the company would have received under the Government's interpretation of that same ACA program. The Government held and diverted $30 million of CoOportunity funds to other ACA insurers under another ACA program by applying an arbitrary and capricious regulation. Plaintiffs bring this lawsuit for a

[1] The U.S. Department of Health and Human Services ("HHS") and its subsidiary agency, the Centers for Medicare & Medicaid Services ("CMS"), are agencies of Defendant, the United States of America. The United States of America, HHS, and CMS are collectively referred to as the "Government."

money judgment on all amounts owed to CoOportunity under the ACA and other statutory and contract grounds, for the benefit of the creditors of the estate, including policyholders, that have been harmed by the Government's illegal conduct.

I. PARTIES

1. Plaintiff, Doug Ommen, is the current Iowa Insurance Commissioner ("Commissioner") appointed by the District Court of Polk County, Iowa, to serve as the liquidator ("Liquidator") of CoOportunity, in the matter captioned *In re CoOportunity Health*, Polk County District Court Case No. EQCE77579. Mr. Ommen brings this suit in his capacity as Liquidator of CoOportunity.

2. Plaintiff, Dan Watkins, brings this suit in his capacity as the court-appointed Special Deputy Liquidator of CoOportunity.

3. Defendant is the United States of America, including its agencies.

II. JURISDICTION AND VENUE

4. This Court has jurisdiction over this action, and venue is proper in this Court, pursuant to 28 U.S.C. § 1491(a)(1) (the Tucker Act), because Plaintiffs bring claims for damages over $10,000 against the United States, and these claims are founded upon the Government's violations of a money-mandating Act of Congress, a money-mandating regulation of an executive department, express or implied-in-fact contracts between the United States and CoOportunity, the wrongful withholding and setoff of funds due and owing to CoOportunity, and the application of an arbitrary and capricious regulation. The United States District Court for the Southern District of Iowa previously ruled that this Court has (and that the Southern District of Iowa lacked) subject-matter jurisdiction over the claims in this Complaint. *See Gerhart v. United States Dep't of Health & Human Servs.*, 242 F. Supp. 3d 806, 814-817 (S.D. Iowa 2017).

III. THE ACA AND THE CO-OP PROGRAM

5. As part of the ACA, Congress created the "Consumer Operated and Oriented Plan" ("CO-OP") program, to help establish non-profit insurance companies to diversify options in purchasing health insurance. Congress directed HHS to establish and administer the CO-OP program. The CO-OP program called for federally funded start-up and solvency loans to the CO-OPs.

6. In the ACA, Congress directed creation of new health insurance marketplaces, or exchanges, to offer consumers organized platforms to shop for coverage with specified benefit levels.

7. To offer plans on the exchange, the ACA required insurers certify their plans as "qualified health plans" ("QHPs") that met certain federally-mandated criteria.

8. Unlike other insurers that made a business decision to willingly offer QHPs, the CO-OPs were required to offer QHPs to individuals and small groups on the exchanges under the ACA and the loan agreements between the CO-OPs and the Government. 42 U.S.C. § 18042(a)(2).

9. CoOportunity was one of twenty-three CO-OPs created under the ACA and was certified by the Government as a QHP to participate on the ACA exchanges.

10. In reliance on the Government's statutory, regulatory, and contractual obligations and inducements, CoOportunity applied for federal funding to operate as a CO-OP and, in early 2012, HHS/CMS approved CoOportunity's business plan and application to operate as a QHP, and authorized federal funding to CoOportunity to operate as a CO-OP as defined in 42 U.S.C. § 18042(a)(1)-(2).

11. CoOportunity was organized under Iowa law, and its home office was in Iowa, but it served the residents of both Iowa and Nebraska.

12. Although CoOportunity received funding and was subject to the federal CO-OP program, the company was established and operated as an Iowa company licensed by the states of Iowa and Nebraska to issue health insurance plans in those states.

13. The Government was the sole funder of CoOportunity with a "start-up loan" and a "solvency loan" totaling $145 million.

IV. THE "3R" PROGRAMS

14. As part of the ACA, Congress created programs to reduce the financial risk carriers faced with the launch of the ACA, particularly since under the ACA, a large group of previously uninsured Americans would obtain health coverage for the first time, and carriers were prohibited from denying or charging higher premiums based on preexisting conditions. These financial programs were especially critical for the start-up CO-OPs.

15. These programs are known as the "3Rs," standing for a three-year reinsurance program, a permanent risk adjustment program, and a three-year risk corridors program. The reinsurance and risk corridors programs operated only during the first three years of full implementation of the ACA, i.e., 2014 to 2016.

16. The 3Rs were proposed by the Government to incent insurers to offer quality, affordable plans on the Exchanges.

17. As explained by the Government, the "overall goal" of the three programs "is to provide certainty and protect against adverse selection in the market while stabilizing premiums in the individual and small group markets as market reforms and Exchange begin in 2014." CMS, Reinsurance, Risk Corridors, and Risk Adjustment Final Rule (Mar. 2012), available at https://www.cms.gov/cciio/resources/files/downloads/3rs-final-rule.pdf.

A. Risk Corridors

18. The risk corridors program was intended to level the playing field for issuers and to protect issuers from certain loss risks associated with the launch of the ACA.

19. Congress mandated that "[t]he Secretary shall establish and administer a program of risk corridors for calendar years 2014, 2015, and 2016 under which a qualified health plan offered in the individual or small group market shall participate in a payment adjustment system based on the ratio of the allowable costs of the plan to the plan's aggregate premiums." 42 U.S.C. § 18062(a).

20. The risk corridors program is designed to limit insurer gains and losses. Under the program, a participating plan either (1) must pay to the Secretary of HHS certain sums if the plan's costs are less than a "target amount" of premium revenues or (2) the "Secretary *shall* pay to the plan" certain sums if the plan's costs are greater than a certain percentage of the "target amount" of premium revenues. *Id.* § 18062(b) (emphasis added); *see also* 45 C.F.R. § 153.510 (setting out the formula by which the sums and target amounts are calculated).

21. The plain language of the ACA provision establishing the risk corridors program "created an obligation of the government to pay participants in the health benefit exchanges the full amount indicated by the statutory formula for payments out under the risk corridors program." *Moda Health Plan, Inc. v. United States*, 892 F.3d 1311, 1322 (Fed. Cir. 2018).

B. Reinsurance

22. The reinsurance program, like the risk corridors program, was only intended to exist for policy years 2014 to 2016.

23. The program provides certain payments to insurers that enroll high-risk individuals.

24. All insurers are required to make payments into the reinsurance fund. *See* 42 U.S.C. § 18061(b)(1).

25. If a specific member's costs for a given policy year exceeds a certain threshold, individual market issuers subject to the ACA's rules are eligible (up to a designated cap) for reimbursement of funds. *Id.* § 18061(b)(1)(B).

C. Risk Adjustment

26. Risk adjustment is the only permanent program of the 3Rs.

27. Using a governmental unit as conduit/intermediary administrator, this program transfers funds from "low actuarial risk plans" to "high actuarial risk plans" within the same state. *See id.* § 18063.

28. The ACA provided that the states could serve as the conduit/intermediary administrators for the risk adjustment program. But, because neither Iowa nor Nebraska elected to operate an exchange, under 45 C.F.R. § 153.310(a)(2), HHS was designated as the entity to administrate the risk adjustment activities on behalf of those states.

29. As such, HHS/CMS determined the actuarial risk each insurer carries for a given policy year. HHS/CMS then served as a conduit for the required payments, which are distributed to spread risk around the various markets in each state. *See* 42 U.S.C. § 18063; 45 C.F.R. § 153.310(a)(2).

30. Even though the ACA made no requirement that it do so, HHS/CMS decided to administer the risk adjustment program in a budget neutral manner because it erroneously concluded that the ACA so required. Accordingly, actual proceeds received from low actuarial risk plans were used to pay higher actuarial risk plans within the same market and state.

V. COOPORTUNITY'S CONTRACTS WITH THE GOVERNMENT

A. The Loan Agreement

31. On February 17, 2012, the Government and CoOportunity closed on a Loan Agreement a copy of which is included as Exhibit A.

32. The Loan Agreement defined the "Lender" as HHS/CMS (Loan Agreement, § 2.1, p. 5) and "Borrower" as CoOportunity. Loan Agreement, p. 1 and § 2.1, p. 3 (Exhibit A); Amendment to Loan Agreement (Exhibit B).[2]

33. The Loan Agreement contemplated two loans. The Loan Agreement defined the term "Loans" as "the Start-Up Loan and the Solvency Loan collectively…." Exhibit A, § 2.1, p. 5. The term "Start-Up Loan," in turn, was defined as the "Loan to Borrower for costs associated with establishing a CO-OP that is governed by this Agreement, and the particular requirements of Appendix 2 – Start-Up Loan Promissory Note." *Id.*§ 2.1, p. 7. The term "Solvency Loan" was defined as "the Loan provided to Borrower in order to meet State solvency and State Reserve Requirements that is governed by this Agreement, and the particular requirements of Appendix 3 – Solvency Loan Promissory Note." *Id.*

34. The Loan Agreement has a *pari passu* provision which provides that "[u]nder this Agreement, Lender is providing to Borrower funds for CO-OP Program purposes through two Loans, *each of which shall be on par with the other for security purposes*, and each of which shall be governed and controlled for all purposes by this Agreement, including its Appendices." *Id.* § 3.1 (emphasis added).

35. The Loan Agreement specified that "[t]he Loans are being provided by Lender to Borrower for the establishment of a CO-OP. The Loans are intended to permit Borrower to offer

[2] The original Loan Agreement identified the "Borrower" as "Midwest Members Health," but that name was changed to CoOportunity Health pursuant to the Amendment to Loan Agreement executed on or about July 23, 2012. *See* Exhibit B.

health plans primarily in the individual and small group markets as described in 45 CFR Part 156." *Id.* § 3.2.

36. As was the case with all CO-OP entities, CoOportunity was required under the terms of the Loan Agreement to offer QHPs. *Id.* §§ 3.2, 3.5, 5.3, 7.1.

37. The Start-Up Loan was $14,700,000 while the initial Solvency Loan was $97,912,100. *Id.* § 3.2. The Solvency Loan and Start-Up Loans were cross-defaulted and cross collateralized. *Id.* § 3.3.

38. There was no grant or pledge of any security interest or lien to secure the debt obligations under the Start-Up Loan and Solvency Loan. *Id.* § 3.4. Rather, the Loan Agreement provided:

> The Loans and other Obligations will be general obligations of Borrower. Because the intent of the Loans, and the Solvency Loan in particular, is to provide financing to Borrower that meets the definition of "risk based capital" for State Insurance Laws purposes, the Loans will have a claim on cash flow and reserves of Borrower that is subordinate to (a) claims payments, (b) Basic Operating Expenses, and (c) maintenance of required reserve funds while Borrower is operating as a CO-OP under State Insurance Laws.

Id.

39. Section 3.5 of the Loan Agreement set forth specific permitted uses of the loan funds while § 3.6 of the Loan Agreement set forth prohibited uses of loan funds.

1. Loan Agreement – Start-Up Loan Provisions

40. Section 4 of the Loan Agreement set forth base provisions regarding the Start-Up Loan.

41. The Promissory Note for the Start-Up Loan was set forth in Appendix 2 of the Loan Agreement. *See id.* at Appendix 2, pp. 47-50.

42. Unlike a traditional promissory note, which has a set principal amount and interest payment, the Promissory Note for the Start-Up Loan does not contain those standard terms and instead includes a Schedule A with "tbd" (to be determined). *Id.*, Appendix 2, p. 50.

43. Schedule A to the Start-Up Loan Promissory Note provides that "No interest or principal payments are due before 5 years from the disbursement for which they constitute an instance of repayment…. A single lump sum payment of principal and interest will be made at the end of 5 years from the date of a specific disbursement." *Id.* at Appendix 2, p. 50.

44. Use of the term "interest" in the Promissory Note to the Start-Up Loan is misleading because, in reality, interest for the Start-Up Loan was set at 0.0%. *Id.* § 4.3, and Appendix 6, p. 61.

45. The Loan Agreement had general language requiring the repayment of the Start-Up Loan. Section 4.4 provides that "Borrower shall make Principal and Interest payments as described in the Start-Up Loan Promissory Note attached hereto and incorporated herein by reference as Appendix 2…. *subject to Borrower's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note arrangements.*" *Id.* § 4.4 (emphasis added).

46. The Loan Agreement further provides:

> Unless Lender terminates this Agreement for cause under Section 16.3 below, Borrower shall be obligated to repay 100% of the Start-Up Loan Principal disbursed, plus any capitalized Interest to Lender in accordance with the Repayment Schedule for the Start-Up Loan, *subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangements.*

Id. (emphasis added).

47. The Loan Agreement is "governed by the laws and common law of the United States…*and by the laws of the States of Iowa and Nebraska to the extent the same do not conflict with applicable Federal law*." *Id.* at § 19.2 (emphasis added).

48. The Appendices to the Loan Agreement are integrated with the Loan Agreement itself. *Id.* § 19.4.

49. Despite being called a "Start-Up Loan," in reality the Start-Up Loan was, in reality, a preferred capital contribution to CoOportunity.

50. Beginning on February 28, 2012 and continuing through December 20, 2013, the Government made eight (8) separate disbursements to CoOportunity under the Start-Up Loan for a total, aggregate distribution amount of $14,700,000.

51. Under the terms of the Start-Up Loan, the first repayment only became due on February 28, 2017, the second became due on April 27, 2017 and the third repayment is not due until January 29, 2018. *Id.*

2. Loan Agreement – Solvency Loan Provisions

52. Section 5 of the Loan Agreement set forth base provisions governing the Solvency Loan.

53. Solvency Loan funds were to "only be used to establish Risk-Based Capital Reserves to be held by Borrower and other capital reserves necessary to meet State Reserve Requirements and other State Insurance Laws…." Exhibit A, § 5.1.

54. A key characteristic of the Solvency Loan was that it was to be "structured so as to comply with applicable State Insurance Laws and the terms of Appendix 3." *Id.* § 5.2.

55. The Promissory Note for the Solvency Loan was originally set forth in Appendix 4 of the Loan Agreement. *Id.* at 55-57. However, it was subsequently revised pursuant to an Amendment to Loan Agreement, which was executed on or about June 24, 2014. *See* Exhibit C.

56. Both CoOportunity and the Government acknowledged that the June 24, 2014 Amendment to Loan Agreement was "necessary to advance the Parties' mutual interest that the Iowa Insurance Commissioner acknowledge the promissory note contained in Appendix 4 of the Agreement as a surplus note within the meaning of Statement of Statutory Accounting Principles (SSAP) No. 41, and thus accept the proceeds of the Solvency Loan provided through the Agreement *as an asset* for regulatory purposes, consistent with the original intentions of the Parties." Exhibit C, p. 1 (emphasis added). Although dated June 24, 2014, the Promissory Note to the Amendment to Loan Agreement was deemed to be effective on March 8, 2013. *Id.* at 2 and 6.

57. The amended Solvency Loan Promissory Note expressly provided that the Iowa Insurance Commissioner had "complete discretion to approve or refuse to approve a payment, repayment, discharge or retirement" of the Promissory Note. *Id.* at 5, ¶ 1.

58. It further provided:

> The rights of the holder hereof to payment of interest and Principal are and shall remain subject and subordinate to the claims of all policyholders and of all contract creditors and all other obligations of Borrower, and, *in the event of any insolvency proceedings, dissolution, or liquidation of Borrower, no payment of interest or principal shall be due or payable upon this Promissory Note until the just claims of all claimants under policies of insurance issued by Borrower and all contract creditors of Borrower have been paid in full*.

Id. at 5, ¶ 3 (emphasis added).

59. The Amendment to Loan Agreement also expressly provided that the Solvency Loan was non-recourse and was "expressly understood that this Promissory Note is solely a corporate obligation of Borrower." Amendment to Loan Agreement, p. 6. It further provided that "[t]he obligation of Borrower under this Promissory Note may not be offset or be subject to recoupment with respect to any liability or obligation owed to Borrower." *Id.* at 6.

60. Unlike a traditional promissory note, which has a set principal amount and interest payment, the Promissory Note for the Solvency Loan does not contain those standard terms and instead has a Schedule A with "tbd" (to be determined). *Id.* at7.

61. Interest on the Solvency Loan was set at .37%. Exhibit A, Appendix 6, p. 61.

62. Under the terms of the Solvency Loan, interest on disbursements made prior to 2018 would begin to run in 2019 and would end 7 years following the date of disbursement. Exhibit C, p. 7. Stated differently, monies received pursuant to the 2012 Solvency Loan would not begin to accrue interest until 2019 and the rate of accrual was just .37%.

63. Repayment obligations for the Solvency Loan were similar to that of the Start-Up Loan: "Borrower shall make Principal and Interest payments as described in Schedule A of the Solvency Loan Promissory Note….*subject to Borrower's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note arrangements*." Exhibit A, § 5.6 (emphasis added).

64. Section 5.6 of the Loan Agreement further provided:

> Unless Lender terminates this Agreement for cause under Section 16.3 below, Borrower shall be obligated to repay 100% of the Solvency Loan amount disbursed, plus any capitalized Interest to Borrower in accordance with the Repayment Schedule for the Solvency Loan, *subject to its ability to meet State Reserve Requirements and other solvency regulations, or requisite surplus note arrangement*s.

Id. (emphasis added).

65. Finally, the Amendment to Loan Agreement further provided on Schedule A to the Promissory Note that "[n]o payment of principal and/or interest shall be made without authorization and approval by the Insurance Commissioner of the state of domicile. In accordance with Statutory Accounting Principles, interest expense will not be recorded in the Borrower's financial statements prior to such approval." Exhibit C, p. 7.

66. Despite being called a Solvency Loan, in reality the "Solvency Loan" was, in reality, a preferred capital contribution to CoOportunity.

67. CoOportunity received the Start-up Loan and Solvency Loan from the Government pursuant to 42 U.S.C. § 18042(b)(1) and the Loan Agreement.

B. The QHP Agreement

68. As part of CoOportunity's entry into the ACA marketplace, CoOportunity and CMS also entered into a "QHP Agreement."

69. CoOportunity executed its QHP Agreements in September 2013. *See, e.g.*, Exhibit E, *QHP Agreement (Iowa)*, CMS & CoOportunity (Sept. 23, 2013). The QHP Agreement was executed by representatives of the Government who had actual authority to bind the United States, and was entered into with mutual assent and consideration by both parties.

70. The QHP Agreement obligated CMS to "undertake all reasonable efforts to implement systems and processes that will support [QHP] functions." *Id.* at 5. It further provided that CMS could amend the agreement to reflect changes in applicable law or regulations, but any such amendments would be prospective only, not retrospective, and CMS was required to give notice of such amendment, so that CoOportunity would have the opportunity to reject it. *Id.* at 7.

71. However, CMS provided no such notice of amendment under the QHP Agreement at any time.

72. Before CoOportunity executed the QHP Agreement, CoOportunity executed an attestation certifying its compliance with the obligations it was undertaking by agreeing to become a QHP on the ACA exchange in Iowa and Nebraska.

73. By executing and submitting this attestation to CMS, CoOportunity agreed to the many obligations and responsibilities imposed upon all QHPs that accept the Government's offer

to participate in the ACA exchanges. Those obligations and responsibilities that CoOportunity undertook include, *inter alia*, licensing, reporting requirements, employment restrictions, marketing parameters, HHS oversight of the QHP's compliance plan, maintenance of an internal grievance process, benefit design standards, cost-sharing limits, rate requirements, enrollment parameters, premium payment process requirements, participating in financial management programs established under the ACA (including the risk corridors and risk adjustment programs), adhering to data standards, and establishing dedicated and secure server environments and data security procedures.

74. CoOportunity affirmatively attested that it would agree to comply with certain "Financial Management" obligations, including, among others:

> (1) CoOportunity attests that it will . . . be bound by Federal statutes and requirements that govern Federal funds. Federal funds include . . . Federal payments related to the risk adjustment, reinsurance, and risk corridors programs.
>
> (2) CoOportunity attests that it will adhere to the risk corridors standards and requirements set by HHS as applicable for:
>
> (a) risk corridors data standards and annual HHS notice of benefit and payment parameters for the calendar years 2014, 2015, and 2016 (45 C.F.R. 153.510); and
>
> remit charges to HHS under the circumstances described in 45 C.F.R. 153.510.
>
> (3) CoOportunity attests that it will:
>
> (a) adhere to the risk adjustment standards and requirements set by HHS in the annual HHS notice of benefit and payment parameters (45 CFR Subparts G and H); and
>
> (b) remit charges to HHS under the circumstances described in 45 C.F.R. 153.610.

Martin E. Hickey, *Qualified Health Plan Program Attestations* (Apr. 25, 2013), at 5.

VI. THE GOVERNMENT AGREED THAT AFTER OPERATING FOR ONE YEAR, COOPORTUNITY WAS INSOLVENT AND SUBJECT TO STATE LIQUIDATION LAW, BUT THE GOVERNMENT VIOLATED THE IOWA COURT'S ORDER PROTECTING HIGHER PRIORITY CREDITORS.

75. CoOportunity first offered health insurance to individuals and groups during the "open enrollment" period beginning on October 1, 2013, for health insurance coverage effective January 1, 2014.

76. During 2014, the company experienced serious and sustained financial distress.

77. On or about September 25, 2014, CoOportunity and the Government entered into a Third Amendment to Loan Agreement (Exhibit D) wherein the "loan" amount was increased from $97,912,100 to $130,612,000.

78. Despite the infusion of more than $32 million, CoOportunity continued to struggle.

79. In December 2014, CMS rejected a second request for additional funding.

80. The same day, then Iowa Insurance Commissioner Nick Gerhart placed CoOportunity under supervision due to its hazardous financial condition as defined by Iowa Code § 507C.9 and Iowa Admin. Code §§ 191-110.1-.8.

81. CoOportunity was subsequently placed in rehabilitation, then into liquidation. The liquidation is currently pending before the Polk County District Court in Iowa.

82. The Polk County District Court has jurisdiction over the CoOportunity liquidation.

83. Effective February 28, 2015, the Polk County District Court entered its Final Order of Liquidation ("Liquidation Order") for CoOportunity. *See* Exhibit F. CoOportunity and state officials provided notice of the Liquidation Order to the Government.

84. The Liquidation Order expressly prohibits any "creditors [or]…other entities (including…federal government entities)…[from u]sing any self-help remedy (including, but not limited to, setting-off monies owed)…." *Id.* at 19-20.

85. On February 13, 2015, the Government issued a Notice of Termination of the CMS Loan Agreement ("Notice of Termination") wherein the Government stated it "has no option but to conclude that CoOportunity is insolvent, and therefore within default consistent with Section 15.1(d) of the [L]oan [A]greement. Therefore, HHS/CMS will terminate the [L]oan [A]greement."

86. In its Notice of Termination, the Government declared: "We of course realize that the debts in question are otherwise subject to disposition under relevant provisions of Iowa law concerning liquidation proceedings."

87. The Iowa insurance liquidation code prohibits set-off of non-mutual debts. Iowa Code § 507C.30.1.

88. The Iowa liquidation code also prohibits setoff of any obligation which "is in any other way in the nature of a capital contribution." Iowa Code § 507C.30.2(5).

89. Under Iowa law, the Government's claims against the CoOportunity estate are subordinate to administrative and policyholder priority claims.

90. Pursuant to the provisions of the Loan Agreement and amendments thereto, the Government is bound by applicable Iowa law as it relates to the liquidation of the CoOportunity estate. *See* Exhibit A, § 19.2.

91. Under the federal McCarran-Ferguson Act, in the absence of a directly contradictory federal law, state law regarding the business of insurance preempts any less specific and generally applicable federal statutes or regulations.

92. The ACA was not a wholesale regulation of the "business of insurance" so broad that it wiped out the extensive and long-standing system of state regulation of insurance.

93. The ACA does not contain provisions dealing with insolvent insurance carriers, meaning the extensive, long-standing state system of insurer supervision, rehabilitation, and liquidation continues to control and "reverse preempts" any federal laws of general application.

94. The ACA did not provide the Government with any unique or preemptive rights with respect to insolvent insurance carriers that are placed into liquidation in their respective domiciles.

95. The absence of any provisions in the ACA dealing with insurer insolvency (including the Government's rights in relation to an insolvent insurer) shows Congressional intent for state laws to continue to regulate insurer supervision, rehabilitation, and liquidation.

96. In addition, Congress expressly directed that state insurance laws continue to apply. The ACA includes an express provision, under a clause titled "No interference with State regulatory authority," which states: "Nothing in this title shall be construed to preempt any State law that does not prevent the application of the provisions of this title." 42 U.S.C. § 18041(d).

97. Congress directed the Secretary of HHS to promulgate regulations "with respect to the repayment of [loans to CO-OPs] *in a manner that is consistent with State solvency regulations and other similar State laws* that may apply." 42 U.S.C. § 18042(b)(3) (emphasis added).

98. The ACA provided that "[i]n promulgating such regulations, the Secretary shall provide that such loans shall be repaid within 5 years and such grants shall be repaid within 15 years, *taking into consideration any appropriate State reserve requirements, solvency*

regulations, and requisite surplus note arrangements that must be constructed in a State to provide for such repayment prior to awarding such loans and grants." *Id.* (emphasis added).

99. In July 2011, CMS published proposed regulations implementing the ACA and noted that insurer liquidation is typically handled under state law rather than federal law, stating as follows:

> State law establishes a variety of required regulatory actions if an insurer's RBC [risk based capital] falls below established levels or percent of RBC. *These regulatory interventions can range from a corrective action plan to liquidation of the insurer if it is insolvent. Solvency and the financial health of insurers is historically a State-regulated function.*[3]

100. There were several comments submitted in response to proposed regulations regarding plans to avert insolvency,[4] and the Government responded by noting that "*[i]n the potential case of insurer financial distress, a CO-OP follows the same process as traditional issuers and must comply with all applicable State laws and regulations*."[5]

101. In the final regulation, the Government addressed the comments only by including ways to "reduc[e] the risk of insolvency."[6] The Government stated that "[m]ost of those who have expressed interest in the program are…likely to be viable because of their private support, healthcare experience, and business expertise."[7]

102. Because of the McCarran-Ferguson Act, Iowa state law regarding insurance insolvency proceedings reverse preempts and takes priority over federal statutes of general application, including 31 U.S.C. §§ 3711-3720e (i.e., the general statutory provisions regarding

[3] Proposed Rules, 45 C.F.R. Part 156, 76 FR 43237-01, July 20, 2011 (emphasis added).
[4] *See* Final Rules, Responses and Comments, 45 C.F.R. 156, E.6 and F Dec. 13, 2011.
[5] *Id.*
[6] *Id.* at Section F, "Alternatives Considered."
[7] *Id.*

collection of monies owed to the Government) with respect to the Government's efforts to recover monies owed to it by an insolvent insurer.

103. Provisions promulgated by HHS/CMS in the C.F.R. are not an "Act of Congress" that supersede or displace the states' authority to regulate the "business of insurance" for purposes of the McCarran-Ferguson Act.

104. Throughout 2015, CoOportunity continued to fulfill all its obligations under the QHP and the Loan Agreements by, among other things, providing all required information to HHS and making reinsurance and other payments.

105. Despite being subject to Iowa insurance insolvency law and being fully aware of both the Liquidation Order and the terms of the Loan Agreement, the Government deliberately violated Iowa insurance insolvency law, the terms of the Loan Agreement and the Liquidation Order by engaging in the following unilateral self-help conduct, among others:

a. In August of 2015, CoOportunity was supposed to receive a reinsurance payment of $71.7 million under the ACA for the 2014 plan year, but the Government reduced that by $5.2 million for a reconciliation reserve and budget sequestration, as the Government did for other carriers. In addition, the Government reduced the reinsurance payment by $11.6 million because the Government contended CoOportunity owed $10 million[8] under the risk adjustment program and $1.6 million under other ACA programs.

[8] The Government assessed CoOportunity risk adjustment charges of $3,442,183.75 (Iowa Small Group), $3,258,008.03 (Nebraska Individual), and $3,208,840.42 (Nebraska Small Group). The Government owed CoOportunity $7,585,020.87 under risk adjustment for the Iowa Individual Market, of which 90% was paid and 10% was withheld due to sequestration.

b. In late 2015, the Department of Justice verbally notified CoOportunity that the Government had placed a "hold" on any funds owed by the Government to CoOportunity, which included $16.4 million that the Government determined it *could* pay for 2014 risk corridors (of the $130 million owed); $5.2 million owed for 2014 reinsurance; $700,000 owed for risk adjustment for 2014[9]; and all 2015 3R payments.

c. Around the same time, the Government requested and received an extension to file its proof of claim in CoOportunity's Liquidation proceeding. When it did file its proof of claim in March 2016, it included a statement that it had used set off to collect $14.7 million against CoOportunity's start-up loan.

d. In August 2016, CoOportunity received notice that the $5.2 million the Government held from the reinsurance payment owed to CoOportunity for the 2014 policy year (for a reconciliation reserve and sequestration) had been set off and used to pay other claimed CoOportunity debts.

e. The Government announced in a letter on March 22, 2016, that: "[t]his letter is to inform you that [the Government] has recovered funds from CoOportunity sufficient to repay the outstanding amount of the Start-up Loan disbursed to CoOportunity Health under the terms of the CMS CO-OP Loan Agreement dated February 17, 2012. [The Government] recovered these funds by exercising its right of offset against payments due from CMS to CoOportunity Health." The Government did not specify

[9] This is the 10% previously withheld due to sequestration. *See supra* n.8.

> exactly how it had "recovered" the funds except to drop a footnote stating: "[s]uch payments may include amounts owed under the reinsurance program, the risk adjustment program, and/or the risk corridors program."

106. The only way the Government was able to effectuate this set-off was through the illegal and improper "administrative hold" on its payment of risk corridors monies that otherwise would have been paid out to CoOportunity *before* the $14.7 million could be paid under the Start-Up Loan because under its express terms, repayment of the Loan was subordinate to policyholder claims.

107. Over a period of several more months in 2015 and 2016, the Government set off funds owed to CoOportunity by the Government in this same manner. When payments from HHS/CMS to CoOportunity became due (such as the pro rata risk corridors payments), the Government would administratively "hold" these payments even though there was, at the time the hold was imposed, no corresponding payment owed by CoOportunity to HHS/CMS. When a payment from CoOportunity finally became due (or allegedly due) to the Government, the Government would then pay itself by setting off the funds subject to the illegal hold.

108. The total amount of funds improperly set off by the Government in this manner was in excess of $30 million.

109. Through these actions, the Government not only deprived CoOportunity of its timely right to these payments, it also allowed the Government to effectively jump priority over other creditors to the CoOportunity estate.

110. The Government has admitted on the record in a proceeding before the U.S. District Court for the Southern District of Iowa that it had no legal authority to institute these administrative holds.

111. The Government's administrative hold and set-off was illegal and violated the Iowa Liquidation statutes.

VII. THE UNITED STATES FAILED TO MAKE MANDATORY RISK CORRIDORS PAYMENTS TO COOPORTUNITY

112. The Government's obligation to pay risk corridors payments is mandatory pursuant to the plain language of the risk corridors provisions of the ACA, which specifies either that (1) a participating plan must pay to the Secretary of HHS certain sums if the plan's costs are less than a "target amount" of premium revenues or (2) the "Secretary *shall* pay to the plan" certain sums if the plan's costs are greater than a certain percentage of the "target amount" of premium revenues. *Id.* § 18062(b) (emphasis added).

113. Similarly, HHS's implementing regulations confirm that HHS "will pay" these amounts. 45 C.F.R. § 153.510(b).

114. Under the statute and HHS's implementing regulations, CoOportunity should have been paid and was owed $130 million from HHS under the risk corridors program for the 2014 policy year.

115. Under the statute and HHS's implementing regulations, CoOportunity should have been paid and was owed $27 million under the Risk Corridors program for the 2015 policy year.

116. Congress did not impose any financial limits or restraints on the Government's mandatory risk corridors payments to QHPs in Section 18062 or any other section of the ACA.

117. Nor did Congress in any way limit the Secretary of HHS's obligation to make full risk corridors payments to QHPs due to appropriations, restrictions on the use of funds, or otherwise either in Section 18062 or anywhere else in the ACA.

118. Accordingly, the Government lacked the statutory authority to pay anything less than 100% of the risk corridors payments due to CoOportunity for the 2014 and 2015 policy years.

119. The regulation implementing the risk corridors program imposed a 30-day deadline for a QHP to fully remit payments due to HHS under the risk corridors program. *See* 45 C.F.R. § 153.510(d).

120. During the proposed rulemaking that ultimately resulted in adoption of the 30-day deadline for QHPs to make payments, CMS and HHS stated the deadline for the Government to make risk corridors payments to QHPs "should be the same" as the QHP's 30-day deadline. *See* 76 FR 41929, 41943 (July 15, 2011); 77 FR 17219, 17238 (Mar. 23, 2012).

A. The Government Repeatedly Confirmed Its Mandatory Obligation To Make Risk Corridor Payments

121. When HHS implemented a final rule regarding HHS's Notice of Benefit and Payment Parameters for 2014, HHS confirmed, "The risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013).

122. Since Congress's enactment of the ACA in 2010, HHS and CMS repeatedly acknowledged publicly, and confirmed to CoOportunity and other QHPs, their statutory and regulatory obligations to make full and timely risk corridors payments to qualifying QHPs.

123. On July 11, 2011, HHS issued a fact sheet on HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment," stating that under the risk corridors program, "qualified health plan issuers with costs greater than three percent of the cost projections will receive payments from HHS to offset a percentage

of those losses." HealthCare.gov, "Affordable Insurance Exchanges: Standards Related to Reinsurance, Risk Corridors and Risk Adjustment" (July 11, 2011).

124. On March 23, 2012, HHS implemented a final rule regarding Standards Related to Reinsurance, Risk Corridors and Risk Adjustment (77 FR 17219). Although HHS recognized that it did not propose deadlines for making risk corridors payments, HHS stated that "QHP issuers who are owed these amounts will want prompt payment, and payment deadlines should be the same for HHS and QHP issuers." 77 FR 17219, 17238 (Mar. 23, 2012).

125. On March 11, 2013, HHS implemented a final rule regarding HHS Notice of Benefit and Payment Parameters for 2014 (78 FR 15409), and confirmed, "[t]he risk corridors program is not statutorily required to be budget neutral. Regardless of the balance of payments and receipts, HHS will remit payments as required under section 1342 of the Affordable Care Act." 78 FR 15409, 15473 (Mar. 11, 2013).

126. Exactly one year later, HHS issued further rulemaking, which indicated the "risk corridors program is likely to be budget neutral or, will result in net revenue to the Federal government." HHS Notice of Benefit and Payment Parameters for 2015, 79 Fed. Reg. 13,744, 13,829 (Mar. 11, 2014).

127. In HHS's response letter to the U.S. Government Accountability Office ("GAO") dated May 20, 2014, HHS again admitted that Section 1342(b)(1) … establishes … the formula to determine … the amounts the Secretary must pay to the QHPs if the risk corridors threshold is met." Letter from William B. Schulz, General Counsel, HHS, to Julia C. Matta, Assistant General Counsel, GAO (May 20, 2014).

128. On June 18, 2014, HHS sent to U.S. Senator Sessions and U.S. Representative Upton identical letters stating that, "As established in statute … [QHP] plans with allowable

costs at least three percent higher than the plan's target amount will receive payments from HHS to offset a percentage of those losses." Letter from Sylvia M. Burwell, Secretary, HHS, to U.S. Senator Jeff Sessions (June 18, 2014).

B. The Government Reversed Course And Claimed HHS Was Not Required To Pay Risk Corridor Obligations When They Are Due

129. Despite the mandatory language in Section 18062 of the ACA and HHS's implementing regulation, and despite the Government's repeated public statements confirming HHS's mandatory obligation to pay the full amount of risk corridors funds owed, HHS and CMS reversed course when they learned that the risk corridors program's incoming collections for the 2014 plan year would be insufficient to pay outgoing amounts owed by HHS under the program.

130. Specifically, on February 2, 2015, CMS issued an announcement, stating in pertinent part:

> HHS/CMS anticipates that Risk Corridors collections will be sufficient to pay for all Risk Corridors payments. If Risk Corridors collections are insufficient to make Risk Corridors payments for a year, all Risk Corridors payments for that year will be reduced pro rata to the extent of any shortfall. Risk Corridors collections received for the next year will first be used to pay off the payment reductions issuers experienced in the previous year in a proportional manner, up to the point where issuers are reimbursed in full for the previous years….[10]

131. On October 1, 2015, HHS and CMS announced that providers would receive only up to 12.6% owed to plans under the risk corridors program for policy year 2014.[11]

[10] *See* CMS FAX ID 8759, Pub'd 02/02/2015, available at: https://www.regtap.info/faq_viewe.php?i=8759 (emphasis added).

[11] *See* CMS, Risk Corridors Payment Proration Rate for 2014 (Oct. 1, 2015), available at https://www.cms.gov/CCIIO/Programs-and-Initiatives/Premium-Stabilization-Programs/Downloads/RiskCorridorsPaymentProrationRatefor2014.pdf.

132. HHS/CMS attributed the shortfall on the Secretary's mandated payments to the plans to a shortfall in issuer payments into the program and purported limits on the Government's ability to pay the remaining obligation despite this shortfall.

133. In a letter to another issuer, CMS confirmed that the balance of risk corridors funds owed by HHS for the 2014 policy year would be paid, but any payment was contingent on sufficient risk corridors collections for the 2015 and 2016 policy years. Letter from Kevin J. Counihan, CEO of Health Insurance Marketplaces & Dir. of CCIIO, to David L. Holmberg, President & CEO of Highmark Health (Apr. 1, 2016). In other words, the Government planned to use the funds collected from policy years 2015 and 2016 to pay off the remainder of the debt from 2014. Only after 100% of 2014 policy risk corridors payments were funded would 2015 and 2016 policy year risk corridors collections be applied to 2015 or 2016 policy year payments due to be paid by HHS.

C. The Government Again Confirmed The ACA Requires Risk Corridor Payments To Be Made In Full

134. Despite the Government's newly articulated (and incorrect) position that payment of risk corridor funds owed by HHS for a given policy year could be delayed until risk corridor revenues are received in subsequent policy years, HHS and CMS nonetheless continued to affirm HHS's obligation to pay, *in full*, amounts owed under the risk corridors program.

135. On February 27, 2015, HHS's implementation of a final rule regarding HHS Notice of Benefit and Payment Parameters for 2016 (80 FR 10749), further confirmed that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." 80 FR 10749, 10779 (Feb. 27, 2015).

136. CMS's letter to state insurance commissioners on July 21, 2015, stated in boldface text that "CMS remains committed to the risk corridors program." Letter from Kevin J.

Counihan, CEO of Health Insurance Marketplaces, CMS, to State Insurance Commissioners (July 12, 2015).

137. On November 19, 2015, CMS issued a public announcement further confirming that "HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers." Bulletin, CMS, "Risk Corridors Payments for the 2014 Benefit Year" (Nov. 19, 2015).

138. Even as recently as September 9, 2016, HHS and CMS admitted that the risk corridors payments for 2014 are currently due and are obligations of the United States for which full payment is required:

> HHS recognizes that the Affordable Care Act requires the Secretary to make full payments to issuers. *HHS will record risk corridors payments due as an obligation of the United States Government for which full payment is required.*

CMS, Risk Corridors Payments for 2015 (Sept. 9, 2016) (emphasis added).

139. Despite their numerous public statements acknowledging their present obligation to make these payments, HHS and CMS have refused to do so, shortchanging CoOportunity and other ACA insurers of billions of dollars in risk corridors funds.

140. Plaintiffs have attempted—through extensive discussions—to resolve this matter outside of this Court.

141. Despite those efforts, HHS and CMS still refuse to satisfy their obligation to pay risk corridor payments that are due and owing. Plaintiffs' only recourse is seeking a money judgment from this Court.

VIII. THE UNITED STATES APPLIED ITS ARBITRARY AND CAPRICIOUS RISK ADJUSTMENT REGULATION TO COOPORTUNITY

142. Because of the impending liquidation, CoOportunity had QHPs in effect for only the first two months of 2015.

143. CoOportunity received approximately $40 million in premiums for those two months.

144. CoOportunity's overall claims costs in 2015 continued at a rate similar to that in late 2014. Incurred claims during the first two months of 2015 totaled approximately $48 million, producing a medical loss ratio ("MLR") exceeding 100%.

145. On June 30, 2016, HHS/CMS issued a final statement of charges owed by issuers for the 2015 policy year under the risk adjustment portion of the 3Rs, which reflected risk adjustment charges of approximately $5.2 million for CoOportunity's Iowa business and approximately $17.3 million for CoOportunity's Nebraska business, for total risk adjustment charges of approximately $22.5 million for the 2015 policy year.

146. Thus, CoOportunity's risk adjustment charges for the brief period of its operation in 2015 represent over half of the premiums collected for the same time period.

147. Under the program, "low actuarial risk plans" in the individual and small group markets make risk adjustment payments to "high actuarial risk plans" in the same markets within the same state. 42 U.S.C. § 18063(a)(1)-(2).

148. The HHS/CMS risk adjustment methodology for 2014 and 2015 did not carry out Congress's intent for the risk adjustment program or the mandate of the ACA. Instead, the Government's methodology adjusts for irrelevant factors like differences in premium rates, consumer choice of metallic tier, and length of member enrollment.

149. Rather than stabilize the market place, the HHS/CMS methodology destabilized the marketplace and unfairly penalized new insurers like CoOportunity.

150. As justification for its risk-adjustment methodology, HHS/CMS stated in conclusory fashion that the program had to be budget neutral. This is incorrect; the ACA does not require the risk-adjustment program to be budget neutral.

151. HHS/CMS did not include any policy rationale or justification for its incorrect conclusion that risk adjustment had to be budget neutral.

152. This incorrect conclusion led to the adoption of arbitrary and capricious methodologies within the risk-adjustment program.

153. Specifically, as opposed to calculating the risk-adjustment payment transfers based on plans' own actual premiums, it instead chose to calculate transfers based on the state's average premium.

154. HHS/CMS's justification for using a statewide average premium was nonsensical, arbitrary and capricious, and grounded entirely in its incorrect conclusion of law that risk adjustment must be budget neutral.

155. HHS/CMS also wrongly stated that this approach would add to "predictability." While a plan is individually aware of its own premium, the statewide average premium depends on knowledge of the business decisions of all of the other insurance providers in a state.

156. A federal district court recently held that HHS/CMS's risk adjustment methodology from 2014 through the present, particularly its use of the statewide average premium and assumption that the program must be run in a budget neutral manner, was arbitrary and capricious. *New Mexico Health Connections v. U.S.*, Case No.: 16-0878-JB/JHR, 2018 WL 1136901, *37 (D. New Mexico Feb. 28, 2018) (motion to alter or amend judgment pending). The court set aside and vacated use of the formula for plan years 2014-2018 and remanded the issue back to HHS to be corrected. *Id.*

157. On July 7, 2018, HHS/CMS issued a press release in which it announced that under the ruling in *New Mexico Health Connections*, HHS/CMS would not make any further collections or payments under the program, including for the 2017 benefit year, until the litigation was resolved. *See* Exhibit A, copy of Press Release, which is no longer available on HHS/CMS website.

158. Within the same month (July 30, 2018), HHS/CMS reversed course, issuing a final rule authorizing collections and payments for the 2017 year. This time, HHS/CMS confirmed its continued use of the statewide average premium and budget neutrality, but in response to the ruling in *New Mexico Health Connections*, HHS/CMS issued an after-the-fact explanation and justification for its use of the statewide average premium and budget neutrality.[12] This post-hoc rationalization of the rule does not rectify its arbitrary and capricious deficiencies, especially for *prior* years' applications of the risk adjustment program and regulations. CoOportunity's actuarial risk scores under the Government's methodology are artificially low due to deficiencies in the Government's risk adjustment methodology, including, among other things, HHS/CMS's use of the statewide average premium to set the amount of payments and charges for the plans within each state. In addition, a plan's actuarial risk is determined on enrollees' risk scores, which are based on provider coding (hierarchical condition categories, or "HCCs") for enrollees' diagnoses and conditions during each year of the program.

159. CoOportunity's enrollment during January and February of 2015 consisted mainly of individuals who were CoOportunity enrollees during the 2014 policy period. Based on this, the actuarial risk of CoOportunity's enrollment should not deviate substantially from the risk in

[12] https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16190.pdf. On August 10, 2018, HHS issued a proposed rule relating to methodology for the 2018 benefit year, and again included this additional explanation. https://s3.amazonaws.com/public-inspection.federalregister.gov/2018-16190.pdf

2014. However, the 2015 risk scores do not reflect this because HHS/CMS's risk adjustment methodology does not provide scores reflecting the actuarial risk of enrollees when they had coverage for only the first two months (or 17%) of a calendar year.

160. CoOportunity enrollees were seeking new coverage in early 2015–at CMS's and CoOportunity's urging–due to the impending liquidation and plan terminations. This caused enrollees to avoid "double deductible" charges related to the unavoidable change of coverage to a new carrier with a new plan that would include a new deductible. This resulted in a decline in provider visits during early 2015, and a corresponding decline in provider diagnoses coding.

161. Under HHS/CMS's methodology, an individual enrollee's risk score does not transfer over from year to year, nor is the prior year's risk score (based on diagnoses codes recorded from claims submitted by providers) factored into calculations for the present year. Rather, enrollees' risk scores are calculated anew after the end of each policy year, when enrollees typically have a full year for provider visits and resulting entries of diagnosis codes for that enrollee.

162. In January and February 2015, CoOportunity enrollees continued to fill drug prescriptions for high-risk conditions, some of them very expensive. However, HHS/CMS's methodology for 2014 and 2015 did not factor in a diagnosis code or assess a risk score based on prescription drug use, even if the drugs are obviously prescribed for high-risk conditions.

163. This means that even though CoOportunity continued to cover many enrollees with high-risk conditions as established through provider diagnoses made during 2014, its resulting 2014 risk score did not carry over into 2015, and the same diagnoses codes present to establish high-risk scores in 2014 were not in 2015 data unless the member visited a doctor

during the brief period of coverage in early 2015 and filed a claim with the identifying diagnoses codes.

164. Among other things, since HHS's methodology does not account for diagnosis coding and risk scores established during 2014, but "resets" at the beginning of 2015, the extremely limited coverage period caused CoOportunity's 2015 diagnosis coding and resulting risk scores to be inaccurate, artificially deflated, and not reflective of the actual risk as intended by the ACA.

165. HHS/CMS's methodology assumes a full twelve-month calculation period, and does not factor into or account for situations involving shorter plan periods. Because a shorter plan period necessarily means a shorter "window" for provider visits, medical events and corresponding diagnosis coding, an obvious result is risk scores that do not reflect actual risk because they are artificially deflated due to the short period of possible claims experience. This is particularly the case in CoOportunity's situation of only having two months of enrollee experience in early 2015, ten to twelve months less than the enrollee experience for other carriers in Iowa and Nebraska. This meant CoOportunity's artificially low risk were measured against the scores of other carriers which were much more reflective of actual risk (at least under HHS/CMS's flawed methodology for measuring risk).

166. Among other factors, the sharp drop in total exposure months had a major impact on the percent of enrollees with claims, percent of enrollees with at least one HCC, the number of claims per enrollee, the number of conditions per enrollee, and risk scores assigned. CoOportunity's member months in 2015 dropped by 83% in Nebraska; in Iowa, member months in 2015 declined by 92% due to the abbreviated coverage period.

167. CoOportunity's 2015 risk adjustment charges are grossly disproportionate, and do not reflect the true actuarial risk of CoOportunity's enrollees as intended by the ACA.

168. In addition, the risk adjustment charge of $10 million assessed to CoOportunity for 2014 did not accurately reflect the actuarial risk of CoOportunity's enrollees as intended by the ACA because, among other reasons, HHS/CMS's risk adjustment methodology did not accurately account for prescription drugs utilized by members and arbitrarily utilized an average statewide premium factor.

169. Due to these irrational and improper applications of the risk adjustment program to CoOportunity for only two months of operation in 2015, CoOportunity requested via letter dated May 24, 2016, that it be excluded from the risk adjustment program for 2015, even though it remained open at the request of CMS.

170. HHS/CMS summarily rejected this request.

171. On April 9, 2018, HHS/CMS issued a memorandum stating that insurers in liquidation would no longer be subject to risk adjustment—the precise relief CoOportunity requested, and was denied, for 2015.

172. HHS/CMS's risk adjustment methodology for 2014 and 2015 is therefore arbitrary, capricious, and an abuse of discretion, and contrary to the risk adjustment statute. In addition, HHS/CMS's refusal to exempt CoOportunity from risk adjustment for the 2015 benefit year was arbitrary and capricious and contrary to the risk adjustment statute.

COUNT I
Payment of Funds Owed Under Money-Mandating Risk Corridors Statute

173. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

174. Section 1342(b)(l) of the ACA mandates compensation, stating the Secretary of HHS "shall pay" risk corridors payments to issuers in accordance with the payment formula set forth in the statute.

175. HHS and CMS's implementing regulation at 45 C.F.R. § 153.510(b) also mandates compensation, stating that HHS "will pay" risk corridors payments to issuers in accordance with the payment formula set forth in the regulation, which is mathematically identical to the formula in § 1342(b)(1) of the ACA.

176. CoOportunity is entitled under Section 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b) to recover full and timely mandated risk corridors payments from the Government in the amount of $130 million for policy year 2014 and $27 million for policy year 2015.

177. Congress's failure to appropriate sufficient funds for risk corridors payments due did not and could not defeat or otherwise abrogate the United States' statutory obligation created by § 1342 to make full and timely risk corridors payments to issuers, including CoOportunity. *See, e.g.*, *Moda*, 892 F.3d at 1325 & n.6.

178. The United States has failed to make full and timely risk corridor payments to CoOportunity, despite the Government confirming in writing that such payments are mandatory.

179. The Government's failure to make full and timely risk corridors payments to CoOportunity constitutes a violation and breach of the Government's mandatory payment obligations under § 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b).

180. As a result of the Government's violation of Section 1342(b)(1) of the ACA and 45 C.F.R. § 153.510(b), CoOportunity has been damaged in the amount of at least $157 million. The Court should enter judgment in favor of CoOportunity for at least that amount and award pre and post-judgment interest, costs, and all other relief this Court deems just and proper.

COUNT II
Breach Of Express and Implied Contract for Risk Corridors Payments

181. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

182. The ACA was essentially a contractual offer by the Government to health insurance carriers: that is, if carriers sold QHPs under the ACA, those carriers would be entitled to the protections under the 3Rs programs to mitigate against risks associate with the launch of the ACA.

183. CoOportunity was one of the carriers that accepted this offer by agreeing to operate as a CO-OP and to sell QHPs. Under the ACA, as a CO-OP, CoOportunity was *required* to offer QHPs in the marketplaces. Consistent with that requirement, CoOportunity's Loan Agreement with the Government *required* CoOportunity to offer QHPs. As it prepared operate as a CO-OP, CoOportunity entered into a valid written QHP Agreement with CMS. The terms of offer and acceptance were unambiguously specified in 42 U.S.C. § 18062 and its implementing regulations, including C.F.R. 153.510.

184. The Loan Agreement and QHP Agreement were executed by representatives of the Government who had actual authority to bind the United States, and were entered into with mutual assent and consideration by both parties.

185. The QHP Agreement obligated CMS to "undertake all reasonable efforts to implement systems and processes that will support [QHP] functions." *Id.* at 5.

186. By agreeing to operate as a CO-OP and sell QHPs under the ACA, CoOportunity agreed to accept the obligations, responsibilities and conditions the Government imposed on QHPs under the ACA and, *inter alia*, 45 C.F.R. §§ 153.10 *et seq.* and 155.10 *et seq.* *See id.*; Martin E. Hickey, *Qualified Health Plan Program Attestations* (Apr. 25, 2013).

187. By operating as a CO-OP and selling QHPs, CoOportunity satisfied and complied with its obligations and/or conditions under the implied and express contracts with the Government.

188. The QHP Agreement incorporates the provisions of § 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b), meaning the Government had a contractual duty to make full and timely risk corridor payments to CoOportunity.

189. In exchange for CoOportunity's participation in the new and risky ACA marketplace, the Government obligated itself to make full and timely risk corridor payments to CoOportunity. CoOportunity was induced to enter the Loan Agreement and the marketplace by this representation and obligation, and the Government's abidance by the terms of the 3R programs was essential and material to CoOportunity's decision.

190. The Government materially breached its implied and express contracts with CoOportunity when it failed to make full and timely risk corridor payments to CoOportunity for policy years 2014 and 2015.

191. As a result of the United States' material breach of contract, CoOportunity has been damaged in the amount of at least $157 million, together with interest, costs of suit, and such other damages or relief as this Court deems just and proper.

192. Additionally, a covenant of good faith and fair dealing is implied in every contract, including those with the Government, and imposes obligations on both contracting parties that include the duty not to interfere with the other party's performance and not to act so as to destroy the reasonable expectations of the other party regarding the fruits of the contract.

193. Under the ACA, the Loan Agreement and QHP Agreement, CoOportunity agreed to sell and provide health care coverage to individuals under qualified health plans in 2014 and

2015, subject to state and federal laws, regulations, and policies. This created the reasonable expectation for CoOportunity that any risk corridor payments owed to it would be paid by the Government in full and in a timely manner, just as the Government expected that any risk corridor remittance charges it was owed would be fully and timely paid by CoOportunity.

194. By failing to make full and timely risk corridor payments to CoOportunity, the United States has destroyed CoOportunity's reasonable expectations regarding the fruits of the QHP Agreement and the Loan Agreement, in breach of the implied covenant of good faith and fair dealing, especially given the Government's insistence that CoOportunity and other QHPs remit any amounts owed under the risk corridors program within 30 days.

195. As a result of the United States' breach of contract, breach of the explicit QHP Agreement, the Loan Agreement, and the covenant of good faith and fair dealing, CoOportunity has been damaged in the amount of at least $157 million. The Court should enter judgment in favor of CoOportunity for at least that amount and award pre and post- judgment interest, costs, and all other damages or relief deemed just and proper.

COUNT III
Improper Administrative Hold and Set Off By The Government

196. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

197. Under Iowa law, the Government's claims against CoOportunity are subordinate to administration costs of the liquidation and to the claims of policyholders and their healthcare providers.

198. In an attempt to circumvent Iowa law governing priority, and in disregard of the liquidation court's Liquidation Order, the Government placed an illegal hold on funds it owed to

CoOportunity and then illegally set-off those funds to pay the Government for claimed debts owed by CoOportunity as those debts became due.

199. The Government had no authority to issue an administrative hold and violated Iowa law and the Liquidation Order by doing so.

200. The Government had no authority to set off amounts it owed to CoOportunity and violated Iowa law and the Liquidation Order by doing so.

201. To the extent federal law governs the Government's claims against CoOportunity, the Government had no authority under federal law to impose an administrative hold and to engage in set-off.

202. The Government's set-off violated Iowa law governing priority because the Government and CoOportunity's debts were non-mutual and the Government's loans were *de facto* capital contributions. To the extent federal law applies, set-off was improper because, among other things, the Government owed CoOportunity more than any debt of CoOportunity subject to any arguable set-off rights. In particular, the full risk corridor payments were obligations of the federal government to CoOportunity, which far exceeded any debt owed by CoOportunity that was even arguably subject to set-off rights.

203. In addition, HHS/CMS's reduction of payments owed to CoOportunity in order to collect risk adjustment charges (via setoff) was improper because the general risk adjustment methodology for 2014 and 2015 was arbitrary and capricious and illegal, and HHS/CMS's specific refusal to exempt CoOportunity from the risk adjustment program for the 2015 benefit year, even though CoOportunity was only in the program for two months, was arbitrary, capricious and illegal.

204. The Government's administrative holds and set-offs violated the terms of the Loan Agreement, under which the Government's claims are subordinate to policyholder claims and any payment of claims by CoOportunity is subject to Iowa laws governing insolvency.

205. As a result of the Government's illegal administrative hold and set-off practice, CoOportunity was damaged in the amount of in excess of $30 million. The Court should enter judgment in favor of CoOportunity for at least that amount and award pre and post-judgment interest, costs, and all other damages or relief deemed just and proper.

COUNT IV
Breach of Contract by Wrongful Setoff

206. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

Breach of contract through set-off which contravened provisions of the Loan Agreement.

207. The Loan Agreement contains a *parri passu* provision which ties the priority of the Start-Up Loan to the priority of the Solvency Loan. Loan Agreement, p. 8, § 3.1.

208. Repayment of the Start-Up Loan and the Solvency Loan were both contractually subordinated by the Government to the payment of other creditor claims of CoOportunity.

209. Under the subordination provisions of the Loan Agreement, CoOportunity's policyholders and other creditors were to be paid before the Government was paid any monies owed.

210. Additionally, CoOportunity's obligation to repay the Start-Up Loan was "subject to Borrower's ability to meet State Reserve Requirements and other solvency regulations or requisite surplus note arrangements." Exhibit A, § 4.4.

211. The provisions of the Loan Agreement subordinating the Government's claims and conditioning CoOportunity's obligation to repay the loan are material and essential to protect the rights of CoOportunity's policyholders and to comply with Iowa law.

212. Given CoOportunity's insolvent condition, it did not have the ability to meet State Reserve Requirements and other solvency regulations. As such, CoOportunity was contractually excused from repaying the start-up loan until other creditors could be paid.

213. Commencing in March 2016, the Government began to illegally set-off funds it illegally held and owed to CoOportunity to pay off amounts allegedly owed by CoOportunity under the start-up loan.

214. By engaging in such set-off, the Government breached the subordination provisions of the Loan Agreement because it obtained payment at the expense of CoOportunity's policyholders and other creditors to whom the Government had expressly subordinated itself under the terms of the Loan Agreement and amendments thereto.

215. Given the provisions of § 4.4 of the Loan Agreement and given CoOportunity's insolvent condition, CoOportunity did not have an obligation to repay the start-up loan to the Government until other creditors could be paid. As such, the Government's set-off breached the Loan Agreement because it enabled the Government to retain $14.7 million which it had no contractual basis to retain.

216. CoOportunity was damaged in the amount of $14.7 million due to the Government's breach of the Loan Agreement. This Court should enter judgment in favor of CoOportunity for at least that amount and award pre and post-judgment interest, costs, and all other relief deemed just and proper.

Breach of contract through set-off that breached the terms of the QHP Agreement

217. As part of the ACA and as part of the consideration to induce CoOportunity to enter into the QHP Agreement, the Government promised that CoOportunity would receive the full benefit of the 3R, reinsurance, risk adjustment, and risk corridor programs.

218. Under the QHP Agreement the Government had an absolute and non-discretionary obligation to make full, complete and timely 3R payments to CoOportunity.

219. The Government's obligation to make full and timely 3Rs payments was material to CoOportunity, which would not have entered into the risky health insurance marketplace without assurance the Government would abide by its obligations under the 3Rs.

220. As set forth above in Count I and Count II, the Government failed to pay CoOportunity the full amount of risk corridors funds owed to CoOportunity for policy years 2014 and 2015.

221. While the Government did assign a small, pro rata amount of policy year 2014 risk corridor funds to pay to CoOportunity, the Government then illegally held and set-off those funds without legal basis and in violation of law.

222. Additionally, in May 2016 the Government wrongfully withheld the CoOportunity 2015 reinsurance payment, again engaging in an illegal administrative hold and eventual setoff. This hold/set-off practice continued over subsequent months with respect to other amounts owed by HHS to CoOportunity.

223. Setting off CoOportunity's pro rata risk corridors payment and reinsurance payment breached the Government's obligation under the QHP Agreement to make full and timely 3R payments to CoOportunity.

224. The Government's breach of the QHP Agreement excused CoOportunity's future obligations under the QHP Agreement, including CoOportunity's obligation to pay risk adjustment charges.

225. Because CoOportunity's obligation to pay risk adjustment charges was excused by the Government's prior breach, the Government breached the QHP Agreement again when it set-off additional funds it owed CoOportunity in order to pay other insurers the $22.5 million it asserted CoOportunity owed for policy year 2015 risk adjustment.

226. In addition, HHS/CMS's reduction of payments owed CoOportunity in order to collect risk adjustment charges for 2014 or 2015 was illegal, improper, and in breach of contract in that those charges have been vacated by the New Mexico District Court because HHS/CMS's risk adjustment methodology was arbitrary and capricious.

227. CoOportunity was damaged in the amount in excess of $30 million as a result of the Government's contractual breach of the QHP Agreement as it pertains to the illegal and improper hold and set-offs. The Court should enter judgment in favor of CoOportunity for at least that amount and award pre and post-judgment interest, costs, and all other relief deemed just and proper.

In the alternative, breach of contract of the QHP Agreement based on being a mere conduit

228. Pleading in the alternative, using a governmental unit as conduit/intermediary administrator, the risk adjustment program was intended to transfer funds from "low actuarial risk plans" to "high actuarial risk plans" within the same state. *See* 42 U.S.C. § 18063.

229. The ACA contemplated that the states would serve as the conduit/intermediary administrator for the risk adjustment program. Because neither Iowa nor Nebraska elected to

operate an exchange, under 45 C.F.R. § 153.310(a)(2), HHS was designated as the entity to administrator the risk adjustment activities on behalf of those states.

230. HHS/CMS served as a conduit for the required payments, which are distributed to spread risk around the market. *See* 42 U.S.C. § 18063; 45 C.F.R. § 153.310(a)(2).

231. Although HHS/CMS serves as an administrator for risk adjustment money transfers, the actual debt obligations run between the insurers that owe risk adjustment payments (on the one hand) and the insurers due risk adjustment payments in the specific markets in Iowa and Nebraska (on the other hand).

232. HHS/CMS operated the risk adjustment program in a cash neutral manner such that actual proceeds received from low actuarial risk plans were transferred to high actuarial risk plans.

233. As the administrator of the risk adjustment program, HHS/CMS was not entitled to retain for its own use monies received from low actuarial risk plans. Rather, it was obligated to simply obtain those funds from low actuarial risk plans and disburse them to high actuarial risk plans.

234. As of August 2015, the Government asserted that CoOportunity was responsible to pay $22 million total for risk adjustment. Assuming these monies were actually owed, they were to be provided to HHS/CMS who, acting simply as a conduit for the risk adjustment monies but who did not have any lawful right to retain use of those funds for its own benefit, was supposed to redistribute the monies to high actuarial risk plans.

235. When acting as the intermediary/conduit for risk adjustment payments, HHS/CMS has not been given any statutory or administrative authority to recover risk adjustment payments from low actuarial risk plans or set off for such funds from wrongfully

withheld funds, particularly where HHS/CMS imposed an indefinite hold on funds until there was a debt against which to set off those funds. 42 U.S.C. § 18063; 45 C.F.R. § 153.310.

236. Nevertheless, the Government engaged in an improper and unauthorized self-help remedy by setting off or netting a total of $22.5 million in risk adjustment charges which CoOportunity allegedly owed for risk adjustment payments against that same amount that the Government owed CoOportunity under other provisions of the 3Rs, but which the Government had refused to pay to CoOportunity.

237. The QHP Agreement contains the following provision: "As part of a monthly payments and collections reconciliation process, CMS will recoup or net payments due to [CoOportunity] *against amounts owed to CMS by [CoOportunity]*…with respect to offering of QHPs, including the following types of payments: APTCs, advance payments of CSRs, and payment Federally-facilitated Exchange user fees." QHP Agreement, p. 5, § II.c (emphasis added).

238. While the Government clearly owed CoOportunity risk corridor and other 3R payments, in contrast CoOportunity did not have an actual debt obligation to the Government by virtue of the risk adjustment payments because HHS/CMS was simply serving as an administrator of that program and the real creditors were the other insurers in the specific markets in the states of Iowa and Nebraska.

239. In addition, the risk adjustment charges have been vacated by the New Mexico District Court, making set-off to collect those charges improper, illegal, and in breach of contract.

240. By effectuating the set-off to recover allegedly owed risk adjustment funds, the Government breached the QHP Agreement which only allows for set-off of actual obligations

owed directly between CoOportunity and HHS/CMS. Stated differently, the Government breached the QHP Agreement by effectuating the set-off because a mutuality of debts was lacking as required by the QHP Agreement. This breach occurred after CoOportunity's obligations to perform under the QHP agreement were excused by the Government's prior breach of the QHP agreement.

241. CoOportunity was damaged in the amount of at least $22.5 million as a result of the Government contractual breach based on its improper set-off of risk adjustment amounts. The Court should enter judgment against the Government for at least that amount and award CoOportunity pre and post-judgment interest, costs, and all other relief deemed just and proper.

COUNT V
Unlawful Taking

242. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

243. In October 2015, the Government elected to pay 12.6% of the risk corridors payments to providers for policy year 2014. *See* ¶ 121. In addition, in 2016 the Government used risk corridor collections for 2015 to pay a portion of balances owed on 2014 benefit year risk corridors payments.

244. CoOportunity's pro rata payment of the risk corridors funds for 2014 constituted a property interest of CoOportunity.

245. The Government unlawfully withheld payments from CoOportunity through an "administrative hold" that the Government later admitted it had no legal authority to institute.

246. The Government then later declared that it was permanently withholding the funds as a set-off.

247. The Government's administrative hold of these funds and the ultimate withholding of the funds constituted a governmental taking in violation of the Fifth Amendment to the United States Constitution.

248. CoOportunity did not receive any just or reasonable compensation from the Government in exchange for HHS/CMS's retention of the risk corridors monies.

249. The CoOportunity estate is lawfully entitled to be compensated for the amount of risk corridors monies that were improperly taken by the Government, totaling $157 million, plus all legally available interest.

250. Further, the risk adjustment monies that were slated to be provided to CoOportunity constituted a property interest of CoOportunity.

251. The Government's retention of the risk adjustment monies that were supposed to be given to CoOportunity constituted a governmental taking in violation of the Fifth Amendment to the United States Constitution.

252. CoOportunity did not receive any just or reasonable compensation from the Government in exchange for HHS/CMS's retention of the risk adjustment monies.

253. The CoOportunity estate is lawfully entitled to be compensated for the amount of risk adjustment monies that were improperly taken by the Government, including all legally available interest. The Court should enter judgment in favor of CoOportunity in an amount to be determined and award CoOportunity pre and post-judgment interests, costs, and all other relief deemed just and proper.

COUNT V
Payment Of Funds Improperly Collected Based On Now-Vacated, Arbitrary And Capricious Risk Adjustment Rules for the 2014 and 2015 Benefit Year

254. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

255. HHS/CMS's promulgation of its risk adjustment methodology and its application of that methodology to CoOportunity are final agencies actions.

256. As discussed and alleged above, HHS/CMS's risk adjustment methodology is arbitrary, capricious, and an abuse of discretion, and contrary to the risk adjustment provisions of the ACA, and is thus invalid under the Administrative Procedures Act.

257. The invalid methodology in the risk adjustment program includes, but is not limited to, HHS/CMS's decision to use statewide average premium for its baseline premium to calculate transfers, as opposed to a plan's own premium, its assumption of budget neutrality in relation to the risk adjustment program, its failure to account for partial year enrollment, and its failure to utilize pharmacy prescription data to identify health diagnoses for risk score calculations.

258. The Government has set off to collect $32.5 million ($10 million in 2014 and $22.5 million in 2015) in risk adjustment payments it claims were due pursuant to this arbitrary, capricious, and illegal risk adjustment methodology.

259. Thus, because the Government set off these funds due to an illegal (and improperly applied) regulation, the setoffs are invalid, and CoOportunity is entitled to be repaid the funds wrongfully taken by the Government, including all legally available interest. The Court should enter judgment in favor of CoOportunity in an amount to be determined and award pre and post-judgment interests, costs, and all other relief deemed just and proper.

COUNT VII
Payment of Funds for Arbitrary. Capricious, and Illegal Refusal to Exempt CoOportunity from the Risk Adjustment Program for 2015

260. Plaintiffs re-allege and incorporate by reference all of the allegations contained in the preceding paragraphs as if fully set forth herein.

261. Even if the risk adjustment regulations themselves are valid, HHS/CMS applied them in an arbitrary and capricious fashion with respect to CoOportunity's risk adjustment obligation for 2015 by failing to account for the limited period of time CoOportunity operated in policy year 2015. HHS/CMS's determination in April 2018 that exempts insurers in liquidation from risk adjustment calculations and charges demonstrates its denial of CoOportunity's request for such action in May 2016 was arbitrary and capricious.

262. HHS/CMS's refusal to exempt CoOportunity from the 2015 benefit year risk adjustment program was arbitrary, capricious, an abuse of discretion, and illegal. As a result, HHS/CMS's risk adjustment charge of $22.5 million to CoOportunity for the 2015 benefit year and collection of that charge via set-off were arbitrary, capricious, an abuse of discretion, and illegal. The Court should enter judgment in favor of CoOportunity in an amount to be determined and award pre and post-judgment interests, costs, and all other relief deemed just and proper.

WHEREFORE, Plaintiffs respectfully request that this Court enter judgment in their favor and against the Defendant, the United States of America, and requests the following relief.

1. That the Court award money damages in the amount CoOportunity is entitled to under § 1342(b)(l) of the ACA and 45 C.F.R. § 153.510(b) regarding the policy year 2014 and 2015 risk corridor payments;

2. That the Court award damages sustained by CoOportunity as a result of the Government's engaging in illegal and unauthorized administrative hold and set-off of CoOportunity funds;

3. That the Court award damages sustained by CoOportunity as a result of the Government's breach of express and implied contract;

4. That the Court award CoOportunity damages sustained by CoOportunity as a result of the Government's arbitrary, capricious, and unlawful risk adjustment charges;

5. That the Court award CoOportunity such additional damages and other monetary relief as is available under applicable law;

6. That the Court award all available interest, including, but not limited to, pre- and post-judgment interest, to CoOportunity;

7. That the Court award all available attorneys' fees and costs to CoOportunity; and

8. That the Court award such other and further relief to CoOportunity as the Court deems just and proper.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that on August 24, 2018, I filed the foregoing document via the Court's ECF system, which will cause a true and correct copy of the same to be served electronically on all ECF-registered counsel of record.

/s/ DOUGLAS J. SCHMIDT
Attorney for Plaintiffs